



MARCH 2008 NEWSLETTER

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

Welcome to the first issue of the Maternity Services Consumer Council Newsletter for the year. It promises to be a very demanding year in the maternity sector especially if the media interest continues at its current rate. As 2007 drew to a close stories about maternity care or the lack of it featured in news items on radio and TV and in the newspapers on almost a daily basis. During January the MSCC was contacted every week by either *Radio New Zealand* or the *New Zealand Herald* with a request for a comment on a maternity services issue. The MSCC has as one of its objectives this year making the need for considerable improvements to the postnatal care and support available to new mothers an election issue, so we intend to use every media opportunity we get to push this issue.

Screening for HIV during pregnancy

This year will see most of the DHBs start antenatal HIV screening as the screening programme which is already underway in the Waikato region is implemented in other parts of the country. In the Auckland region the three DHBs together with the Northland DHB are working together on this project and currently running sessions for GPs and midwives on how the programme will be implemented. One of the major problems is the lack of informed consent around blood tests taken during pregnancy, as the majority of pregnant women do not know what tests are undertaken when they first go for a blood test at the beginning of their pregnancy. The MSCC frequently hears from childbirth educators that few women know they have been tested for syphilis, for example. Midwives also report that in the Auckland region a good many women that they take on LMC care for, have already had an HIV test but were not told by the GP who ordered the test. As the HIV test becomes a routine part of the first blood tests taken during pregnancy, the lack of informed consent that continues to surround antenatal screening is an issue of major concern to the MSCC. Efforts so far to bring this to the attention of the appropriate authorities appear to have been largely unsuccessful.

What's in this issue of the newsletter

This issue of the MSCC newsletter contains a summary of some of the statistics from the National Maternity Report for 2004, an article on the increased risk of respiratory infections in babies born by elective caesarean sections, a brief description of a book called "*The Birth House*" that was published last year, an update on the reviews being carried out into A1/A2 milk.



NATIONAL MATERNITY REPORT FOR 2004

In July last year the New Zealand Health Information Service (NZHIS) finally published the National Maternity Report for 2004. It is the fifth report in the series of National Reports on maternity services.

The report contains information on the outcomes, availability and utilisation of maternity services for women who gave birth in New Zealand in 2004. As with the 2003 report there is significantly less data than there was in the maternity reports for previous years. The stakeholder advisory group that provided input into the production of the report was disbanded several years ago and the impetus for producing timely information has been lost. The MSCC began making enquiries about when we can expect the 2005 report to be published six months ago and recently sent another letter to the Minister of Health about this.

MNIS

The data is based on information reported to the National Minimum Dataset (NMDA) and to the Maternal and Newborn Information System (MNIS). MNIS was established in 2001 and contains data from 1999 onwards. The data is collected from two major sources – HealthPAC (Health Payments, Agreements and Compliance, formerly known as Health Benefits Ltd) which collects data from claims for payments submitted by lead maternity carers (LMCs) for maternity services provided during pregnancy, birth and the postnatal period, and from NMDA which has data reported when a person is discharged from hospital.

The NMDA has achieved complete coverage of all hospital births, but the MNIS coverage decreased from a peak coverage of 83% in 2003 to 77% in 2004. The report's states that "this decrease appears to be due to a reduction in the number of claims submitted by LMCs for maternity services provided in 2004," and comments that "continued improvement in coverage is critical in order to realise the full potential of MNIS as a key source of maternal and child health data."

This report includes information not included in previous reports, such as

- rates of maternal death,
- distribution of liveborn babies by birth weight and sex, and by gestational age,
- postnatal midwifery home visits made, by mother's age group, ethnicity and parity,
- planned homebirth.

Tables on private specialist obstetrician consultations and private specialist paediatrician consultations have been dropped "because they present only a small proportion of the overall number of private consultations performed in New Zealand."

In 2004 a total of 54,875 mothers gave birth (compared to 54,581 in 2003) in New Zealand hospitals to 55,213 liveborn babies (compared to 55,119 in 2003) and 441 (0.8%) babies who were stillborn. However Statistics NZ reported the registration of 58,723 liveborn babies to 57,591 mothers for the same period. The report says that births outside hospitals may account for the difference between in-hospital birth numbers and the Statistics NZ numbers.

Age of women giving birth

The data reveals that in 2004 the median age for NZ women to have a baby was 30.3 years (compared to 30.2 in 2003 and 29.7 years in 2002). For Maori mothers the median age was 26.0 years and for Pacific mothers it was 27.7 years.

The percentage of mothers aged 30 years and over continued to gradually increase, accounting for 51.2% of births in 2004 (compared to 50.6% in 2003). Correspondingly the percentage of mothers aged 20-29 years continued to decrease – 41.6% in 2004 compared to 42.4% in 2003. 7.2% of mothers were less than 20 years of age (compared to 7% in 2003).

Ethnicity of mothers

The majority of mothers who gave birth in 2004 were European (57.1%) while 19.9% of births were to Maori women (19.8% in 2003), 10.1% were to Pacific women (10.5% in 2003), and 8.8% to Asian women (8.6% in 2003). Maori women tend to have children at a younger age than women in other ethnic groups and in 2004 their fertility rate peaked in the 20 – 24 age group. Maori girls also accounted for nearly half of births to teenage mothers.

In comparison, the peak for Pacific women was in the 25-29 age group and for Asian and European women in the 30-34 age group.

Decline in normal births

The report reveals that in 2004 66.5% of mothers had a vaginal birth, compared to 67.4% in 2003. In 2004 23.7% of women had a caesarean section compared to 23.1% in 2003 and 22.7% in 2002. Of this figure 14.5% were acute caesarean sections and 9.2% were elective. Operative vaginal births (forceps (3.1%) and vacuum (6%) extractions) rose from 8.9% in 2003 to 9.6% in 2004, although the latter continues to increase as these are considered to be less traumatic for both mother and baby. Only 23.9% of women had an unassisted vaginal birth!

Caesarean sections

Age is one factor associated with the caesarean births as the percentage of normal births decreased markedly with the increasing age of the mother – in 2004 37.6% of women over 40 years of age had a caesarean section (35.8% in 2003) compared with only 13.4% of women in the 16 – 19 age group. Maori and Pacific women were more likely to have a normal birth (spontaneous birth without assistance) compared with women in other ethnic groups. In contrast, caesarean sections were more common among Asian and European mothers.

While acute/emergency caesarean sections accounted for the majority of caesarean sections, European women are more likely to have an elective caesarean section.

In Auckland in 2004, North Shore Hospital recorded a caesarean section rate of 32.3%, Auckland City Hospital's caesarean section rate was 29.6%, and for both Waitakere and Middlemore hospitals it was 18.2%.

Like other developed countries New Zealand's overall caesarean section rate has continued to increase – from 11.7% of all births in 1988 to 20.8% in 2000 and 23.7% in 2004. The report notes that "currently no consensus exists in New Zealand regarding the optimal caesarean section rate for the best health outcomes. However, there is general consensus that the current rate is too high."

Ultrasound scans

The average number of ultrasound scans performed on pregnant mothers in 2004 was 2.4 which represented a slight increase from the 2003 average of 2.1. Around 9% of mothers had no ultrasound examinations. Asian and Pacific mothers had the highest proportion of no reported scans (13.3% and 13.1% respectively). In contrast 37.9% of mothers had three or more ultrasound scans with the highest proportion for European mothers (43.3%). Repeated ultrasound scans were also more common amongst older mothers and mothers living in urban areas.

Inductions

Inductions are one of the factors associated with the rise in the caesarean section rate. In 2004 20.4% of mothers were induced (19.7% in 2003). The report notes that ethnic differences are also apparent in the rate of induced birth, although the ethnic disparities are not as great as those for epidurals – European (22.8 per 100 births), Asian (18.5 per 100 births), Maori (15.5 per 100 births), and Pacific (18.1 per 100 births). Mothers aged 40 years or over had the highest rate of induction (32.2 per 100 births, compared to 25.8 in 2003).

Rates of inductions ranged from a high of 27.5% in Southland DHB to 12.4% in Hawkes Bay DHB and 12.9% in Lakes DHB.

Epidurals

The national rate of epidural administration was 28% in 2004 (compared to 24.2% in 2003). This figure excludes the 9.2% of births by elective caesarean sections. The range of epidural use ranged from 44.7% in Auckland DHB and 42.9% in Capital and Coast DHB (40% in 2003) to 5.4% in Lakes DHB (3.7% in 2003). These figures do not include births by elective caesarean sections.

There are also ethnic differences in the use of epidurals. European women (33 per 100 births, compared to 28.3 in 2003) and Asian women (36.4 per 100 births, compared to 32 in 2003) have double the use of epidurals of Maori (14.8 per 100 births) and Pacific 18.4 per 100 births) women. Mothers aged 35-39 years had the highest rate of epidural use (31% compared to 24.8% in 2003).

Pre-term births

In 2004 7.1% of babies were born before 37 weeks of pregnancy compared to 7.2% in 2003. Maori women had the same rate of pre-term births as European women (7.4%). Both Asian women (6.2%) and Pacific women (6.2%) had fewer pre-term babies. In 2004 1% of New Zealand babies weighed less than 1500g at birth.

Postnatal readmissions

In 2004 8.1% of mothers required a postnatal re-admission, down from 8.3% of mothers in 2003. Taranaki, Tairāwhiti and Hawkes Bay DHBs had the highest rates of postnatal re-admission for mothers. The majority of mothers were readmitted for 'postpartum care and examination' (31.2%), 'infections of the breast associated with childbirth' (15.4%) or for 'other puerperal infections' (11.3%). The average length of stay for these mothers was 2.5 days.

Lead Maternity Carers (LMCs)

In 2004 75% of women had a midwife as their LMC at first registration, and 75.9% had a midwife as their LMC when they gave birth. 5.6% of women had a GP as their LMC at first registration and this figure had dropped to 4.5% at the time of giving birth. 6.1% of women had an obstetrician as their LMC at first registration, and 6% at birth. For the remaining percentages it was either not known or was not stated.

Midwives had the highest proportion of mothers aged under 30 years, while obstetricians were more likely to be the LMC for women aged over 30 years. Maori mothers were more likely to register with a midwife (81.9%) and less than 1% registered with an obstetrician.

Tairāwhiti DHB had the highest proportion of its mothers registered with a midwife (95.8%), Lakes had 94.3% and Whanganui had 88.4%, whereas mothers in South Canterbury DHB were more likely to have an obstetrician as their LMC (66.3%). In the Wairarapa 38.9% of women had a GP as their LMC.

Postnatal Care

LMCs are obliged to provide postnatal care until 4 - 6 weeks after the birth. This includes a minimum of seven postnatal visits of which 5 – 10 are home visits by a midwife. In 2004, 18.6% of home visits remain unreported. However this is an improvement from the 28% of visits that were unreported in 2003! In 2004 2.7% of mothers had 1-4 home visits, 45.3% had 5-7 visits, 26.9% had 8-10 visits and 6.5% had more than 10 home visits.

Breastfeeding

The reports notes that the breastfeeding data is based on reports by LMCs for infant feeding at 2 weeks of age and at discharge from LMC care (4 – 6 weeks). The majority of babies (84.9% - 38,361) had a breastfeeding status reported at two weeks and 15.1% (6848) had a breastfeeding status reported as unknown.

Nearly 60% of babies had an exclusively breastfed status at two weeks (57.4%), whereas at discharge from LMC care, the proportion of babies being exclusively had decreased to just under half (49.3%).

The rate of exclusive or full breastfeeding appeared to be lower for teenage mothers, and to a lesser extent among Asian and Pacific mothers. Maori mothers aged between 25-29 years were more likely to exclusively or fully breastfeed. For Pacific and European mothers, exclusive or full breastfeeding was more common amongst mothers aged 30-44 years.

- **As the *Report on Maternity 2004* is yet to made available on the Ministry of Health website www.moh.govt.nz, write to PO Box 5013, Wellington.**

The Birth House

This gripping first novel by radio journalist Ami McKay was written after she moved with her family to Scots Bay in Nova Scotia and discovered that her new home was once known as the birth house.

The story is set in a small village in Nova Scotia and is centred around Dora Rare, the first female to be born in five generations of Rares. As a child Dora is befriended by Miss Babineau, an outspoken midwife with a talent for telling tales and a kitchen filled with folk remedies. Dora becomes Miss B's apprentice at the outset of World War I, learning the age-old practices of midwifery and its secret ways. Together they help the women of Scots Bay through infertility, difficult labours, unwanted pregnancies and even unfulfilling marriages.

Trouble looms when Dr Gilbert Thomas arrives in town with promises of sterile, painless childbirth, causing some of the local women to question Miss Babineau's methods. After her death, it falls to Dora to protect the birthing traditions of her community, as Dr Thomas sets about undermining her credibility. The divisions in Scots Bay grow deeper after the tragic death of a woman who sought Dora's help, and betrayal, accusations and exile follow.

To find out what happens next you will have to read the book yourself. The MSCC has a copy if anyone wants to borrow it. Just phone the office on 520-5314.

BABIES BORN BY ELECTIVE CAESAREANS HAVE INCREASED RISK OF SERIOUS RESPIRATORY PROBLEMS

A recent paper published in *British Medical Journal* in December 2007 received a great deal of publicity both in New Zealand as well as around the world. The study was undertaken in a university of hospital in Denmark revealed that when comparing birth by elective caesarean section to vaginal birth babies have a twofold to fourfold increased risk of neonatal respiratory morbidity and an even higher risk of serious respiratory morbidity newborns born at full term.

“Lack of hormones associated with labour could explain this association. During spontaneous labour there is a decrease in secretion of fetal lung liquid and an increase in its absorption and the release of surfactant is stimulated. This may be mediated by a raised level of catecholamines in the fetus in response to the rupture of membranes and labour. When caesarean sections are carried out before labour this catecholamine surge is absent,” the Danish authors of this study reported.

The researchers studied all liveborn babies without malformations born between 37 and 41 weeks who were born between 1 January 2 1998 and 31 December 2006, which represented a total of 34,458 babies. All pregnancies affected by intrauterine growth retardation, diabetes and pre-eclampsia were excluded, as were babies in breech presentation. They concluded that “compared with newborns delivered vaginally or by emergency caesarean sections, those delivered by elective caesarean section around term have an increased risk of overall and serious respiratory morbidity. The relative risk increased with decreasing gestational age.”

The researchers also pointed out that the option of giving corticosteroids at the end of pregnancy to women who give birth by elective caesarean section might reduce neonatal respiratory morbidity. This has been tested in a randomized controlled trial, which showed that betamethasone given during the antenatal period reduced neonatal respiratory morbidity as did delaying the birth until 39 weeks’ gestation. However, the long term safety of antenatal steroid administration is still being debated.

When the *Sunday Star Times* reporter contacted the MSCC and asked for a comment on these findings, Lynda Williams pointed out that a study by Lagercrantz and Slotkin published in *Scientific American* in April 1986 said much the same thing. Entitled “The Stress of Being Born” the paper described how during the second stage of labour, the role of a catecholamine surge is to protect the fetus during the stress of birth and to enhance fetal function after separation from its mother. Part of this surge is due to normal hypoxia occurring in nearly all newborns. The actions of the catecholamines serve to improve breathing, protect the baby’s heart and brain, stimulate the newborn baby and facilitate bonding. Interfering with this process will of course cause problems.

- Hansen AK et al “Risk of respiratory morbidity in term infants delivered by elective caesarean section: cohort study.” *British Medical Journal*, Dec 2007.

EASY WAYS TO RESIST CHANGE IN OBSTETRICS

In light of the preceding article, it is timely to revisit an item (with a few changes) that were published in the *British Medical Journal* in December 2004. These are the time-honoured techniques that help doctors resist changing their ways of practicing obstetrics:

Don’t pay attention

Get so busy with your obstetric practice that you don’t have time to read, attend meetings, understand your own practice or observe the practice of colleagues.

Attack the data

When provided with new information (or new studies that confirm old information from previous studies):

Firstly, diss the source. No-one expects you really to believe information from sources outside your specialty or geographical area.

Secondly, question the validity of the information. Every study or report contains some loophole in its fabric, however small, that can be snagged and used to unravel the validity of the whole study. Use the common logical ploy that holds that if any aspect of the study is imperfect, the entire study results must be wrong.

Thirdly, question the applicability to your patients. Studies are done “out there” and can’t possibly reflect the unique nature of your practice. This technique is especially useful when data from large studies contradict impressions gleaned from personal experience with a few patients.

Maintain absolute confidence

Remember all the smart professors you had and realise that everything you need to know to practice good medicine was taught in medical school. Instead of worrying about this newfangled “evidence based” medicine, stick with “belief based medicine” and organise your thoughts by using the criteria below.

Levels of belief

Class 0: Things I believe

Class 0a: Things I believe despite the available data

Class 1: Randomised controlled clinical trials that agree with what I believe

Class 2: Other prospectively collected data

Class 3: Expert opinion

Class 4: Randomised controlled clinical trials that don’t agree with what I believe

Class 5: What you believe that I don’t

Follow the pack

Waiting for your colleagues to change before you (reluctantly) join them. Of course if you follow the first technique correctly, you will never know what your colleagues are doing.

Blame the patients

Claim you’d like to practise differently but your patients wouldn’t like it. Everyone will understand why you still insist on routine electronic fetal monitoring throughout labour, and will always agree to perform a caesarean section upon maternal request.

Show how much you have changed

Point to all the new drugs you use as a result of information provided by pharmaceutical representatives. After all, it’s more important to feel up to date than to actually be up to date.

Pull rank

When a patient brings in information they’ve downloaded off the internet, or a midwife makes a suggestion, make sure you ignore it. Be sure to say, “When did you get your medical degree?”

Simply refuse

When presented with threatening new information, say what was muttered after a presentation during a continuing education session: “I wouldn’t believe this information even if it were true.”



TWO REVIEWS ON A1/A2 MILK DEBATE

In December 2007 Food Safety Minister Lianne Dalziel announced that there will be two reviews into the food safety implications of A1/A2 milk. Dr Stuart Slorach, former Chair of the Management Board of the European Food Safety Agency (EFSA), has been appointed to head an independent review into the risk management decision-making processes adopted by the NZ Food Safety Authority (NZFSA).

The Cabinet paper on the arrangements for the two reviews state that “NZFSA prepared these Terms of Reference” for the first review. Three of the eight terms of reference focus on Professor Boyd Swinburn’s report, *Beta-casein A1 and A2 in milk and human health*, the NZFSA’s response to the report, the delayed release of the lay summary prepared by Professor Swinburn and his non-availability to respond to media queries resulting from the release of his report. There are repeated references to risk management and risk management systems but little about the public’s right to information upon which to make their own decisions. The fact that NZFSA is playing such a major role calls into question how much credibility can be attached to the outcome.

On 1 February 2008 the NZFSA announced that first stage of Dr Slorach’s review was nearing completion and after two weeks in New Zealand Dr Slorach was returning to Europe, where he will visit the government food safety agencies of Ireland, Denmark and Sweden. Having been carefully shepherded around New Zealand by the NZFSA it is hoped that Dr Slorach will have considerably more independence when visiting the European food safety agencies.

Dr Slorach will return to New Zealand in late March to finalise his review. His report is required to include a description of the NZFSA system, a description of international best practice in the area, a comparison between the NZFSA system and best practice, and a commentary on the application in recent risk management decision-making matters. How much involvement the NZFSA has in the final report will also be a cause for concern.

The second review involves a re-examination of the scientific research relating to A1/A2 milk, and the NZFSA is currently working with the European FSA in relation to reviewing the science.

- Further information on the reviews can be found on NZFSA’s website at:
www.nzfsa.govt.nz/publications/hot-topics/hot-topic-a1-and-a2-milk.htm

CONFERENCES

NSU Screening Symposium 2008

Te Papa Museum, 14-15 April 2008

Get screened and live forever? A forum aims to explore the opportunities, challenges, benefits and harms of screening.

How much can screening achieve? Are we heading in the right direction and where do we draw the line? The 2008 Screening Symposium will pose these questions, challenge people to think about what screening can and cannot achieve, and create a forum for debate and discussion.

Keynote speakers include Professor Alistair Woodward, Professor Simon Chapman, Associate Professor Papaarangi Reid, and Professor David Roder.

The Symposium is a 'must attend' for anyone who works in screening or in an area affected by screening, or who has an interest in the issue.

<http://www.nsu.govt.nz/2468.asp>



Birth, Breastfeeding and Beyond

Auckland, Wednesday 4 June 2008

**Capers Bookstore bring the following speakers together in Auckland
Michel Odent, James McKenna, Alison Barrett & Carol Bartle**

Topics: Breastfeeding in the age of the safe caesarean, Where do babies come from? Breastfeeding and Safe Co-Sleeping, Oxytocin in the age of the "Scientification of Love", The Scientification of Breastfeeding - For better or worse, Mother-Baby choreography and post-birth improvisations, Mother-Infant Breastfeeding and Bedsharing: Ongoing research

<http://www.capersbookstore.com.au/events/bbb.htm>

FROM THE NEWSPAPERS

This year is election year and with postnatal care on the MSCC agenda yet again, borrowing from how the Dutch provide maternity care to new mothers in order to put pressure on our politicians for some much needed improvements to our maternity care system seems like a really good idea here in New Zealand as well.

Tories plan nurses at home for all new babies

[Nicholas Watt](#), political editor

(This article appeared in [the Observer](#) on [Sunday February 03 2008](#).)

A Conservative government would aim to provide a dedicated maternity nurse for every new mother in their home for up to six hours a day in the first week after the baby's birth under radical plans to transform UK maternity care.

In a major shift in direction, which will prompt charges that the Tories are embracing the 'nanny state', David Cameron has told his front bench to examine plans that would lead to the appointment of thousands of new maternity nurses. He is impressed by a ground-breaking Dutch system under which nurses have a range of duties in the first week after birth, including:

- Showing new mothers how to breastfeed and bathe their baby;
- Looking after older children and making sure healthy meals are provided;
- Taking care of laundry and light household cleaning;
- Monitoring visitors to the mother's home to ensure that rest times are not interrupted;
- Keeping a diary with details of the mother and baby's progress for use by doctors and midwives.

The Tory leader believes that the Dutch system, known as 'kraamzorg', would be a vast improvement on the British system, which provides little support for new mothers once they have left hospital or given birth at home under the direction of a midwife, unless a baby is deemed to be 'at risk'.

As he prepares to launch a new offensive on family-friendly policies in the run-up to next month's Tory spring conference in Gateshead, Cameron has instructed two leading members of his shadow cabinet to travel to the Netherlands to examine its extensive maternity care. Cameron has told Michael Gove, the shadow Children's Secretary, and Andrew Lansley, the shadow Health Secretary, that a Conservative government must do better than Labour, which has improved care for toddlers but not for the newly born.

Gove yesterday praised the Dutch system. A father of two young children, he told The Observer: 'The Dutch system of maternity nurses for all helps parents in the vital first few days, ensuring there's an experienced extra pair of hands there to guarantee both mother and baby get rest while providing expertise on everything from bathing to breastfeeding. 'If we can provide a better level of support for parents in the first months, we may be able to help crack some of the problems of inequality and social mobility which hold us back as a country, by ensuring that every child gets the sort of support that currently only the wealthier can buy.'

The new Tory policy move will be seen by Labour as an attempt to deflect attention from the downfall of Derek Conway, who was stripped of the Tory whip and suspended from the Commons last week for 10 days after he paid what some MPs called his 'all but invisible son' to work for him.

In addition to the maternity initiative, the Tories announce a raft of new policies today, including one on crime - with a pledge to allow police to charge a wider range of offenders, instead of passing paperwork to prosecutors - and another to help small businesses.

A poll in the Sunday Telegraph today puts the Tories ahead, though their lead is down to five points. The Tories are on 37 per cent, down three points, Labour is on 32 per cent, down one, and the Liberal Democrats are up three on 21 per cent.

Labour is likely to attack the maternity plan as an unrealistic and expensive spending commitment. The Observer estimates that the initiative for new mothers would cost at least £150m a year if fully implemented across England and Wales, where there were 669,601 births in 2006.

A specialised maternity nurse providing the Dutch level of cover would probably be able to assist two new mothers a week at a cost of £1,000.

Cameron will dismiss such attacks on the grounds that he would move cautiously. A British version would be introduced in stages because a 'big bang' approach would be prohibitively expensive. It could be piloted first in areas of deprivation. If successful it would be then be rolled out further. A British system would also be funded by the state, unlike the continental model, which is funded through a combination of state help, insurance and co-payments.

Cameron's proposal may alarm Tory traditionalists who will see it as an example of the sort of intrusive politics normally associated with Labour. The leadership accepts that the policy marks a big step, but insists that it is not adopting the 'nanny state'.

One leadership source said: 'There is one view of the world which says leave everything to the state. There is another view which is don't nationalise these things, leave it to the mother and father. The Cameron view is that parents are the most important people in a child's life. Given the nature of modern life, you cannot say the state should be neutral. We have to consider what we can do to support people.'

Senior Tory sources say the announcement shows that Cameron is developing his family-friendly policies as he talks about what role the state should play in people's lives.



A BLAST FROM THE PAST! (ARE WE REALLY MAKING ANY PROGRESS?)

Auckland's shortage of midwives is chronic - *NZ Herald* Nov 1986

St Helens Hospital in Mt Albert is chronically short of midwives, despite a recent recruitment of overseas staff. Principal nurse Anne Nightingale says there is an urgent need for more midwives to be trained in New Zealand.

But Auckland Hospital Board chief nurse Ann Murphy says while there has been a nationwide midwife shortage in the past the situation has improved considerably.

Miss Nightingale says St Helens has not had a full complement of midwives in the past two years. At best the hospital is short of three or four midwives but there have been 16 or 17 vacancies at times, she says. "If we don't get on and do something about improving the numbers training we'll be in queer street soon." While midwives are seldom required to work extra shifts Miss Nightingale says most seniors do regular overtime.

The hospital has supplemented staff with bureau nurses but nursing agencies face a similar shortage of midwives. The arrival of some six overseas midwives in the past few months has eased the shortage, and another three or four are expected before Christmas.

But overseas staff provide only a temporary solution, as most do not stay in New Zealand. "Nurses who tend to want to come here are usually relatively young in their careers, and they are often on short term working holidays," Miss Nightingale says. She claims New Zealand is not training enough midwives to meet the needs of hospitals here.

Shortages are nationwide and most severe among senior staff, Miss Nightingale says. Between 1980 and 1985 only 105 trained midwives graduated from New Zealand programmes. Numbers are slowly increasing with about 30 qualifying last year. But Miss Nightingale says St Helens alone could "swallow up 10 midwives at any time." More than 3000 babies are born each at St Helens alone, and the hospital's birth rate is steadily growing.

Miss Nightingale says Auckland Hospital Board funds allow for only 10 midwives to be trained each year though the board has New Zealand's three largest obstetric hospitals.

Miss Murphy says the board will train another three midwives at the Auckland Technical Institute next year, bringing the total to 13. The board is working towards improving the situation all the time and will continue recruiting staff in Great Britain.

Taken from *Save the Midwives* No 11 Summer 86/87