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Maternity Services Consumer Council

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

This is the second issue of the MSCC's Newsletter for 2013. Since we sent out the March newsletter we have been busy revising some of our pamphlets in preparation for a reprint of those we are running out of. We have written a number of grant applications for reprinting costs as well as some of our operational costs, and have been mailing out thousands of our pamphlets.

Funding application results

The MSCC is very appreciative of the funding we have received so far this year, and we are working hard on avoiding the mid-year financial low we have experienced over the past two years. We have recently received funding from the North & South Trust for a reprint of some our pamphlets, and we are extremely appreciative of this grant.

Cord blood banking

The controversial issue of cord blood banking has been brought to the fore recently due to the increasing pressure both the MSCC and the NZ College of Midwives have come under to refrain from commenting on this topic. Following a recent meeting the MSCC was asked "to consider keeping to maternity issues rather than those affecting the wider health sector." We were also asked to consider withdrawing our pamphlets prior to the scheduled revision and reprints. For the record the MSCC has no intention of withdrawing any of our pamphlets. Following the recent updating of both the *Epidurals during Labour*, and *Caesarean Section* pamphlets, we have recently revised one of the "Your Choice" series, updating several sections and strengthening the section on cord blood banking with some recent references. The MSCC will continue to research this and many other issues. We have also consulted with experts who do not have a vested and/or financial interest in cord blood banking. For more on this issue see page 6.

What's in this issue of the newsletter

The June issue of the newsletter contains a thoroughly researched article on the importance of delayed cord clamping, some observations on cord blood banking, an item about the $18.2 million for maternal mental health services in the North Island, a summary of an article about not rushing mothers into labour when their waters break before contractions begin, as well as information on several workshops and events.

Don't forget to check the dates for the MSCC's Steering Group meetings for the rest of the year. We look forward to seeing you there.

Lynda + Nicola

LMC'S, LEAVE THAT CORD ALONE!

The December 2012 issue of the MSCC's newsletter featured an article on the review by obstetrician David Hutchon on the dangers of early cord clamping. The paper was published online in the November 2012 issue of the *Journal of Obstetrics and Gynaecology*. (1) Since then the MSCC has learned that Dr Hutchon worked for a while as an obstetrician at Greymouth Hospital where he was held in high regard. He may have retired now, but he is not alone in his stance on premature cord clamping.

The UK

The issue of leaving the cord for 2 – 3 minutes before clamping and cutting it, or leaving it until it has stopped pulsating has become a major issue in the UK, with midwives, obstetricians and paediatricians joining the movement to change the practice around cord clamping. Childbirth experts are urging the National Health Service (NHS) to reverse its policy on premature cord clamping, and medical bodies, senior doctors and the National Childbirth Trust are calling for maternity care providers to stop routinely clamping the cord within seconds of the baby's brth. (2) They argue that there is now good evidence that newborn babies are at risk of developing iron-deficiency anaemic as a result of being deprived of 25 – 33% of their blood volume at birth. (3)(4) Anaemia is associated with brain development, and iron deficiency even without anaemia has been associated with impaired development among infants. About 10% of UK toddlers are iron-deficient, and both iron deficiency and iron deficiency anaemia are major public health problems in young children worldwide. (2)(3)

The scientific evidence inspired the Royal College of Midwives and the Royal College of Obstetricians to change their guidelines in November 2012 recommending delaying clamping of the cord for around three minutes after birth.

The USA

In the USA obstetrician Dr Nicholas Fogelson found himself in the unenviable position of being anointed as the guru of delayed cord clamping after he penned a post in 2009 entitled "Delayed Cord Clamping Should be Standard Practice in Obstetrics." (5) Later he gave a grand round on the topic. (6) Both were viewed by thousands and while he acknowledged that he had "contributed to a growing movement towards delaying cord clamping after the birth of preterm and term neonates," he subsequently posted another article denying that he was an expert in delayed cord clamping, describing himself as, among other things, a physician with intellectual expertise in maternal health and first hand experience in its practice, a position which gave him a platform for his opinion. (7)

In his December 2011 article Nicholas Fogelson wrote:
"Delayed cord clamping is more akin to the natural process of birth that we have evolved towards, and to the birth process shared by all land mammals. Immediate cord clamping clearly reduces the amount of blood in the infant in

terms of volume, blood cells, and iron content. In my mind, this action removes blood from the infant that the infant was "destined" to receive absent the intervention of immediate cord clamping." He goes on to point out that "there is no real data to suggest that delayed cord clamping is at all harmful to an infant. For that reason, the combination of the underlying physiologic and rational argument with the available data is compelling enough to me to support a policy of routine delayed cord clamping for term and preterm neonates." (7)

New Zealand

In New Zealand midwives and obstetricians have been less than enthusiastic in terms of changing their practice around cord clamping and the active management of the third stage of labour – the time between the birth of the baby and the separation and birth of the placenta. Active management which involves the mother being given an injection in her thigh of artificial oxytocin, the baby's umbilical cord being clamped and cut within a minute or so of the birth, and the cord being pulled to help deliver the placenta, is the norm in the vast majority of births in New Zealand.

The National Women's Annual Clinical report for 2011 states "In 2011, active management of third stage was used in at least 90% of vaginal births." (8)

The Midwifery and Maternity Providers Organisation (MMPO) statistics for 2011 revealed that the percentage of active management for the 52% of the births in New Zealand that are included in the MMPO statistics was 70.6%. (9)

There is little reason to hope that the reports for 2012 will reveal much change in these statistics.

Postpartum haemorrhage

In her *Nutrition Reviews* paper, Camila Chaparro wrote "because of the past inclusion of early cord clamping as part of the protocol for active management of the third stage of labour to prevent postpartum haemorrhage – a set of procedures promoted during the last two decades for the prevention of maternal postpartum haemorrhage – a belief commonly exists among practitioners that delayed cord clamping will increase maternal bleeding. However, there is no evidence to support a relationship between cord clamping time (independent of other active management techniques) and postpartum haemorrhage." (4)

Jaundice

There is also no evidence to support the relationship between delayed cord clamping and hyperbilirubinaemia, commonly known as jaundice. Ola Andersson's paper, in reporting that delayed cord clamping improved iron status and reduced the prevalence of iron deficiency at four months of age, and reduced prevalence of neonatal anaemia, also reported that delayed cord clamping did not result in postnatal respiratory symptoms, polycythaemia (too many red blood cells), or hyperbilirubinaemia requiring phototherapy. (3)

Resuscitation

In describing the drivers that are preventing widespread adoption of delayed cord clamping David Hutchon lists cord blood gases, resuscitation, nuchal cord, cord blood banking and the need for neonatal blood group in rhesus negative mother. For babies requiring resuscitation, he noted that "current practice is to transfer the baby immediately and this requires cord clamping. There is however, increasing opinion and evidence that maintaining a placental circulation in these babies will aid recovery … Initiation of resuscitation is possible at the side of the mother without clamping the cord." (1)

Cord blood banking

David Hutchon also commented that delayed cord clamping results in much smaller volumes for cord blood collection and that after a physiological transition there is rarely sufficient for stem cell banking. Cord blood banks "will therefore need to consider other methods to harvest the billions of stem cells left in the placenta if life-saving use of the cells is to continue." (1)

An experienced and enthusiastic UK midwife has posted an article recording her practice as a "vampire-midwife" and the prize she won for collecting the most cord blood in the hospital where she worked. She describes her post, "Confessions of a vampire-midwife," on midwifethinking.com as "a small attempt to repent for my sins." (10) See following article for more on this issue.

WHO recommendations

A recent review of physiological versus active management of the third stage of labour in the Cochrane Library stated that the current World Health Organisation (WHO) recommendations are to delay cord clamping as it is no longer considered best practice. (11)(12)

Mothers

Lastly, but most importantly, mothers are also involved in the movement to make delayed cord clamping routine practice. There are many wonderful informative, evidence-based websites that discuss the many advantages to babies and mothers of not interfering with the natural process immediately after birth. The *Scienceofmom* is one such website. (13) There is also a website devoted to the issue (14) as well as many others. (15)

The demand for change is growing and it is critical that New Zealand mothers join forces to protect their babies from being deprived at birth from what nature intended them to have – their full quota of blood.

References

1. DRJ Hutchon. "Immediate or early cord clamping vs delayed clamping." *Journal of Obstetrics and Gynaecology*. November 2012; 32:724-729.
2. http://www.guardian.co.uk/society/2013/apr/25/cutting-cord-babies-risk-nhs

3. Ola Andersson et al. “Effect of delayed versus early umbilical cord clamping on neonatal outcomes and iron status at 4 months: a randomised controlled trial. *British Medical Journal* 2011;343:d7157 doi.
4. Camila M Chaparro. “Timing of umbilical cord clamping: effect on iron endowment of the newborn and later iron status.” *Nutrition Reviews* 2011 Volume 69(Suppl.1):530-536.
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6. http://www.youtube.com/watch?v=cX-zD8jKne0 and http://www.youtube.com/watch?v=YDLywaBTd-o
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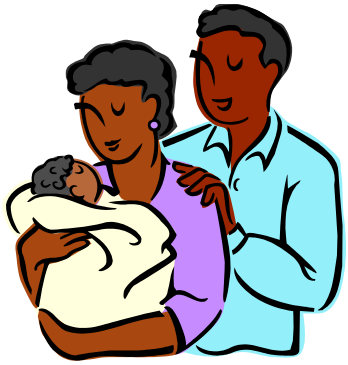
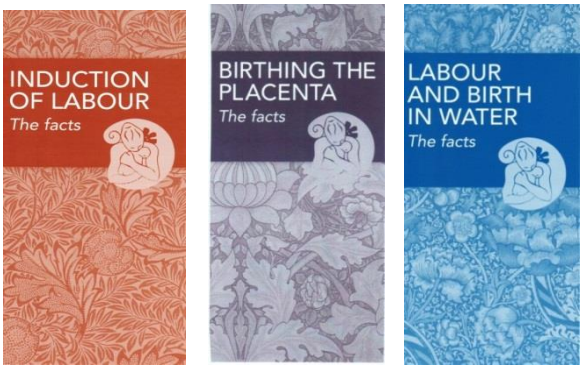
14. http://cord-clamping.com/
15. http://www.thebirthpause.com/2013/02/optimal-cord-clamping-all-of-human.html



We are getting lots of orders for our three new leaflets. If your order form does not have these on please download the latest order form off our website MSCC Order Form

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.



CORD BLOOD BANKING

Over the past few years the publication of evidence supporting delayed cord clamping has introduced significant issues for parents considering cord blood banking. As described in the previous article, prematurely clamping and cutting the cord and collecting cord blood are interventions which deprive the newborn baby of its own blood, blood it needs "to fill the new pulmonary circulation and other parts of the circulation which now need to be much more active such as the diaphragmatic and chest muscles, kidneys and gut … Logically, without the additional blood, the neonate has to steal from the rest of the circulation to allow the lung circulation to fill." (1) This makes it almost impossible to collect sufficient cord blood for banking in a cord blood bank.

There are also other reasons for believing that cord blood banking is not necessary or even desirable. The first banking of unrelated umbilical cord blood began in New York in 1993, and similar public non-profit cord blood banks were established in Paris, Milan, Dusseldorf and Sydney soon after. This was quickly followed by the establishment of private cord blood banks, including one in New Zealand that was established in 2003. (2)

In an article published in *Nature* in 2008, Michael Sullivan, a New Zealand paediatric oncologist (children's cancer specialist) and international expert in the field, wrote "The establishment of commercial cord blood banks was controversial at the time and remains so because clinical evidence supporting autologous (using the child's own cord blood stem cells) cord blood storage was, and still is, lacking. Indeed, in its 2004 report on the ethics of umbilical cord blood banking, the European Union Group on the Ethics of Science and New Technologies raised serious ethical concerns regarding commercial cord blood banking. The principal ethical objection is the promotion to expectant parents of the future benefits of autologous cord banking as biological insurance to treat diseases for which at present there is "no medical evidence for the validity of treatment." (2)

Five years on, there is still a dearth of peer reviewed published medical evidence that supports the need for cord blood banking. The New Zealand College of Midwives is currently working on a draft consensus statement on "Umbilical cord blood collection and banking" which states:

"*The New Zealand College of Midwives believes that evidence of benefit for routine private cord blood collection and banking is lacking.*

Furthermore NZCOM believes that any interference with the third stage of labour needs to be kept at a minimum to ensure best outcomes for both mother and baby. Unnecessary interference carries risk to both mother and baby.

The midwife should be focused on the immediate care of the mother and baby during the third stage of labour; and the management of the third stage should

not be compromised by non evidence based interventions such as routine cord blood collection.

Early clamping of the umbilical cord for cord blood collection may be harmful to a baby. In healthy newborns, deferred cord clamping enhances placental transfusion and iron stores and reduces jaundice in babies at birth.

Parents wishing to collect and store their own babies cord blood privately need to receive evidence based advice and information if they are to balance the inherent risks of altering a physiological process for no medically indicated reason." (3)

Another significant issue is the fact that stem cell technology has developed rapidly to the point where it has made the collection and storage of cord blood "a superfluous service." (2) At a recent meeting in Auckland a stem cell researcher stated that "we do not need stem cells from cord blood to do any of the treatment they describe as technology has moved on in relation to cultivating cells in a lab now." (4)

It is absolutely essential that parents are given evidence-based information on cord blood banking, something they are unlikely to get from the cord blood banks. Parents also need information on the alternatives, alternatives that do not involve interfering in the natural processes of a physiological third stage.

As stated in the MSCC's new pamphlet, *Birthing the Placenta*, in a healthy mother the process of giving birth naturally results in a complex process in which, after the mother has given birth to her baby, she continues to release surges of natural oxytocin. Skin-to-skin contact and the baby's first breastfeed further increase the levels of oxytocin in the mother. This stimulates the uterus to continue contracting down and results in the placenta detaching from the uterine wall and being expelled along with the membranes or sac that has contained the baby throughout the pregnancy. These contractions stop or lessen any bleeding that occurs as the placenta separates from the uterus following the birth. (5)(6)

There is no place for collecting cord blood in such a scenario. As David Hutchon pointed out cord blood banks will need to come up with other methods of collecting the stem cells.

References

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2. Michael Sullivan. "Banking on cord blood stem cells" "*Nature Reviews/Cancer*" 2008.
3. New Zealand College of Midwives. Draft 5 of Consensus Statement on "Umbilical cord blood collection and banking." 2013.
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6. Michel Odent. *Childbirth in the Age of Plastics*. Pinter & Martin 2011.

A MOTHER AND BABY UNIT FOR AUCKLAND?

Hidden in the inaccessible depths of the May Budget was a line announcing that there was an extra $18.2 million of funding over four years for new dedicated acute inpatient beds for new mothers experiencing postnatal depression and other mental illness in the greater Auckland region, and new specialist community services around the North Island. These services are expected to help around 650 mothers and their babies a year. Apparently this was as much of a surprise to the Auckland District Health Board as it was to women's health groups who have been advocating for this for the past two decades.

In a press release dated 27 May 2013 Health Minister Tony Ryall said: "The Government has taken on board expert advice. This recommends that supporting mothers and babies together at this critical early stage not only has an immediate positive impact upon their mental health and well being, but also helps prevent potential future mental health issues for the baby.

Currently new mothers with severe mental illness are often treated and supported in adult acute mental health units separated from their babies and families. Mothers will now get the support of the new specialised maternal mental health services with their babies beside them." (1)

Unfortunately, it seems that the new dedicated acute in-patient beds will probably be located at Auckland hospital, with an additional 10 – 14 community residential beds, mostly in the Auckland area. The MSCC has liaised with the Postnatal Psychosis Support Group, the Postnatal Distress Support Network and other health and community groups about the need for a mother and baby unit during the past 15 years or more. We held meetings, wrote numerous letters to the Minister/Ministry of Health and various other health agencies about the need for such a facility, as well as other respite care facilities. We wanted a separate unit in the community, where the focus is on the mother and her baby, and where the mother is provided with mental health services in the context of the maternity care she and her baby are receiving, and not the other way round.

In his press release Tony Ryall says he expects that these services will start providing the help that is needed in 2014 with full capacity in 2015.

It is to be hoped that the DHBs will involve the maternal mental health groups that have worked so hard and, until now, so fruitlessly to bring the vision into reality. Given our long term investment in this endeavour we will be writing to the DHBs and inviting ourselves to their planning meetings.

Reference:

http://www.beehive.govt.nz/release/budget-2013-18-million-extra-help-mothers-post-natal-depression

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 2013 are**:**

11 June, 9 July, 13 August, 17 September, 15 October, 12 November and 10 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.

POSTNATAL DISTRESS SUPPORT NETWORK COURSES

The Postnatal Distress Support Network provides free support services to women throughout the Auckland region who are affected by baby blues, antenatal and postnatal distress and depression, anxiety, stress and birth trauma.

The West Auckland-based group is now running a new course for mothers. The Wellness Resilience Action Planning (WRAP) course for PND provides a safe, facilitated space for new mothers to come along and talk about being a new mother, and discuss the joys and challenges that it brings. Topics include self-care, balancing family and other aspects of life, communication skills, assertive-ness and much more.

Booking for the 6-week course is essential as spaces are limited on the course and in the creche. The cost is $60 which includes the crèche fees and a workbook.

For further information or to book, call the
Parenting Place on 0800 53 56 59
Further information on the PND Support Network
Is available at http://www.posnataldestress.org.nz/

PRE-LABOUR RUPTURE OF MEMBRANES

The pre-labour rupture of membranes is *another* area where patience and a hands-off approach is to be recommended. The midwifethinking.com website features an excellent article on impatience and the risks of waiting when caring for those mothers whose waters break before labour begins.

Despite what many women are told, the research evidence does not support the proposition that the baby is at an increased risk of infection following pre-labour rupture of membranes. There is a slightly increased risk of a uterine infection for the mother, but this can be diagnosed and treated if it occurs.

The current practice of getting labour started and getting the baby out as soon as possible when a pre-labour rupture of membranes occurs is fairly new. The guidelines around when to start augmenting labour after the waters have broken have shifted the goal posts over the past few decades. It was once 72 hours, then 48 hours, then 18 hours and then 12 hours and so on.

A Cochrane review that compared the outcomes for augmented labours with those where a wait and watch approach was used (expectant management) concluded that “Fewer infants went to neonatal intensive care under planned (augmented labour) management although no differences were seen in neonatal infection rates.”

The thinking midwife examines this conclusion and writes:
“More infants went to the neonatal intensive care nursery if their mother waited for labour to start. Not surprising really considering that it’s policy to routinely send newborns to the nursery for observation after “prolonged rupture of membranes” in most hospitals. What is significant, is that there was no increase in infection rates for these babies. Basically babies were separated from their mothers for no reason at all – to be observed, just in case. The implications of this unnecessary separation for the baby, mother and breastfeeding are ignored despite the available evidence supporting skin-to-skin contact. Allowing uninterrupted skin-to-skin contact could reduce the chance of infection due to colonization of the baby by the mother’s bacteria, reduced stress levels and early breastfeeding initiation. Even if there are concerns about a baby, the mother is probably the best person to ‘observe” her baby’s well-being.”

There is the same lack of evidence to support the practice of giving mothers and babies high doses of antibiotics during labour. In addition, these antibiotics may have short-term and long-term side effects.

Reference:
http://midwifethinking.com/2010/09/10/pre-labour-rupture-of-membranes-impatience-and-risk/

CONFERENCES/WORKSHOPS 2013

Birthspirit

The Wise-Woman Midwife and the Birth Machine Workshop

These workshops by Maggie Banks aim to strengthen the midwifery foundation of supporting, protecting and promoting physiological birth in primary care settings to ensure healthy outcomes for well women and their babies throughout continuum of pregnancy, birthing and early mothering.

They will be held at the Birthspirit Cottage at Tamahere, as well as in Christchurch, Palmerston North, Whangarei, Auckland and Tauranga between March and July 2013.

www.birthspirit.co.nz/Education/Seminars/TheWiseWomanMidwife&TheBirthMachine.php

'Working Towards Safer Beginnings'

The Perinatal and Maternal Mortality Review Committee will hold its annual workshop at Te Papa in Wellington on 12 June 2013.

Key note speaker: Professor Marian Knight from the University of Oxford, UK.

For further information see: http://www.hqsc.govt.nz/news-and-events/event/804/

The 6th Joan Donley Midwifery Research Forum

The NZ College of Midwives is holding its 6th Biennial Joan Donley Midwifery Research Forum in Queenstown on **19 – 20 September 2013**.

Further information is available at:
http://www.midwife.org.nz/index.cfm/1,140,0,0,html/The-JDMRC-Research-Forum