ISSUE 88
September 2012

Maternity Services Consumer Council

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

This is the third issue of the MSCC's Newsletter for 2012. Since we sent out the June newsletter we have produced two new pamphlets in our "The Facts" series, taken part in the stakeholder consultation meeting on the effectiveness of the WHO Code of marketing of breastmilk substitutes in New Zealand, produced an Annual Report and held our AGM, attended the NWH Annual Clinical Report day, written lots of grant applications, and mailed out thousands of our pamphlets.

Obtaining funding for our work

The arrival of a cheque for $32,000 at the end of June from Lottery Community meant that the MSCC's funding crisis is over – for the rest of this year anyway. Prior to going on maternity leave sooner than expected, Nicola produced grant applications for the five COGS committees in the Auckland region. The results for these will arrive in November.

Welcome to Emma

As noted above, Nicola has had to leave us earlier than expected to prepare for the birth of her baby. The MSCC is very fortunate that Emma Ryburn was able to step into the administration role for the next year while Nicola is on maternity leave.

Two new pamphlets

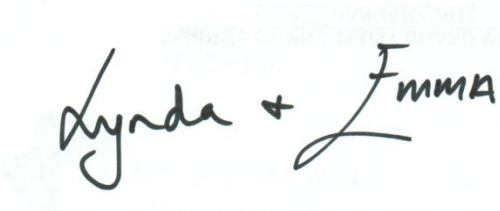
The MSCC has produced two new pamphlets in our "The Facts" series – *Induction of Labour* and *Birthing the Placenta*. See page 8 for further information on these. An order form is available on the MSCC website – www.maternity.org.nz

What's in this issue of the newsletter

The September issue of the newsletter contains an article on Professor Peter van der Weijer's presentation at NWH Annual Clinical Report day, a summary of some of the statistical information in the NWH Annual Clinical Report for 2011, information on our two new pamphlets, and an article on a new initiative, Mothers Milk NZ.

Getting the MSCC Newsletter via email

The MSCC is encouraging 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.



THE NETHERLANDS VS NATIONAL WOMEN'S

This year's National Women's Annual Clinical Report day featured a professor from the Netherlands who undertook the traditional maternity critique. Professor Peter van der Weijer arrived in Auckland from the Netherlands 18 months ago and is currently working part-time for Waitemata DHB as clinical director for gynaecology at Women's Health and part-time as Associate Professor of Obstetrics and Gynaecology at Auckland University.

Professor van der Weijer introduced himself as the new kid on the block, but he brings a wealth of life, medical and teaching experience to both roles. He began his address by noting that previous comparisons of NWH's annual reports have largely been with Australia, and commented "but if both are flawed then this isn't particularly useful." He then announced that this year's comparison was going to be with the Netherlands, and not with a major tertiary maternity hospital in the Netherlands but with the maternity data for the whole country. He then provided some background information on his homeland.

The population of the Netherlands numbers 16.4 million compared to New Zealand's 4.4 million, is comprised of 41,526 sq kms compared to New Zealand's 271,000 sq kms, and has a population density of 490 per sq km compared to 16 per sq km in New Zealand.

The Netherlands population consists of 142 nationalities with 76% being European, and the majority of the rest Mediterranean and Creole, compared to New Zealand's 148 nationalities with 70% being European and the majority of the rest being Maori, Pacific and Asian.

After a brief comparison of the healthcare systems, and health insurance systems of both countries, Professor van der Weijer then began comparing the outcomes of maternity care between the Netherlands' 179,500 births and NWH's 7,500 births. His presentation focused on risk selection, the model of care and governance. He noted that for the first time the rate of iatrogenic onset of birth at NWH (51.8%) which includes inducing labour, had exceeded the rate of the spontaneous onset of labour (48%). NWH's caesarean section rate was 32.5% whereas the Netherlands had the lowest caesarean section rate in the world – 15.6%. Professor van der Weijer pointed to both NWH's high iatrogenic intervention rate and its high iatrogenic complication rate. He was very concerned that the peripartum hysterectomy rate had risen from 7 in 2010 to 12 in 2011. He also stressed that amniotic fluid embolism, which has resulted in a number of maternal deaths in New Zealand over the past few years, is clearly related to induction and the age of the woman.

In discussing the issue of scope of practice the professor emphasised the importance of promoting and facilitating the physiological processes of pregnancy and childbirth, and the need to identify complications that arise in mother and

baby early in pregnancy, to make appropriate medical decisions and implement emergency measures as necessary. He described how well this worked in the Netherlands because the obstetricians there have a philosophy that birth is a normal process, whereas it is very obvious that obstetricians at NWH do not share the same philosophy. The audience was told that women in the Netherlands do not have the option of having their maternity care provided by an obstetrician if they are healthy and their pregnancy is normal. Nor are they permitted to opt for a caesarean birth when there is no medical reason for performing a caesarean section.

The model of care being provided at National Women's is failing women, the professor said. As well as the high iatrogenic intervention rate, there is a discrepancy in maternity care between care providers. These results and the high iatrogenic complication rate point to the need to change the model of care and to begin individual benchmarking of the obstetricians. Don't be afraid of change, he encouraged the audience.

He was obviously not impressed with the system of private obstetricians that New Zealanders take for granted and referred to the fallacy of free enterprise which results in such high rates of unnecessary and harmful interventions. The model of care and the governance of the maternity care system must change, he said.

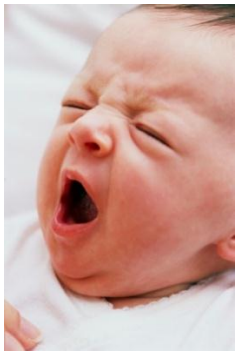
He ended his presentation with a patient's perspective – don't let me die, don't harm me unnecessarily, and leave me my dignity.

Peter van der Weijer's challenge was a breath of fresh air to National Women's Annual Clinical Report day, and the MSCC looks forward to the report back that has become part of the start of each year's event.

Professor van der Weijer's PowerPoint presentation is available at:

http://nationalwomenshealth.adhb.govt.nz/Portals/0/Annual%20Reports/Presentations%202012/2%20Peter%20v%20weijer%202012%20annual%20report.pdf

An article summarising some of the statistical information in the NWH's Annual Clinical Report begins on page 4.



NATIONAL WOMEN'S CLINICAL REPORT FOR 2011

National Women's released its Annual Clinical Report for 2011 in August 2012. The report is the 19th in the current series. The annual seminar examining the information contained in the report took place on 8th August.

The 250-page report contains a wealth of statistical information on the 7493 women who gave birth at NWH in 2011 and the 7657 babies they gave birth to plus the 33 women who gave birth before they actually got to the delivery unit. Two women gave birth twice during 2011 and are counted twice in the report. In 2011 there were 159 sets of twins (there were 149 in 2010) and four sets of triplets (there were 4 sets in 2010).

Normal births

While the intervention rates have remained much the same over the past few years, this year sees a small increase in the number of normal births. In 2011 55.6% (4183 out of 7523 birthing mothers) had what the report refers to as a "spontaneous vertex birth" and 0.8% (60 birthing mothers) had a vaginal breech birth. This represents a 1% increase in the percentage of normal births compared to 2010.

In 2011 46.7% of first-time mothers had a spontaneous vertex birth compared to 45.2% in 2010.

Water birth

In 2011 there were 15 babies born in water, compared to 29 in 2010. Three of the mothers were under the care of National Women's LMC service, 11 were under the care of an independent midwife, and one by a private obstetrician. None of the babies were admitted to NICU, and none had an Apgar score of less that 7 at one minute after birth.

Induction of labour

The induction rate has risen from 28.7% in 2010 to 32.7% in 2011. More than one in three (38.5%) first-time mothers with a full-term baby had an induction of labour in 2011 which the report states is a significant rise. The rate for multiparous mothers with no previous caesarean birth was 35%.

The report notes "Diabetes was the most frequent reason for induction of labour in 2011. In previous years the most frequent causes have been term PROM (premature rupture of membranes) and post dates pregnancy. When post dates was the primary indication for induction, 10% occurred prior to 41 weeks and 21.5% occurred at or beyond 42 weeks."

The establishment of "the post dates virtual clinic at the end of 2011 has meant that referrals for postdates induction of labour prior to 41 weeks will not be accepted in women meeting the criteria for a normal birth pathway."

The report also points out that the emergency caesarean section rate following induction is higher that following spontaneous onset of labour, for both first-time mothers and multiparous mothers without a previous caesarean section. For first-time mothers induction is associated with a 2-fold increase in the risk of an emergency caesarean section – from 17% to 35%.

Induction of labour increases with maternal age – from 35.3% among mothers under 20 years of age to 41.7% of mothers over 41, while spontaneous onset of labour dropped from 60.2% to 21.3% in these age groups. Induction of labour is also associated with maternity care provided by private obstetricians (32.8%) who also have the lowest rate of spontaneous onset of labour at 27.9% compared to 60.8% for GPs and 61.2% for independent midwives.

32.5% caesarean section rate

In 2011 the caesarean section rate was 32.5%, compared to 32.3% in 2010, 31.2% in 2009 - and **20.8% in 1995 and 1996**. There was little difference between the caesarean section rates for first-time mothers (34.5%, compared to 33.5% in 2010) and for mothers having subsequent births (30.8%, compared to 31.2% in 2010). This is because 61% of women who had had one prior caesarean section had an elective repeat caesarean.

The elective caesarean rate is highest among women attending a private obstetrician (37%) and lowest among independent midwives (7%). European women are twice as likely to have an elective caesarean section as women of other ethnicities.

The vaginal birth rate in women who had a trial of labour varied significantly by onset to labour, from 63% if labour started spontaneously to 51% if labour was induced.

The VBAC (Vaginal Birth After Caesarean) rate in mothers having a second baby after a previous caesarean section varies by LMC (Lead Maternity Carer). Only 8% of mothers who had a private obstetrician had a VBAC, compared to 29% in mothers with NW midwives, and 32% in mothers with an independent midwife. A Positive Birth after Caesarean Clinic was started in February 2011 and next year's clinical report will include VBAC rates for the women who attended this clinic.

Forceps and Ventouse

The rate of forceps and ventouse deliveries (combined under the term "instrumental vaginal birth") decreased in 2011. It was 11% of all births and the report notes that it has not been below 12% since 1997.

Forceps were used for 6.4% of vaginal births (down from 6.8% in 2010) and ventouse for 10.7% (down from 11.3% in 2010). For first-time mothers the rate of instrumental vaginal birth 18.2%, and for multiparous mothers the rate was 4.7%.

Some mothers are subjected to more than one instrument – forceps and ventouse, or different types of forceps, and to the birth of a baby by caesarean section after an attempted vaginal instrumental birth. In 2011 34 mothers had a double instrumental birth, and 67 mothers had an attempted vaginal instrumental birth prior to emergency caesarean section compared to 47 in 2010. The report notes that these figures are very concerning due to the significantly increased maternal and neonatal morbidity known to be associated with double instrumental delivery and with emergency caesarean following a failed attempt at an instrumental delivery.

Epidurals

The epidural rate among labouring women was 60.8% in 2011. For first-time mothers it was 83% if labour was induced and 55.8% if labouring spontaneously. For multipara it was 53.2% if labour was induced and 27.4% if labouring spontaneously. The use of epidurals is highest in first-time European women (76.2%) who are over the age of 40 (87.2%), who use a private obstetrician (85.2%).

Multiple births

The percentage of babies born in a multiple pregnancy has remained stable over the past eight years, and was 2.2% in 2011 compared to 2% in 2010.

Out of the total of 330 babies born in a multiple pregnancy 26 died. Of the 128 twin pregnancies that reached term, 78 were delivered by elective caesarean section. Only 14 (10.9%) went into spontaneous labour. The report states that 62% of twins are delivered by caesarean section and that caesarean section is now the norm. 60% of twins are born preterm.

Breech birth

Of the 314 singleton babies presenting as a breech, 268 were delivered by caesarean section. Among the 35 breech births at 32-36 weeks the percentage of caesarean deliveries was 81%, despite the fact there is absolutely no evidence to support such a practice. For the 213 breech births at 37 weeks and over the percentage of caesarean sections was 97%.

As in previous years the report again acknowledges that the findings of the Hannah Term Breech Trial has had a major effect on clinical practice and resulted in a dramatic increase in the number of caesarean sections performed for breech births, despite the flawed methodology of this trial.

Unfortunately the publication of numerous papers on the short and long term harms to the health of both mothers and babies of non-labour caesarean birth has not had the same effect on clinical practice.

Both the Royal Australia and New Zealand College of Obstetrics and Gynaecology and the Royal College of Obstetrics and Gynaecology have added a statement to their guidelines on breech births to the effect that women should be treated as individuals and that a vaginal birth can be safe. The report notes that the NWH guideline on mode of birth for breech presentation will be updated in 2012.

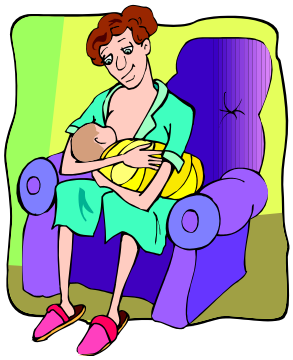
Postpartum Haemorrhage
The postpartum haemorrhage (PPH) rate continues to rise and it remains a cause for considerable concern. It is associated with the increasing caesarean section rate. The overall primary PPH rate (500mls and over) was 35.5%. It was 16% for spontaneous vaginal birth to 78.7% for emergency caesarean section and 64.1% for elective caesarean section. It also varied by onset of birth, from 24.8% in spontaneous onset to 34% in induced labour.

Postpartum Hysterectomy
In 2011 twelve women had an emergency postpartum hysterectomy compared to seven in 2010. Hysterectomies following birth are usually associated with repeat caesarean sections.

Maternal Mortality
There were two maternal deaths in 2011. Details of these deaths were sent to the Perinatal and Maternal Mortality Review Committee (PMMRC).

Breastfeeding
In 2011 81% of mothers were discharged from National Women's exclusively breastfeeding their babies.

- **A copy of the 2011 Annual Clinical Report** can be found at:
  http://nationalwomenshealth.adhb.govt.nz/Portals/0/Annual%20Reports/Annual%20Clinical%20Report%202011.pdf



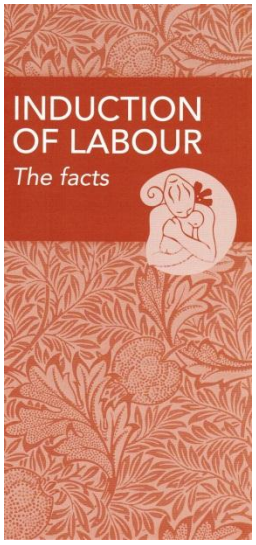
THE MSCC'S TWO NEW PAMPHLETS

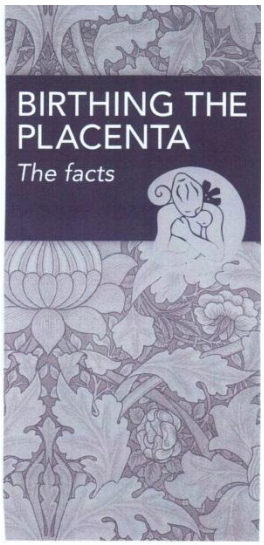
Thanks to a grant from First Sovereign, the MSCC has produced two new pamphlets in its *The Facts* series, and is in the process of writing a third on water birth.

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. It includes a list of references, and recommended websites and books to read.

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. The pamphlet includes a list of references, and recommended websites.

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 – 10 copies, to 50c for orders of 100 or more.





Want 'Better Beginnings' for Future New Zealanders?

Support the Maternity Manifesto

The manifesto seeks:

Normal Labour and Birth	Labour and birth which starts, progresses and ends naturally to be the New Zealand definition of "normal birth" and the goal for maternity services quality assessment.
Alternatives to Hospital Birthing	New Zealand needs promotion and support for healthy women to access birth centres or birth at home to increase "normal birth" rates.
Mother-Baby Unity Care Of All Sick Newborns	The New Zealand "rooming-in" standard for healthy babies and sick children should be applied to the care of sick babies.
Human Milk Banks	New Zealand, like most other countries, should re-establish human milk banks utilizing the high level of screening techniques now available.
Comprehensive Implementation of the WHO Code.	New Zealand needs to fully adopt the WHO Code to regulate the marketing of breast milk substitutes.

- Become & encourage **Individual Supporters**
- Encourage organisations to be **Group Supporters**
- Encourage **Community Leaders** to sign-up
- Make a donation

@ www.maternitymanifesto.org.nz

PARENTS CENTRE Where parenting is everything!
NZ COLLEGE OF MIDWIVES
activebirth taranaki
Kathy Fray
Mother's Milk NZ
thrive .org.nz teen parent support trust
birthcare
bay babies
WOMEN'S HEALTH Action
MAMA MATERNITY
NZBA

are some of the group supporters of the Maternity Manifesto!

Mother's Milk NZ

Mothers Milk NZ is a collaborative, which decided to champion a fundraising effort, for a much needed and long awaited breast milk bank for New Zealand. Breast milk is currently being shared between consenting donors and mothers in need of donor supplementation. However, Mothers Milk NZ would like to help further by sharing this liquid gold with other babies, who may only have access to formula products and are vulnerable to conditions and diseases that come from not being provided with human breast milk.

World Health Organisation states: "WHO recommends that low-birth-weight (LBW) infants, including those with very low birth weight (VLBW), should be fed mother's own milk. If these infants cannot be fed mother's own milk, they should be fed donor human milk (in settings where safe and affordable milk banking facilities are available or can be set up) or standard infant formula."

With this in mind, Mothers Milk NZ would like to bring New Zealand standards up to speed with our international partners, as unlike other countries we have yet to provide the gold standard of donor milk in our neonatal units. To improve outcomes, Mothers Milk NZ would like to help provide donated human specific milk, which has been carefully screened and pasteurized. This milk can be made available to sick or premature babies, adopted and large for gestation infants, the babies of mothers who are on medication and mothers who have twins or triplets etc.

Mothers Milk NZ is working in partnership with World Organic to offer mothers and friends quality organic skincare and to raise funds to help support Mothers Milk NZ's fundraising initiative, toward breast milk bank equipment.

Mothers Milk NZ receives a 20% percentage of the cost of any products that you purchase through the web shop or on the day:-

http://www.worldorganic.co.nz/mothersmilknz

All Customers: Contact Mothers Milk NZ for an invitation to our next Mothers Milk NZ: World Organic "**Mothers and friends pamper session"** where you can try these gorgeous products.

World Organic offers luxurious certified organic skin care line for people who care about the purity and quality of the products they use. World Organics skincare brands, River Veda and The Organic Skin Co, are packed with organic ingredients. Both brands bear the highly-respected European ECOCERT organic certification.

Ecocert Organic Certification

All World Organic products have been recognised with the certification mark Ecocert Organic. This guarantees that all products:

- Are free of synthetic chemical colours and synthetic fragrances
- Are free from GMO ingredients, nano particles, DEA and carbomers
- Are free from parabens, minerals, silicons, SLS and PEG (polyethylenglycol)

Mothers Milk NZ will be **launching this initiative** in conjunction with **World Breast Milk Sharing Week 24-30th of September** at The Grey Lynn Community Centre

Come and share stories and support for this very worthy endeavor and sample the World Organic Range. Bookings taken if you would like to host a fundraising pamper session.

Grey Lynn Community Centre

TUESDAY 25TH SEPTEMBER

2:30pm