Maternity Manifesto 2011; Better Beginnings.

We seek government support for:

**Normal Labour and Birth**

Labour and birth which starts, progresses and ends naturally achieves most couples’ desired birth outcome as well as uses less of limited health resources in both the short and long terms.

This should be the New Zealand definition of “normal birth” and the gold standard or goal for maternity services quality assessment. New Zealand needs campaigns to monitor and improve such “normal birth” rates.

**Alternatives to Hospital Birthing**

The place of birth dramatically affects birth outcomes – specifically, healthy women giving birth in hospital maternity units have more interventions than at birthing centres or at home. However perinatal morbidity and mortality at birthing centres and home are comparable to hospital, with higher maternal satisfaction. Yet the vast majority of New Zealand births are in hospital with increasing intervention rates.

Promotion and support for healthy women to access birth centres or birth at home will increase “normal birth” rates, benefiting women, whanau and the community.

**Mother-Baby Unity**

Care Of All Sick Newborns

There is growing evidence of the benefits and means to not separate sick newborns from their mothers, as such separation leads to long-term poor outcomes.

The New Zealand “rooming-in” standard for healthy babies and sick children should be applied to the care of sick babies.

**Human Milk Banks**

When mother’s milk is not available for a baby, the next best choice is human milk from another mother.

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.**

To achieve the MOH target to raise the proportion of infants exclusively breastfed for at least the first six months, New Zealand needs to fully adopt the WHO Code to regulate the marketing of breast milk substitutes, as marketing currently undermines the efforts of our women and community.

Our goal is optimal maternity care outcomes for New Zealanders with more efficient use of limited health resources than presently happens. Evidence suggests that the directions we seek are consistent with this goal.

**Normal Labour and Birth.**

New Zealand women, like their UK counterparts, often say that they would ‘prefer to avoid interventions, provided that their baby is safe’\(^1\), but there is no way of knowing how many women in NZ achieve this goal. The NZ definition of ‘Normal birth’ used for national data collection refers to any vaginal birth in NZ \(^2\), in contrast to WHO\(^3\) and UK\(^4\) definitions of “Normal Birth” which refer to a labour that starts, progresses and ends naturally or spontaneously. Natural labour uses less of our limited health resources as well as achieving NZ mothers’ birth preferences.
As well as meaningful definitions, the UK and Canada also have campaigns to monitor and improve rates of ‘Normal Birth’ and programmes to lower surgical birth outcomes. The UK campaign was launched by an All-Party Parliamentary Group on Maternity (APPGM) which is “a cross-party group of MPs and Peers with an interest in the maternity services. Established in 2000 the group raises awareness of the important part maternity provision has to play in improving women and babies’ health”. The UK “Campaign for Normal Birth” is a practical, accessible and evidence based effort, developed and supported by a broad range of maternity professional and user organisations including the Royal College of Midwives, Royal College of Obstetricians & Gynaecologists and the National Childbirth Trust, which has no NZ equivalent!

In the UK, ‘normal birth’ rates are recognised as an indicator of maternity services quality. Therefore we call on the government of New Zealand to specifically:

- Set a definition for ‘normal birth’ consistent with international standards,
- Develop an accessible, practical NZ campaign to increase ‘Normal Birth’,

### Alternatives to Hospital Birthing

There is growing New Zealand evidence which shows that place of birth - home, primary, secondary or tertiary maternity unit – has a dramatic effect on interventions such as: epidural anaesthesia, induction and augmentation of labour, operative vaginal delivery including caesarean section rates. Evidence indicates that when healthy women labour and birth in secondary or tertiary hospital maternity units, they have incrementally increased risk of the aforementioned interventions, compared to birthing at home or in a primary birthing unit - even when they have continuity of carer. There is similar impact of place on birth outcomes in Australia though there the differences are related to private or public hospital based care. New Zealand studies are also beginning to show that place of birth impacts on midwives’ practices.

Though the rate of childbirth interventions is much higher in hospital units, the outcomes (perinatal mortality and morbidity) are comparable to home and primary birthing units for low risk women. Low risk women report higher satisfaction with their birth experience in “home-like” environments compared to those birthing in hospital environments.

Yet most low risk women in New Zealand give birth in hospitals for example nearly 84% of all births in 2007 occurred in a tertiary or secondary hospital. Meanwhile, the UK the July 2011 Expert Advisory Group report of the Royal College of Obstetricians and Gynaecologists said; “Too much care is provided within secondary and tertiary settings. Too many babies are born in the traditional ‘hospital’ setting. We need to drive this care back into the community with the appropriate provision of facilities and professionals with appropriate skills.”

### Primary Birthing Units (Birth Centres).

Increased understanding of the impact of environmental factors on labour and birth confirm the findings of UK surveys of women who have birthed at home, in hospitals and birth centres, as to factors which aid or hinder progress. These elements have been incorporated into the Mind-Body-Spirit Architecture of Bianca Lepori to create spaces which optimally support physiological labour and birth. Few, if any, of these elements feature in the passive patient, clinical set-up of NZ maternity hospital units.

A Birth Centre can:

- address social exclusion by creating an open, flexible and accessible non-judgmental approach to care.
• build communities by forging links with parallel agencies
• reduce the costs of maternity care by lowering the intervention rates including lower caesarean section rates
• enhance recruitment and retention of midwives through increased job satisfaction
• encourage partnership and multidisciplinary efforts by working in the heart of the community.

Creating local birth centres that are appropriately designed community managed, family-friendly and culturally sensitive across New Zealand would also extend the benefits of Whanau Ora and integrated health centres to all whanau and communities. However as the funding for all levels of maternity facilities are vested in the hands of District Health Boards (DHB) the development of primary birthing units as an alternative to hospitals in Wellington, Dunedin, Palmerston North and Waitemata have to-date been thwarted.

Therefore we call on the government of New Zealand to specifically

• Widely publish data on all birth outcomes and their trends to aid women’s informed choice,
• Provide dedicated support and funding to ensure equitable access of well women to local community oriented, physiologically appropriate and culturally sensitive primary birthing units.

Homebirth Promotion.

In the UK there are campaigns by the national health services and parliaments of each member country to increase homebirth rates. The Royal College of Obstetricians publicly supports homebirth stating:

“The review of the diverse evidence available on homebirth practice and service provision demonstrates that home birth is a safe option for many women.”

Similarly in Canada, medical groups acknowledge the growing evidence supporting homebirth with a midwife as a valid birth option for well women. The most recent West Australian government review confirmed there is “no evidence of adverse outcomes associated with planned home birth in low risk pregnancy”.

More overt support by the NZ government and MOH for normal birth by low risk women in the community would be consistent with the evidence, collaborative nature of our maternity services as well as supportive of the relationship between NZ women and their midwives. Additionally the parliament and its agencies should address any unbalanced media which contributes to social distrust of normal birth or reinforces the myth that hospital is safer.

Therefore we call on the government of New Zealand to;

• Address misinformation that birth is inherently dangerous and celebrate New Zealand’s unique, whanau centred maternity services
• Publicly support birth at home with a known midwife as a safe and valid option for well women
• Engage in partnership with women, midwives, media and the medical profession to achieve these goals.

Mother-Baby Unity Care Of All Sick Newborns.

Around the world, a mother or father’s body is gradually replacing the incubator as the site for care of sick newborns, even for those on ventilators. The Breastfeeding Authority of New Zealand has produced posters, a leaflet and DVD outlining and promoting the benefits of Skin-to-Skin Care for Newborn Babies, as this is evidence-based practice to aid the initiation of breastfeeding. This information is becoming main stream as there is a You Tube video explaining the benefits and means to incorporate Skin-to-Skin care for all babies after birth as well as a 6 part series on evidence about the consciousness of babies called ‘What babies want’ including the negative impacts of mother-baby separation.

The Newborn Services Clinical Guidelines of Auckland District Health Board website outlines the benefits of Kangaroo Mother Care (KMC). KMC is the central use of Skin-to-Skin care in the management of premature or sick infants. However this unit’s protocols as to when they employ this approach results in periodic use. Mothers report even
periodic use of KMC is not common in New Zealand Neonatal Intensive Care Unit (NICU) facilities. The emphasis in New Zealand NICU remains on using hospital procedures and practices (e.g., ventilation) in the care of sick and pre-term infants, rather than on relationship-based care such as establishing breastfeeding. Most parents of NICU babies in New Zealand are almost secondary to their children’s medical care, with the mother often feeling little more than a milk supplier.

Rooming-in of mother and baby promoting close physical proximity during the hospital stay is the norm for healthy newborns and sick children in New Zealand; this rooming-in policy should be extended to neonatal units. The number of babies admitted to New Zealand neonatal units because of prematurity or illness is substantial; estimated to be greater than 7% and rising. Improvements in medical care have resulted in impressive survival statistics for premature babies, but the accompanying mother-baby separation can have negative long-term effects for infants and their families. Observed effects include:

- increased rate of mental illness due to attachment issues
- Increased eating disorders
- significant risk of parental abuse

Internationally, new standards of care in both resource-rich and poor countries support a more humane model of neonatal care. It is recognised that many of the adverse health outcomes that babies experience in the NICU setting are less a result of their prematurity, and more about maternal infant separation.

The benefits of keeping mothers and babies together include:

- Improved breastfeeding rates leading to health benefits for both the baby and mother
- Improved maternal-infant attachment and decreased likelihood of child abuse and mental illness
- Increased and earlier readiness for discharge from hospital, with increased confidence and trust in the mother/baby relationship and increased ability to cope with the stress and emotions of having a premature or sick baby
- The acknowledgement of the importance of the baby within the family unit
- Better health outcomes for less cost.
- Dr Pat Tuohy (Chief Advisor Child and Youth Health) said in 2003: “Over the past few decades there has been a significant shift in the models of care for parents and their babies. There is increased contact between parents and their babies to enable bonding and parents now expect to be able to spend as much time with their baby as possible. This model of care extended into the future may ultimately lead to the provision of facilities such as beds for mothers beside their baby’s incubator or cot in neonatal units.” Nearly a decade later, there is still no New Zealand plan to support this recognised need.

Therefore we call on the government of New Zealand to

- Develop an action plan for all NICUs to practice 24 hour rooming in for mothers and babies.
- Require that DHBs enable any mother who wishes to room-in the right and means to do so,
- Ensure that all DHBs have Kangaroo Mother Care policy and practices throughout their facilities.

Human Milk Banks.

The ongoing joint WHO and UNICEF position, most recently endorsed by the World Health Assembly in 2002, states that: “Where it is not possible for the biological mother to breastfeed, the first alternative, if available, should be the use of human breast milk from other sources. Human milk banks should be made available in appropriate situations.”

The New Zealand Breastfeeding Authority (31 maternity professional and consumer organisation members) published a statement in support of human milk banking in February 2010. This statement lists supportive evidence about the benefits of breastmilk for premature babies, as well as quoting the aforementioned WHO/UNICEF position.
The AIDS epidemic last century led to the closure of the majority of milk banks around the world. However improved screening techniques for the HIV virus and other pathogens such as Hepatitis C, has seen an international resurgence in milk banks in the last 20 years.

There is indisputable evidence of the vital superiority of breast milk, particularly when compared to the possible poor outcomes of giving premature babies artificial substitutes, for example at least a threefold increased risk of life threatening Necrotizing Enterocolitis (NEC). Internationally, human milk banks have been recognised as a means to meet fundamental human rights of our most vulnerable infants.

Table 1: Numbers of milk banks around the world

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of milk banks</th>
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<tbody>
<tr>
<td>Europe (23 countries)</td>
<td>158</td>
</tr>
<tr>
<td>North America</td>
<td>16</td>
</tr>
<tr>
<td>India</td>
<td>25</td>
</tr>
<tr>
<td>Brazil *</td>
<td>186</td>
</tr>
<tr>
<td>Australia**</td>
<td>4</td>
</tr>
<tr>
<td>New Zealand</td>
<td>0</td>
</tr>
</tbody>
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* Brazilians have developed banks in most other Latin American countries & several African nations
** King Edward Memorial Hospital (Perth) has developed guidelines to establish milk banks elsewhere in Australasia.

New Zealand has no milk banks despite increasing public support and public informal milk sharing in the absence of a bank, as evidenced by the growing memberships of 2 Face book groups “Mother’s Milk NZ” and “Eats on Feet NZ”. Meanwhile groups of maternity care workers in several regional centres (Christchurch, Waikato, Auckland and Wellington) have lobbied for milk banks but so far have been unable to secure effective support from their respective DHB, as reported on ‘Campbell Live’ this year. Yet government support of milk banking in New Zealand would be consistent with many policies and directives promoting breastfeeding as optimal nutrition for all infants.

Therefore we call upon the government of New Zealand to

- Provide dedicated funding, bureaucratic and legislative support to establish a national human milk bank service for all premature and sick babies, wherever they are in New Zealand.

Comprehensive Implementation of the WHO Code.

The WHO recognises the impact of marketing breast-milk substitutes on breastfeeding prevalence and duration through its International Code of Marketing of Breast-Milk Substitutes. This code seeks to ethically and appropriately regulate such marketing worldwide.

The MOH has a target to increase the proportion of infants exclusively breastfed at: six weeks to 74% or greater, three months to 57% or greater, six months to 27% or greater, yet New Zealand has adopted a voluntary and diluted interpretation of the Code.

Current New Zealand advertising campaigns promoting “follow-on” formula do not contravene this voluntary standard, though they sabotage the aforementioned MOH targets, let alone the WHO recommendation to continue breastfeeding into the child’s second year of life. Evidence shows that the longer a baby receives breast-milk, the greater the health benefits for the infant, his mother and family. Stronger guidelines are needed especially to raise the current levels of breastfeeding above 13-14% for Maori or 17-18% for Pacific Islanders, our most vulnerable families.

In May 2010 the United Nations (UN) World Assembly expressed concern about voluntary means to address violations of “the Code”. “Look what they are doing” presents some of the evidence used in a petition to parliament which has resulted in an imminent review of ‘the Code’ in New Zealand.
Meanwhile studies have estimate that 1.45 million infant lives are lost annually due to suboptimal breastfeeding in 'developing countries' and confirm that infant feeding decisions significantly affect mother-child health outcomes globally, even in settings with clean water and good sanitation, such as New Zealand.

We call on the government of New Zealand to

- Implement a compulsory "code" supported by rigorous legislative, regulatory and community based measures such as education.

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