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Maternity Services Consumer Council

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

This is the fourth and final issue of the MSCC's Newsletter for 2012. Since we sent out the September newsletter we have produced another new pamphlet in our "The Facts" series, joined the *26 for babies* campaign and produced a submission to the select committee, written grant applications, and mailed out thousands of our pamphlets.

Congratulations to Nicola & her family
Nicola's baby daughter, Poppy, was born on 28 September weighing 1.5kg. Since her early arrival Poppy has thrived and in November attended her first MSCC meeting. We look forward to seeing her at many more MSCC meetings.

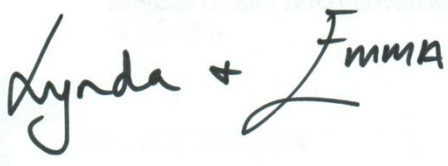
Funding application results
Thanks to the efforts of both Nicola and Emma the MSCC received a total of $6,733 from four of the five regional COGS committees, $5,000 for the reprinting of some of our pamphlets from Pub Charity, and $5,760 from the ASB Community Trust for some of our administration and organisational costs. The MSCC is very appreciative of the funding we have received this year, and we end the year with enough money to carry us through to the end of the summer.

Another new pamphlet
The MSCC has produced a third new pamphlet in our "The Facts" series – *Labour and Birth in Water*. See page 10 for further information on these. An order form is available on the MSCC website – www.maternity.org.nz

What's in this issue of the newsletter
The December issue of the newsletter contains an article by a retired obstetrician on why cutting the cord before it has stopped pulsating is harmful to the baby, an article on what the MOH's maternity report revealed about the outcomes for healthy first-time mothers, a summary of the review of Counties Manukau DHB's maternity services, information on our three new pamphlets, an update on Mothers Milk NZ, and a book review.

Don't forget to check the dates for the MSCC's Steering Group meetings for 2013.

We wish you all a very happy Christmas and New Year, and hope you all find time for plenty of rest and relaxation over the summer break.



THE DANGERS OF EARLY CORD CLAMPING

In November 2012 the *Journal of Obstetrics and Gynaecology* featured an online review of early cord clamping vs delayed clamping. Written by DJR Hutchon, a retired obstetrician in the UK, the review outlined the history of early cord clamping, examined the evidence for its introduction and continued use, and the need to abandon this intervention due to the adverse impact it has on the baby.

"Over the past 40 years, there have been a number of review articles attempting to rationalise cord clamping practice. Early cord clamping was originally thought to be important in active management of third stage of labour, but this was never evidence based. Without an evidence base to justify it, early cord clamping in clinical practice has remained very variable," the review began. (1)

The practice of early cord clamping varies among practitioners and in different countries. This is because some believe the baby does not get enough blood when the cord is clamped quickly, while others believe the baby may get too much blood when clamping is delayed until the cord has stopped pulsating.

Definitions
In his review, Hutchon defines immediate or early cord clamping (ICC) as clamping the umbilical cord while there is still significant circulation. This is clearly an intervention, he says. Delayed cord clamping (DCC) is when the physiological process of vessel constriction has commenced or been completed. DCC means there will be less or no impact on the baby's circulation.

History
The tradition of using a linen tie around the umbilical cord goes back thousands of years, but Aristotle realised that the baby may be harmed if tying and cutting the cord too soon after the birth. He wasn't alone is his belief. In the last decades of the 18th century both Erasmus Darwin and Charles White proposed that the baby may be harmed if the cord is clamped too soon.

The 20 May 1899 issue of the *Lancet* featured a brief article by Edward Magennis in which he announced that he had designed a midwifery surgical clamp to take the place of scissors and ligatures. This first cord clamp came with instructions that it should only be applied when "the cord has ceased to pulsate."

Textbooks
In his review Hutchon points out that the majority of English language textbooks do not provide an accurate description of physiological transition, that period of time when the baby's circulatory system is making significant changes as it makes the transition from life inside the womb to breathing on its own. While the physiology of transition is only partly understood, natural closure of he placental circulation does occur within about five minutes. It does not require the outside intervention of a cord clamp, Hutchon maintains. He goes on to state that

"virtually every textbook of physiology describes the cord clamp as part of the physiological process. At best, these descriptions are confusing to a student, but they also affect research papers. A study to define the normal range heart rate in the first 10 minutes after birth of infants who did not receive any postnatal medical interventions, ignored the fact that all these babies had had the medical intervention of early cord clamping."

Hutchon also takes issue with the use of the terms "delayed cord clamping" which he argues implies a delay in something which should be done sooner, and "placental transfusion" which implies a specific volume of blood being transferred from the placenta to the baby. This blood is actually the baby's own blood.

The evidence

The evidence about cord clamping is separated between pre-term babies and term babies. Hutchon refers to the evidence of two systematic reviews which demonstrated that there are short-term benefits for pre-term babies – less need for transfusion, less anaemia, less intraventricular haemorrhage and less late onset sepsis – when the cord is left to stop pulsating before it is clamped. Delayed cord clamping also seems to offer a protective effect for very low birth weight male infants against motor disability at seven months corrected age

He also points out that all the studies compared delayed cord clamping as the intervention or the experimental treatment with ICC as the control. This has the effect that when the difference is slight, evidence to support DCC is weak. The reality is that ICC is the intervention and all studies therefore show weak evidence of harm for ICC. According to Andrew Weeks, if immediate cord clamping was a medication it would be withdrawn immediately. (2)

Informed consent

As ICC is not thought of as an intervention, then midwives and obstetricians may well not discuss the issue, or ask for consent when carrying out cord clamping. Hutchon maintains that because the procedure is interfering with normal physiology, informed consent is legally required. Mothers must therefore be given information about the advantages of DCC and the impact on the baby of ICC.

"ICC immediately stops the return of oxygenated blood and results in increasing asphyxia of the neonate. It also results in a degree of hypovolaemia [a state of decreased blood volume or decrease in volume of blood plasma], which sometimes can be severe. Both asphyxia and hypovolaemia would distress an adult and indeed may be fatal." (1) Hutchon states that ICC is probably unethical.

References

1. DJR Hutchon. "Immediate or early cord clamping vs delayed clamping." *Journal of Obstetrics and Gynaecology*. November 2012;32:724-729.

2. A Weeks. "Early umbilical cord clamping increases the risk of neonatal anaemia and infant iron deficiency." *British Medical Journal*. 2004. 335:312.

Risky Deliveries for Healthy Mums

Newspaper reports[i] about the latest release of the Ministry of Health's Maternity Clinical Indicators [ii] suggest that either; reporters and some organisations do not understand the origins and meaning of these *'indicators',* or they have no concern for the welfare of healthy, first-time mothers and their babies?

The various rates of different childbirth interventions reported last month by the MOH, including caesarean section rates, are the outcomes ONLY for women who are *'standard primipara'*; that is they are healthy, first-time mothers *"aged between 20 and 34 years at the time of birth in a hospital or birthing unit",* whose birth of a single, head first baby at term followed a pregnancy with no *"recorded obstetric complications that are indications for specific obstetric intervention."* Their healthy circumstances mean they are amongst the most likely women who should have had a normal or natural labour and birth. Or as this report says, this group should have had *"low intervention and complication rates …… consistent across hospitals"*.

However, this report states, for example, that during 2010 in New Zealand hospitals:

- only 50.6% to 85.5% of all the healthy, first-time mothers in their local DHB had a vaginal delivery (which may have been induced and, or augmented).
- from 4.4% to 23.5% of all the healthy, first-time mothers in their DHB had an Instrumental delivery.
- from 8.5% to 25.9% of all the healthy, first-time mothers in their DHB had a caesarean section.
- only 16.7% to 58.3% of all the healthy, first-time mothers in any DHB had an Intact perineum.

Thus this report shows the variable rates of traumatic interventions for healthy, first-time mothers birthing in New Zealand hospitals, depending on who is caring for them or in which hospital. This report is NOT about the percentage of ALL women undergoing each or only one intervention in each DHB in 2010, for example caesarean delivery as suggested by the media response.

Here in New Zealand, unlike in the UK[iii] there is no MOH definition about, and therefore no collecting the numbers (or percentages) of women who labour and birth their babies naturally in any maternity unit, whether they are having their first, or a subsequent baby. Though approximately 5% of New Zealand women who currently birth at home each year, begin and end their labours naturally.

Thus the MSCC through the Maternity Manifesto is seeking government and community support for "*Labour and birth which start, progresses and ends naturally to be the New Zealand definition of "normal birth" and the gold standard or goal for maternity services quality assessment*".

Uninformed Maternity Media and Commentators

The medical language and statistical format of this MOH report makes its meaning and significance unclear to many people. Thus "*Jenn Hooper, spokeswoman for 'Action to Improve Maternity', slammed the results and review as meaningless* saying "*With caesareans, unless they are actually leading to a lot of deaths do we actually care?"* However those of us who know about maternity issues and research are very concerned about the costs to individual women, babies, families and our society including the health budget, of inappropriately high and rising levels of traumatic birth events, in an otherwise healthy population.

New Zealand families deserve to have a maternity care system which prioritises the healthiest outcomes for the majority of its population and accountability for the outcomes of its services New Zealand families and the community also need investigative journalists to present balanced and knowledgeable analysis of our health service and its outcomes.

If you agree please sign-up as an individual and, or group supporter of the Maternity Manifesto, and encourage others to do the same at www.maternitymanifesto.org.nz.

[i] http://www.stuff.co.nz/auckland/local-news/7933263/Review-into-caesarean-birthshttp:
[ii] http://www.health.govt.nz/publication/new-zealand-maternity-clinical-indicators-2010
iii http://www.rcog.org.uk/what-we-do/campaigning-and-opinions/statement/rcog-statement-response-joint-commissioning-document

MSCC Meeting Dates for 2013

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 first half of 2013 are**:**

5 February, 5 March, 2 April, 7 May, 4 June and 2 July.

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.

MATERNITY CARE IN COUNTIES MANUKAU IS FAILING MOTHERS & BABIES

The report of the review of maternity care in the Counties Manukau DHB area was released on 15 November. Commissioned by the Counties Manukau DHB, the Maternity Care Review Panel was chaired by Professor Ron Paterson and panel members included Anne Candy, Siniua Lilo, Professor Lesley McCowan, Dr Ray Naden and Maggie O'Brien.

In the Chairman's Foreword, Ron Paterson stated that many women with high needs do not have access to an adequate standard of maternity care, and that decisive action is needed to address the underlying population health factors that contribute to Counties Manukau's high rates of perinatal morbidity and mortality.

Nothing new

The contributing factors to the rate of perinatal morbidity and mortality in Counties Manukau identified in the report are not new to many of the health professionals and consumer groups who have been involved either directly or indirectly in maternity care in the Auckland region over the past decade. Attempts have been made over the years to draw attention to the concerns of the women about the state of maternity care in South Auckland and to get the DHB or the Ministry of Health to do act. The general public knew almost nothing about these problems because, unlike other DHBs, the vast majority of items about maternity services included in the agendas of Counties Manukau DHB meetings took place 'in committee.' What finally led to the commissioning of this review was the 5th Annual Report of the National Perinatal and Maternal Mortality Review Committee (PMMRC) which identified that Counties Manukau had a significantly higher perinatal mortality rate than the rest of New Zealand, particularly among Maori and Pacific women.

Access to LMC midwives and continuity of care

One of the issues identified by the review was that pregnant women in Counties Manukau do not have the same level of access to self-employed midwives that women in other DHBs do. Only 51% of pregnant women in Counties Manukau have their primary maternity care provided by an LMC midwife. There are a number of reasons behind the low numbers of LMC midwives providing care in South Auckland. Many women in this area are living in poverty, have few resources and when they are pregnant they present with complex health, financial and social needs. Because the Section 88 funding mechanism is a one-size-fits-all payment system which has no financial incentives to provide the extra care that these women need, self-employed midwives are understandably reluctant to take on these women and provide LMC care.

The other models of care available in South Auckland are what are referred to as case-loading DHB midwives, and shared care in which maternity care is shared

between a GP and the Counties Manukau DHB midwifery team. Neither of these two models of care provides the same level of continuity of care that LMC midwifery care does, and there have been complaints about the shared care arrangement for many years. There are concerns about the knowledge, expertise and skills of the GPs providing shared maternity care in South Auckland, some of whom are not appropriately qualified to provide maternity care. It is doubtful as to whether they engaged in continuing medical education activities that focus on providing primary maternity care, and whether they are vocationally registered.

The maternity care provided by this shared care model is substandard and the MSCC has been aware for some years that pregnant women were not being advised of their options by the shared care GPs. Women have phoned the MSCC office complaining about the care they received, their lack of choices, being seen by different doctors and midwives during their antenatal visits, and the unacceptably few postnatal visits.

The inadequate level of maternity care being provided in South Auckland has been allowed to continue for a number of years and this has undoubtedly contributed to self-employed midwives not wanting to work there. It should not have taken a PMMRC report to finally galvanise Counties Manukau DHB into action, if indeed they have been galvanized into action.

MOH responsibility

The Ministry of Health must also share some of the responsibility for the current situation. The Ministry has permitted the Counties Manukau DHB to continue flouting the maternity service requirements that other DHBs were required to meet. Concerns about the situation in Counties Manukau have been expressed at both national and regional meetings during the past decade. When exceptions to maternity service requirements are permitted, it is of course mothers and babies who suffer the consequences.

Increase in Section 88 funding

The increase in Section 88 funding that midwives obtained this year was insufficient and will do nothing to improve the LMC midwifery shortage in South Auckland. The NZ College of Midwives made extensive submissions to the Ministry about the need to increase the Section 88 fees as there had been no fee increase since 2007. The result was a small increase in fees for first trimester care and for postnatal care. It is woefully inadequate and does little to cover the increased workload midwives have to take on. It also will not cover the extra maternity care and support needed by mothers in South Auckland who have complex health and social needs.

Mothers and babies in Counties Manukau

The report notes that 14% of all births in New Zealand are to women residing in Counties Manukau. Approximately 8,500 babies are born each year to women living in the CMDHB area, of whom more than 50% are born to Maori or Pacific

mothers, and to mothers who predominantly live in areas of high socioeconomic deprivation. Maori and Pacific mothers are more likely to have a stillborn baby or to lose a baby in the neonatal period compared to European mothers.

The report notes that Counties Manukau has more women with high health needs during pregnancy than any other part of the country. These include obese women, smokers, teenage mothers and older mothers who have had several pregnancies. However, in one of two reports produced for the CMDHB, researcher Dr Catherine Jackson, commented that "ethnicity was not an independent risk factor for perinatal death, ie it is not being Maori or Pacific that places you at higher risk. It is the increased odds of exposure to risk factors such as smoking, obesity, premature birth, etc."

While the review was commissioned by the CMDHB and the report was focused on the issues and the needs of the women in South Auckland, there were many factors described in the report that also apply to women in West Auckland.

All women are vulnerable

The Panel interviewed staff and self-employed LMC midwives and asked about services provided to vulnerable women. They were repeatedly told that "all women are vulnerable." The report notes that Dr Jackson concluded that 81% of women who delivered at CMDHB facilities during 2007-2009 would be classified as high risk based on the PMMRC criteria, but cautioned that this serves to highlight "the limitations of a high-risk approach in a population that is predominantly high risk."

The MSCC considers it essential that all CMDHB women are provided with high quality maternity care, not just those singled out as being "vulnerable" or "high needs." Improving services to all women avoids stigmatising or marginalising particular groups of women who are assessed, labeled and subsequently assigned to receive special services. All women are entitled to a high standard of maternity care, including continuity of care, not just those identified as "most vulnerable."

The recommendations

The report contains a raft of recommendations for improving both maternity care and reproductive health services in Counties Manukau. Many of the recommendations have the word "urgent" attached to them.

The Panel makes a strong statement at the beginning of the report about "the critical importance of providing care in a culturally appropriate manner." One of the recommendations refers to the need to ensure "that educational material and information is provided in a variety of languages, that the maternity workforce better reflects the wider community, and that maternity care is provided in a manner that more appropriately meets the needs and requirements of different cultural groups."

Other recommendations include:

- encourage women who are healthy and have a normal pregnancy to opt for midwifery care and to birth at a primary birthing unit
- seek an urgent review by the Ministry of Health of the section 88 funding mechanism for LMCs nationally, in order to create incentives to provide care for women who have clinical or social risk factors
- encourage midwives to work as self-employed practitioners in the CMDHB region and increase the number of LMCs available to provide care to women
- review, as a matter of urgency, the current delivery and funding of family planning services in the CMDHB area, with a view to increasing access to these service, particularly for young and "at-risk" women
- consider the establishment of a local non-surgical termination of pregnancy service as Counties Manukau women who require termination of pregnancy have difficulty travelling to the service at Greenlane Hospital
- improve access to pregnancy related ultrasound scanning
- implement a comprehensive and integrated maternity information system

The prioritisation of the vulnerable

There are four recommendations concerning vulnerable "high needs" women:

- establish a set of criteria to define and identify the most socially and medically vulnerable pregnant women
- establish a vulnerable women's multi-disciplinary group as soon as possibly to which those women who are identified as most vulnerable can be referred
- consider ways in which those identified as most vulnerable can be provided with continuity of care – eg, through LMC or case-loading DHB midwives and/or specialty teams with dedicated additional social work/community health worker input
- urgently consider the development of comprehensive social worker and/or community health worker support services, to assist pregnant women to address the social factors that may impact on their health status and their ability of access and receive appropriate maternity care.

The report also stresses the importance of getting women to attend "a full pregnancy assessment appointment" with a midwife or GP in the first 10 weeks of pregnancy. About 25% of pregnant women in Counties Manukau do not have any antenatal care and this group has the highest perinatal mortality rate.

However, until a system of high quality, culturally appropriate maternity care is established in Counties Manukau pregnant women will remain isolated from the services they need. Defining them as one of those in the "most socially and medically vulnerable" group is also unlikely to win them over.

A copy of the *External Review of Maternity Care in the Counties Manukau District* is available at:
http://www.cmdhb.org.nz/News_Publications/Reports/report-external-maternitycare-review.pdf

THE MSCC'S THREE NEW PAMPHLETS

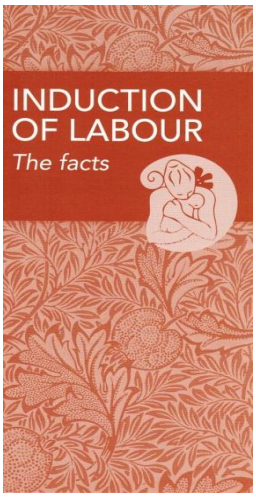
Thanks to a grant from First Sovereign, the MSCC has produced three new pamphlets in its *The Facts* series.

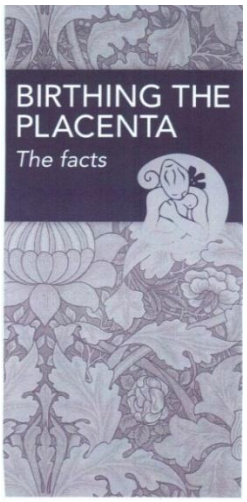
INDUCTION OF LABOUR: The facts
This pamphlet describes what induction of labour is, outlines the reasons why women may be advised to have their labour induced, describes the medical methods of induction, and nonmedical or 'natural' methods of induction, details the risks of induction, and includes a section on the important role of natural oxytocin as the main birth hormone of birth.

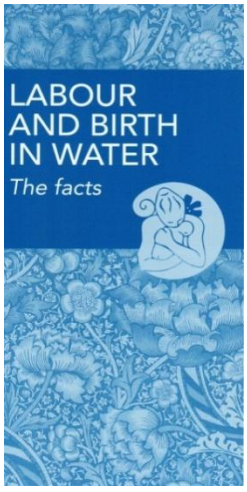
BIRTHING THE PLACENTA: The facts
This pamphlet describes what the medical model of birthing refers to as the third stage of labour, explains the process of a physiological third stage, outlines what is involved in an actively managed third stage, lists the reasons given for active management, and details the risks involved in an actively managed third stage of labour. There is also information on the problems with the research studies on the third stage of labour, the inadvisability of cord blood banking, and what lotus birth is about.

LABOUR & BIRTH IN WATER: The facts
This pamphlet outlines the history of women's use of water during labour, lists the benefits of labouring and birthing in water, discusses the research evidence on the use of water during labour, describes the process of giving birth in water, as well as water births at home.

Cost
There is a charge for the *Induction of Labour* and *Birthing the Placenta* pamphlets, as for the first two in the MSCC's *The Facts* series – *Caesarean Section* and *Epidurals during Labour*. One copy of each is provided free of charge, while orders for multiple copies range from $1 each for 2 – 20 copies, to 50c for orders of 100 or more.







Mothers Milk NZ Fundraising Launch

Mothers Milk NZ

We began with our Launch day on the 25th of September, to coincide with World Breast Milk Sharing Week 24-30th of September.

Since then, the world of Mothers Milk NZ took on a life of its own. Interviews both in print and on the couch all in a matter of a couple of weeks since the launch, meant there was little time to contemplate and more time applied to just doing.

We have now raised $219.00 with one donation coming from as far as Singapore. We have hosted one pamper party with World Organic with more to come on the horizon.

At the World Organic pamper party, I had the opportunity to try more of their products, and did the classic try it all on one arm to compare skin quality. I thought a dry elbow is as good a place as any, and discovered it was still smooth and moisture laden 4 days later. Something my other moisturiser could not manage. So I am extremely happy we are aligned with such a fabulous product range.

Since our launch I met a wonderful woman from AUT via our Facebook page. She suggested I approach the business students from AUT's Enactus Team, (formally SIFE –Students in Free Enterprise) *a community of student, academic and business leaders committed to using the power of entrepreneurial action to transform lives and shape a better more sustainable world.* These Students will help Mothers Milk NZ with our fundraising, marketing, IT support, accounts etc, and in return they have got a project to compete with internationally.

National Competitions are dramatic, energy-filled events where Enactus teams showcase the collective impact of their community outreach efforts. Students present their projects and are evaluated by business leaders serving as judges who rank them on how successful they were at using business concepts to improve the quality of life and standard of living for those in need. The winners of these national competitions are then invited to compete at the prestigious Enactus World Cup.

MMNZ will now be able to get the support needed to lift our fundraising efforts off the ground at the business end, hopefully this will fast track us in the New Year as I have a stack of ideas waiting in the wings to roll out nationwide.

If anyone is able to help out in their region please contact us on mothersmilknz@gmail.com We have people currently in Auckland and Wellington waiting to help out and would love more volunteers in other regions. The level of assistance is up to you, and can be as simple as spreading the word through your network, to distributing flyers or to assisting at events. The choice is yours when the time comes. Feel free to email us if you would like to be on our database to receive newsletters and updates for upcoming events and fundraising achievements.

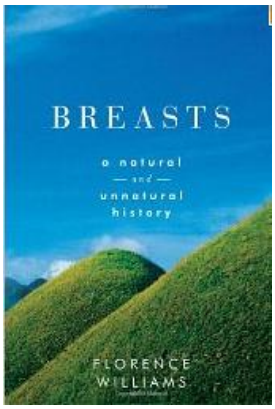
To purchase products from World Organic go to:
www.worldorganic.co.nz/mothersmilknz

Or donate to, Mothers Milk NZ account - 01 0194 0396938 00

Thank you and have a wonderful fun filled relaxing summer holiday!

Emma Ryburn

Book review



"Breasts: a natural and unnatural history"

by Florence Williams

This is required reading for all those who have breasts! For such a popular part of human anatomy, we know surprisingly little about our breasts and Florence Williams' book helps to fill in the gaps in our knowledge. For instance, did you know breastmilk sells on the Internet for 262 times the price of oil?

The breast is an evolutionary masterpiece and Florence traces its developmental journey, from the theories that the (mostly male) scientific community has propounded, mainly to do with sexual attraction, through more likely theories of the breast's development and purpose to nourish our young, to today's assault on the breast of chemicals, toxins and plastic surgery. Breasts are the "first responders" to environmental changes and as such are exquisitely vulnerable to our modern lifestyle.

"Breasts" is also the story of Florence's journey to discover more about her own breasts which, as she says, she didn't really think a lot about until she became a mother. She breastfed both her children, but it wasn't until her second child came along that she read a news report that changed her view of breasts and breastmilk. The report was about the levels of industrial chemicals scientists were discovering in milk produced by both land and marine mammals (including humans). She sent off her breastmilk to a German laboratory and was astounded by the results. That was the beginning of this book.

"Breasts" is written in an easy-to-read style but still manages to get all the scientific information across. It begins with evolutionary theories of breast development and why humans are the only mammals to have "breasts", although all other mammals have mammary glands. Florence does a great job of debunking the sexual attraction theories and delves into the role of breasts in natural selection as a way to sustain pregnancy and lactation by providing extra fat stores, especially as we have babies with energy-hungry brains.

She then covers the "plumbing" of the breast and how breastmilk is produced, then goes onto breast enlargement and modern Western cultural stereotypes. The remainder of the book is devoted to the impact of our environment and lifestyle on our breasts, how this relates to the rising incidence of breast cancer, to the effects of toxins in our breastmilk on the health of our children. It is an eye-opening tale.

Karin Martin