**ISSUE 95**
**June 2014**

Maternity Services Consumer Council

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

Welcome to the second issue of the MSCC's Newsletter for 2014. Over the past three months we have written a leaflet on gestational diabetes which is the sixth leaflet in our *The Facts* series (see page 5), organised the audit of the MSCC accounts, researched the early history of the MSCC for our website, and attended the Sarah Buckley seminar. We have also written several grant applications, responded to requests for information, and have mailed out thousands of our pamphlets.

## Funding applications

The MSCC is very appreciative of the $4,000 we received from Pub Charity for a reprint of one of our leaflets and for some postage paid envelopes which we plan to buy prior to the increase in postage which is due to come into effect on 1 July. We have also submitted grant applications to the ASB Community Trust and COGS.

## MSCC's new website

The MSCC has continued working on updating our website. The new website design has made it much easier to check out our leaflets and we have noticed a significant increase in women asking us to send us a single copy of some or all of our leaflets due to the fact that we have highlighted the fact that single copies are available at no cost.

We have also begun putting an account of some of the MSCC's early history on the website.

## What's in this issue of the newsletter

The June issue of the newsletter contains an article of the Women's Health Collaboration between Auckland and Waitemata DHBs, a report on the antenatal HIV screening programme, a summary of an interesting article on the use of pethidine that appeared in the *Journal of the NZ College of Midwives*, an article on oxytocin written after Nicola and Lynda attended the recent Sarah Buckley seminar, and a notice of a good night out at the movies which is a fundraising event for the Postnatal Distress Support Network Trust.

Don't forget to check the dates for the MSCC's Steering Group meetings for the second half of 2014.

Happy reading!

Lynda + Nicola

# WOMEN'S HEALTH COLLABORATION

One of the items on the agenda for the Waitemata DHB Community and Public Health Advisory Committee (CPHAC) meeting that took place on 19 March 2014 was the planned Women's Health Collaboration project. The project will focus on maternity services across Auckland and Waitemata DHBs over a 10-year planning horizon.

The information paper states that the Auckland and Waitemata DHBs have agreed to work collaboratively to plan the future of women's health services. In typical Board-speak it states that "*Women's Health services have been tasked by their Chief Executives with creating a strategic and innovative plan that will reduce the "duplication of services," better use the "combined resources, expertise and facilities," and "look at options around the acute theatre requirements out of hours" for women's health services. Of particular interest to the Chief Executives are maternity services along the "western corridor."*

Your guess is as good as mine as to what this actually means. How about this for a translation - there are too many maternity hospitals across the two DHBs, so let's bring back labour wards with lots of women all giving birth in the one room, close the theatres out of hours so no caesareans at night, and use corridors for West Auckland women giving birth.

Of course, this is all quite beyond the expertise of the two DHBs so "independent advisors have been engaged to assist with developing a preferred configuration model for service provision over a ten year horizon." After an RFP (Request for Proposals) process Health Partners Consulting Group got the job. Who are they? A bunch of blokes, of course. You may recognise the names of some of them – Stephen McKernan, former Director General of the Ministry of Health and before that CEO at Counties Manukau DHB, Gary Jackson, a public health medicine specialist, Chris Mules, who also worked at both the Ministry of Health and Counties Manukau DHB, and six others. When a member of the public muttered crossly about the gender of the group, Ruth Bijl, the Funding and Development Manager, managed to come up with the names of a couple of women – Rana Wong and Sharon Shea. However, there is no sign of Sharon in the line-up on the Health Partners website - http://www.healthpartnersconsulting.com/

The aim of this very expensive project "is to develop a collaborative primary and secondary maternity service model across the two DHBs, with a focus on improving patient outcomes, equity and fair access to services. Critical to the success of the project is early, close and meaningful engagement of clinicians, management teams, consumers, primary care and the DHB Boards and Committees." There is unlikely to be nearly enough consultation with consumers and consumer groups so contact Chris Mules and ask for an interview.

The agenda paper listed the current challenges faced by each DHB and also noted that any changes within one DHB's maternity service configuration may significantly impact the other. DHB boundaries are artificial and do not take account of natural population flows across them.

The minutes of the March CPHAC meeting state that "the cost of the independent advisers is $200,000 spread across the two DHBs. They will be expected to provide robust analysis, robust modelling and projections of what can be expected over time; and a number of options that the Steering Group would then consult on. With regard to maternity expertise, that would be provided from within the DHB to the advisers."

When Board member Sandra Coney raised the issue of the high caesarean section rate, Ruth admitted that reducing caesarean section rates is one of the drivers for the project, but at this stage they are trying not to pre-empt solutions, but to concentrate on setting up a good process for the collaboration project.

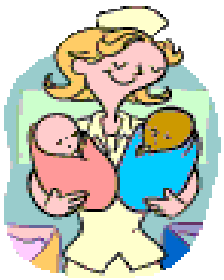
Sandra also raised the issue of Waitakere's maternity hospital. "Linda Harun advised that it is accepted that facilities on the Waitakere Hospital site were not purpose built for maternity and they wanted to find the right long-term solution. However in the short term there is also commitment to improving the current facilities." What exactly does this mean? Well, it's back to the future as the upgrade plans from 2004 are fished out of some old filing cabinet, dusted off and given a new lease of life.

**The timeframes for the $200,000 project**

The modelling and analysis will begin in March and be completed by the end of May. Options will be identified and a paper produced during June and July. Stakeholder workshops will be held during June and July.

A draft service plan with proposed options for DHB sign off will be completed by 31 August. There will be a public consultation in November and early December, and a final report is due to be presented to the DHBs in January 2015.

The MSCC has a copy of the DHB Agenda paper and minutes (a total of five pages) on the Women's Health Collaboration project which we will email to anyone interested. Email the MSCC at mscc@maternity.org.nz



# HIV SCREENING DURING PREGNANCY

Each year the MSCC puts in an Official Information Act request to the National Health Board asking for the numbers and ethnicity of women identified as being HIV+ during pregnancy as a result of the antenatal HIV screening programme.

The resulting letter from this year's request revealed that in 2013 one woman was found to be HIV+ as a result of antenatal screening.

In 2012 two women were identified as being HIV+ as part of antenatal screening. In 2011 only one woman was diagnosed as HIV+ during her pregnancy.

In each of the previous two years three women identified as being HIV+ as a result of antenatal screening.

**Costs of the 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 who may gain a benefit. 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 4 – 5 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 being screened for HIV, as well as the lack of informed consent for an HIV test.

**Lack of informed consent**

Reports from childbirth educators in the Auckland region 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.

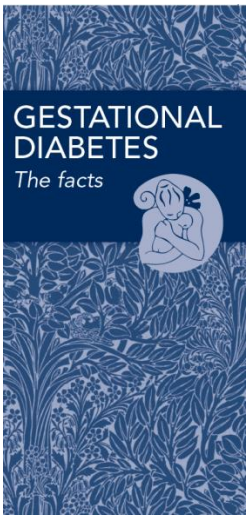
**Non-negative results**

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, and a subsequent blood test will usually result in a negative HIV test.

The impact of being told that the test for HIV was not negative, and that another blood sample is needed 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 cause more harm than good. Careful monitoring is therefore needed to make sure 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 difficult to justify the considerable resources being spent on it, especially when such screening does more harm than good.




**The MSCC has produced a sixth leaflet in its "*The Facts*" series.**

The Gestational Diabetes leaflet describes what GDM is, the process of screening for GDM, the disadvantages of having a single test, treating GDM, and outlines the differing opinions on gestational diabetes, the risk of overdiagnosis, and how to minimise the risks.

There is a charge for all the leaflets in "*The Facts*" series, but a free copy is included with this issue of the newsletter.

## MSCC Meeting Dates for 2014

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 2014 are**: 8 July, 5 August, 7 October, 4 November, 2 December.** There will be no meeting in September.

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.

# PETHIDINE – DOESN'T WORK BUT STILL IN USE

The latest issue of the NZ College of Midwives Journal features an excellent discussion on pethidine's place in midwifery practice. (1) The fact that pethidine still has a place in midwifery practice is amazing in itself.

Most women do not know that pethidine is not effective at reducing pain. It is a sedative, a synthetic opioid, not a form of pain relief. Sedatives alter the perception of pain rather than providing true analgesia. Because pethidine did not undergo randomised controlled trials (RCTs) before it was introduced into clinical practice, there is no evidence that it is effective at reducing pain or that it shortens labour – two widely-held beliefs about this drug.

It is currently the only controlled drug able to be prescribed by New Zealand midwives. As changes to the New Zealand Misuse of Drugs Act (1975) regarding the prescription of opioids by midwives are being discussed with the Ministry of Health, it is likely that, in the future, midwives will be able to prescribe a wider range of controlled drugs for use during labour.

The NZCOM Journal article outlines some interesting history on the use of pethidine and its use during labour. It was first used in Germany in 1939 as sedation and pain relief for wounded soldiers during World War II. "It spread rapidly throughout society and was widely celebrated by women suffering dysmenorrhea, so much so that by the late 1940s many were addicted. Its use became regulated in 1949, around the time midwives began using it for labour. In midwifery, pethidine was referred to as "sedation" and was used to reduce anxiety in labour." (1)

A 2011 Cochrane systematic review of opioids in labour found that they all provide poor pain relief, and all of them caused significant side effects including drowsiness and nausea in the mother. Because the studies were poor quality ones, the review was not able to find any evidence for or against pethidine as compared to other opioids.

Pethidine is really bad news for babies. It readily crosses the placenta with maximum levels found in the baby's blood stream between one and five hours after being administered to the mother. Effects on the unborn baby include reduced short term beat-to-beat variability of the baby's heart, and once the baby is born studies have revealed side effects which include depressed muscle tone, respiratory effort and sucking ability, and reduced Apgar scores. "Other studies have raised additional concerns regarding the potential association between the use of opioids in labour and development of neonatal drug dependency in later life, though this has not been proven." (1)

A retrospective study of opiate addicts in Sweden undertaken to test the hypothesis that opiate addiction in adults might stem partly from an imprinting

process during birth when opioids are given to the mother found that, after controlling for hospital birth, order of birth, duration of labour, presentation other than vertex, surgical intervention, asphyxia, meconium-stained amniotic fluid and birth weight, the relative risk for offspring subsequently becoming an adult opiate addict increased with administration of opiates, barbiturates and nitrous oxide. (2)

Contrary to the widely-held belief that the effects of pethidine are worse for the baby if given close to the birth, the side effects of acidosis and respiratory depression are increased if pethidine is given three to five hours before birth but are barely discernible if given within an hour of birth. This is because the drug has not reached sufficient levels in the baby. “Regardless of their effects on respiratory depression, the longer lasting influence of pethidine’s metabolites will persist regardless of timing of dose. These effects may be more subtle or ‘hidden’ at birth, but will go on to affect the baby for several days while the original dose of pethidine is being metabolised by the baby’s liver.”

Another major drawback is that pethidine has a prolonged sedative effect on the newborn baby and this affects their ability to breastfeed. Pethidine also accumulates in colostrum and mature breast milk.

The NZCOM Journal article concludes by stating that “pethidine offers temporary, relatively weak analgesia. It is an effective sedative, inducing sleepiness, and reduced awareness and control. It has long been believed that pethidine shortens labour but the current available evidence suggests this is not the case. Ideally, opioids chosen for midwifery use will have rapid onset of effect, be efficiently metabolized and eliminated, and have minimal side effects. Pethidine causes more side effects than other opioids such as morphine and fentanyl: these other drugs have shorter half-lives and may also have fewer undesirable effects on newborns.” (1)

Two New Zealand DHBs have stopped offering pethidine and are now using either fentanyl or morphine, administered by midwives, but prescribed by doctors. Whether the current review of the legislation results in midwives being able to prescribe morphine and fentanyl as well as pethidine remains to be seen.

In the meantime, women must to be given full and accurate information on all the pain relieving drugs available during labour. The truth about the side effects of pethidine on both mother and baby has been known for decades. Despite the significant impact it has on babies and the significant risks attached to its use it is incredible that it is still being used to sedate women in labour.

**Reference**

1. Chloe Goodson & Ruth Martis. “Pethidine: to prescribe or not to prescribe? A discussion surrounding pethidine’s place in midwifery practice and New Zealand prescribing legislation.” *NZ Journal College of Midwives. Journal 49*
2. Bertil Jacobson et al. “Opiate addiction in adult offspring through possible imprinting after obstetric treatment.” *British Medical Journal*. 1990.

# OXYTOCIN

On Friday 11 April Lynda and Nicola attended Sarah Buckley's "Undisturbing Birth" seminar, and got a wonderfully inspiring tiki tour of the hormones of birth, how they work, and what happens when they are interfered with. The following article focuses on the hormone oxytocin.

Oxytocin is a Greek word meaning "quick birth." It is a mammalian hormone that also acts as a neurotransmitter in the brain and its role during childbirth has been known for more than a century. It stimulates contractions of the smooth muscle tissue in the wall of the uterus during labour, facilitating the birth by dilating the cervix, and then helping the mother bond with her baby after the birth. Up until the last month or so of pregnancy, the uterus is relatively insensitive to oxytocin. As the time of birth approaches the uterine muscles become sensitive to increased secretion of oxytocin.

After the birth, oxytocin helps with the secretion of milk from the mammary glands. The baby's suckling on the breast stimulates the nerve cells in the brain to release oxytocin which are then secreted into the blood and result in the let-down reflex.

The increased knowledge of the important role of oxytocin during sex, birth and breastfeeding has resulted in oxytocin being called the hormone of love.

More recent research has discovered that oxytocin also has antianxiety effects that help us relax and reduces our blood pressure. It increases the pain threshold and also promotes growth and healing by modulating inflammation by decreasing certain cytokines (small proteins that are important in cell signaling). Thus, the increased release in oxytocin following positive social interactions has the potential to improve wound healing. A study by Marazziti and colleagues found increases in plasma oxytocin following a social interaction were correlated with faster wound healing. They hypothesized this was due to oxytocin reducing inflammation, thus allowing the wound to heal faster. This study provides preliminary evidence that positive social interactions may directly impact aspects of health.(1)

On a societal level, oxytocin plays a major part in social interactions and building trust in relationships. Professor Paul Zak, a pioneer in the field of neuro-economics, refers to oxytocin as "the moral molecule." In a TED talk he describes how oxytocin is responsible for trust, empathy, generosity and other feelings that help build a stable society.(2) He has also discovered that social networking triggers the same release of oxytocin in the brain – meaning that e-connections are interpreted by the brain in the same way as in-person connections.(3)

During one of her morning presentations at the Auckland seminar Sarah Buckley stated that oxytocin is also made in the heart and the heart has lots of oxytocin receptors.

Oxytocin is so important to human health and well-being that it is on the World Health Organisation's List of Essential Medicines which is a list of the most important medications needed in a basic health system. Of course, what is being referred to here is synthetic oxytocin.

**The use of synthetic oxytocin during labour**

While synthetic oxytocin is chemically equivalent to the oxytocin produced naturally, it acts very differently when used during labour. The labouring woman's own oxytocin is released in pulses, whereas synthetic oxytocin is administered in a much higher dose that is maintained at the same high level. It achieves minimal passage through the blood brain barrier.

Synthetic oxytocin results in stronger and longer-lasting contractions which are also closer together. It reduces foetal blood oxygen levels, and requires careful monitoring, produces an abnormal foetal heart rate, and results in a lower Apgar score at five minutes after the birth. The use of synthetic oxytocin reduces the number of uterine oxytocin receptors, inhibits the rise of beta-endorphin (a potent endorphin that acts like a powerful natural painkiller) and increases the risk of postpartum haemorrhage (bleeding after the birth).

Sarah Buckley referred to one study of about 700 women whose previous labour had been induced which revealed that they had longer labours with subsequent births. This is because induction with synthetic oxytocin reduces the number of oxytocin receptors that are increased just prior to labour.

**Making birth safe**

Natural oxytocin works to make birth safe. At the end of pregnancy it prepares the brain and the breast for labour, it promotes the ease and efficiency of contractions and aids effective pushing, and protects the mother from bleeding after the birth.

This raises the question – how many obstetricians and midwives understand exactly what the use of synthetic oxytocin during labour does, how it interferes with the birth process, and the risks it poses to both mother and baby?

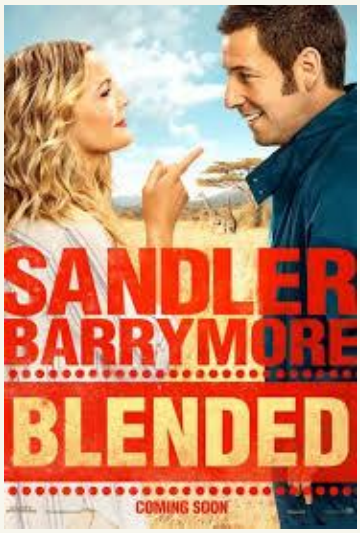
Women need good information about the role of this amazing hormone and the part it plays in childbirth, and why the use of synthetic oxytocin should be reserved for life threatening situations.

**References**

1. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2888874
2. http://www.ted.com/talks/paul_zak_trust_morality_and_oxytocin
3. http://www.ted.com/speakers/paul_zak

# Postnatal Distress Support Network Trust Movie Night

## Come along for an awesome night out watching the movie Blended!




**When: Thursday, 19th June 2014, at 7.30 pm**
**Where: Berkeley Cinemas, 32-34 Anzac St, Takapuna, Auckland**
**How to book: email us at pnd.org@xtra.co.nz**

**Tickets: $25.00 which includes:**
*** A glass of wine**
*** Nibbles**
*** A goodie bag**
*** The chance to win awesome spot prizes**

**Please make payment to:**
**Post Natal Distress**
**12-3039-0895060-01**

**Please put your full name (first and last name) as the reference**

# CONFERENCES/WORKSHOPS 2014

**The Perinatal & Maternal Mortality Review Committee** is holding its annual conference on Tuesday 17 June 2014 at Te Papa, Wellington.

## TOPIC: From Audit to Action

This year's programme will include:

- An overview of the latest annual report
- The results of 3 years of neonatal morbidity and mortality review
- Talking to families about post-mortem
- Cooling and the neonate
- Risk assessment in maternity.

To register go to: https://mortalityreviewworkshops2014.lilregie.com

## NZ College of Midwives 2014 National Conference

**This year's NZ College of Midwives Conference will be held on 28 - 31st August 2014 in Hamilton.**

This years Conference Theme is: **Midwifery relationships are the bridge to quality**


**Further information is available at:**
**www.midwife.org.nz/resources-events/nzcom-conference/**