NEW ZEALAND COLLEGE OF MIDWIVES
P O BOX 21-106
CHRISTCHURCH

New Zealand
College of Midwives [Inc]

NEWSLETTER

Volume 2 No 6 : April 1990

Nurses Act Amendment Bill

W I N News

What Autonomy Means for Midwives

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New Zealand College of Midwives
Membership Form

Regional Information

Name _____

Address _____

Telephone _____ Home _____ Work

Place of Work _____

Type of Membership

Full Member (Registered Midwife Full or Part Time)	$52.00
Full Member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged)	$26.00
Associate Member (Other interested individual)	$52.00
Associate Member (Unwaged interested individual)	$26.00
Affiliated Member (Other Groups e.g. Parent Centre, La Leche League, etc)	$26.00

Method of Payment

Please tick your choice of payment method.

☐ Subscription payable to College Treasurer (Please enclose cheque or money order)

☐ Deduction from Salary (Please arrange with your pay office)

National Information

Name _____

Address _____

Telephone _____ Home _____ Work

Date of Birth _____ NZNA Member YES/NO

Type of Membership

Full — Waged ☐ / Unwaged ☐

Associate — Waged ☐ / Unwaged ☐

Affiliate ☐

Place of Work _____

Please return completed form (together with money if applicable) to
Local Regional Treasurer
New Zealand College of Midwives
Address:

Notes

FROM THE BOARD OF MANAGEMENT

Dear Members,

Most regions will be aware that the seasons are changing and Autumn will be here. We hope everyone up North affected by the torrential rain and flooding have recovered with minimum damage to themselves and their property.

No doubt your region is preparing for or presently in the midst of fund raising to assist members travelling to the NZCOM's Conference in August and the ICM Japan Congress in October. Don't hesitate in becoming involved - it makes the job loads easier and you'll probably enjoy yourself..

You will all have heard about if not read the articles in the Listener over the past three weeks. Congratulations to Bronwen and Karen. Your comments were superb. Noting the comments from the majority of GPs and obstetricians, we need to work at opening communication between midwives and doctors to help them realise that what we want is to provide choice from women. If you haven't already done so, now's the time to write a letter to the editor of the Listener with your comments supporting autonomy.

Groups who had compiled subsmissions on the Nurses Act Amendment Bill recently had the opportunity to speak to their submission. Sally Pairman and Jacqui Anderson represented the National Committee and spoke to the NZCOM Submission. Read on for more information on this.

Founder member badges have just arrived and will be posted to members who ordered them over the next few weeks.

Subscriptions for 1990 are due on the 30 April. Those members who did not pay their 1989 subscription will cease receiving a newsletter from this date unless their subscription is paid in full. (Your regional committee will have informed you if your 1989 sub was waived, i.e if 1988 sub was paid after 01 January 1989). Although presently, as per the Constitution, membership is not terminated until a year following failure to pay a subscription, it is anticipated this will change at the AGM in August.

SO LET THE MONEY ROLL IN .....

Board of Management

NEWS AND VIEWS

[1] NZ COLLEGE OF MIDWIVES JOURNAL

The second issue of our wonderful Journal will be available for purchase at the beginning of April. The Journal can be obtained from your Regional Committee. Following the AGM in August, it is hoped that subscription to the Journal will be included in the annual membership subscription.

A number of unsold copies of the first issue have been discovered. Anyone wishing to purchase this inaugural issue, please write to: *BOARD OF MANAGEMENT*
NZ College of Midwives
P O Box 21-106
Christchurch

[2] DIRECT ENTRY TO MIDWIFERY

You will all be aware of the Discussion Paper and Draft Proposal for a Direct Entry Midwifery Course produced by the Save the Midwives Direct Entry Midwifery Task Force and endorsed by the NZCOM. It will have been discussed at your local Regional College meeting.

Many midwives will presently be formulating personal beliefs on Direct Entry to Midwifery. We urge you to obtain a copy of the draft proposal to assist you in fully understanding the proposal and what Direct Entry will mean for midwifery in New Zealand. The Direct Entry Midwifery Task Force welcomes any comments on the draft proposal.

To receive a copy of this 32-page document, please send a self addressed, stamped envelope (long 40c size) to: *Judi Stridd*
Save the Midwives
Direct Entry Midwifery
Discussion paper
RD 3 Wellsford

[5] THE STORK DIDN'T BRING ME

by Marie-Francine Hebert, Meadowbank, 1988

A delightful kit to help children learn about reproduction. It contains a book, board game and parents guide. The story of a couple getting pregnant and having a baby is told in clear and simple language by a child whose parents comfortably include sex in their daily routine.

Available from: Education Unit Bookshop, Family Planning Assn, 214 Karangahape Road, Auckland

Home births not just for the 'way-out'

by Nicole Parish

Home births aren't just for 'way-out' or 'alternative people' — they're for anyone who is fit and able.

That's the message for National Home Birth Week from the Horowhenua Home Birth Support Group.

Horowhenua midwife Jane Stojanovic said each case was assessed on its merits but anyone able to have a baby in a small rural maternity hospital such as Otaki or Levin should be able to have a home birth.

The number of home births occurring in the area was still small but the possible closure of hospitals like Otaki Maternity could see it increase, she said.

Basil Dellaberca, seventh child of Delia and Mike, was born at home in Levin two months ago, and his mum and dad were more than happy with the experience.

It was her first home birth but Delia was sure it was what she wanted after becoming increasingly disillusioned with the hospital environment.

Since her first child was born at Palmerston North, hospitals have changed to work in more with a mother's needs and wants but she still had to fit-in with a system and routine, said Delia.

"I just didn't want to be part of that system anymore."

Having her baby at home the way she wanted it meant she felt more in control of the whole process, she said.

Routine procedures such as temperature taking could be done when it suited Delia rather than the nurses.

Jane became her personal midwife and visited three times before the birth to learn what Delia's individual needs were and to familiarise herself with the house.

Delia said having the same midwife present throughout her labour was important for her confidence.

In a hospital it means labour can just begin to feel comfortable with an attendant nurse only to have her go off duty and she goes into the birthing room, she said.

In a home birth the midwife is responsible for the whole birth though a doctor must be present at the end to check that everything's okay.

The midwife visits the mother and baby a further 12 times after the birth.

Having her husband and children with her the whole time was also a big bonus, she said.

In the past Mike had often missed out on seeing his children born either because he was not allowed in the theatre or because he had to go home and look after the others.

Delia said the children enjoyed the experience, popping in an out to see how she was getting on or for a cuddle, and making cups of tea for the adults.

At no time did she feel concerned or frightened that she had done the wrong thing and has no regrets.

And husband Mike also was in full support of the home birth, saying he felt more involved and able to help than with any of the previous births.

Jane has been acting as home birth midwife in the Horowhenua for the last six months and firmly believes it is a "worthwhile" option for anyone not keen on hospital births.

She carries everything with her found in a maternity hospital except analgesics or pain relief.

Jane uses natural pain relief such as hot baths and massage.

About 40% Home births take place in New Zealand each year — 40 or 50 of these in Palmerston North, she said.

The birthing team — Delia Dellaberca with Basil and husband Mike and personal midwife, Jane Stojanovic.

[2] WISE WOMAN HERBAL FOR THE CHILDBEARING YEAR

by Susan S Weed Cost : $23.30

This book is both sensitive and informative - a joy to read. It contains clear guidelines for the use of herbs throughout the childbirth process, from pre-conception to infant care, including preparing herbs for use. It is comprehensive, easy to follow and includes Susan Weed's personal preferences/experiences with herbal preparations. Potentially toxic herbs are clearly marked and side effects documented.

As Susan Weed states:

> "The major focus of my work is to teach ordinary people that they can heal and maintain health themselves by using common plants (weeds), compassionate intuition and simple ritual."

I highly recommend this book particularly to midwives and women anticipating pregnancy.

Available from Kate Sheppard Women's Bookshop, Christchurch

- by Julie Hasson

[3] MOTHERHOOD: WHAT IT DOES TO YOUR MIND

by Jane Price, Pandora/Unwin Hyman Cost : $19.95 (Paperback)

"Why didn't anyone tell me it would be like this?" A radical new approach to the psychology of motherhood. Jane Price draws on women's accounts of their feelings at every stage of pregannncy and early motherhood to give us a better understanding of those intense emotions. Available in New Zealand bookstores.

[4] COPING WITH MISCARRIAGE

by Kitch Cuthbert & Sandra Van Eden Long, Reed/Methuen 1987

Written to help women and their partners cope with this distressing event. Offers information, reassurance and support and gives health professionals an insight into their role in helping women during and after miscarriage.

Available from: Education Unit Bookshop, Family Planning Assn, 214 Karangahape Road, Auckland

[3] BILL INTRODUCED SEEKING DEATH PENALTY FOR ABORTION

From: CENTRE FOR WOMEN'S RESOURCE PHILLIPINES
2nd Floor Mar Santos Bldg, 43 Roces Ave, Quezon City, Phillipines

"...A bill is being discussed in the Phillipine Senate about the death penalty to be meted on abortion practitioners, women who undergo abortion and relatives who encourage the process (as provided in our penal code). It is ironical because our 1987 Constitution has abolished the death penalty we previously had. The conservative Senator Ernesto F Herrera wants to resurrect the death penalty for abortion which is a clear attempt to further limit women's reproductive rights...."

"The Senator explains, "this bill seeks to impose the death penalty for abortion, infanticide and parricide, murder or homicide of a minor of not over twelve (12) years of age, to highlight the rigours of the punitive sanctions for these crimes."

[4] ROOMING INNERS DO SLEEP AT NIGHT

A major argument against implementing a room-in policy on maternity wards has been the disturbance of a mother's sleep. This is also the reason most often presented by mothers who choose not to room-in when the option is available. The evidence, however, suggests that sleep disturbances may not be influenced by rooming-in.

In a Colorado study of 21 hospitalized mother-infant pairs, sleep data was collected from the mothers on the first two nights after birth. All mothers spent the daytime hours with their babies; but at night, 10 mothers sent their babies to the nursery, and 11 mothers kept their babies with them. Neither group of moms was satisfied with either the quality or quantity of sleep. (Are postpartum expectations unrealistic? Are maternity wards not set up for sleeping?)
Those who roomed-in slept an average of 5.55 hours each night, while those separated from their new borns slept an average of 5.35 hours. In addition, the rooming-in group reported a slightly higher quality of sleep.

The authors point out that although the sample size is large enough to draw generalized conclusions, the findings do not support the commonly held belief that mothers will sleep better if their babies are removed to the nursery overnight. *(Journal of Obstetrics, Gynecologic, and Neonatal Nursing, March/April 1988).*

[5] MIDIRS - CHANGE OF ADDRESS

MIDIRS INFORMATION & RESOURCE SERVICE
Institute of Child Health
Royal Hospital for Sick Children
St Michael's Hill
Bristol BS2 8BJ
ENGLAND

New Zealand College of Midwives

Consumerism Feminism Midwifery

National Conference — Women in Partnership
August 17 to 20, 1990, Knox College, Dunedin

Keynote Speaker

Dr. Marsden Wagner
Regional Officer for Maternal and Child Health, WHO

Programme

Friday 17		Annual General Meeting (evening)
Saturday 18	*Consumerism*	Opening Ceremony, Cocktail Party (evening)
Sunday 19	*Midwifery*	Conference Dinner (evening)
Monday 20	*Feminism*	Closing Ceremony

Those wishing to present papers or workshops should inform the Conference Committee before February 28, 1990.

Conference proceedings will be published after the Conference and be available for purchase from the College in November 1990.

New Zealand College of Midwives — National Conference
August 17 to 20, 1990, Knox College, Dunedin

☐ I will be attending the Conference, please send me a registration form.

☐ I would like information on accommodation / creche facilities.

☐ I would like to present a paper / workshop (please see reverse).

Name _____

Address _____

_____

_____

BOOKS

[1] LOVE START - PRE BIRTH BONDING

by Eve Marnie Cost : approx $23.00

Written by a New Zealand born, Australian trained Midwife who has been living and working in USA since 1969.

This book I could recommend as worthwhile reading for any couple planning pregnancy, to midwives and in fact anyone helping an expectant couple through their pregnancy and birth experience.

Love Start
- provides steps to develop a solid loving relationship with your baby before birth;
- gives you guidelines to create a birth plan that specifies exactly how you want the birth of your child to be;
- teaches you how to use Visualization and relaxation techniques to ease the anxiety and pain associated with childbirth;
- tells you how to communicate with your unborn baby using conversation, positive thoughts, touch and music;
- provides information about childbirth and identifies the differences between giving birth in a hospital environment or Birthing Centre.

My only criticism would be that the book is based on looking at the American Health and Birthing Society which is quite different to that present in New Zealand. However, it is not difficult to sift through these bits and perhaps encourages New Zealand women to be more questioning and assertive in the care and management suggested to them during their pregnancy and labour. A quality that needs enhancing in New Zealand women.

Available from Kate Sheppard Women's Book Shop, Christchurch.

- by Kathy Anderson

tool," warns that human waste carries potentially dangerous viruses "that can be transmitted either by poor hand washing or by handling of dirty diapers." It reviews the three types of diapering—home washing, diaper services, and throwaways—but makes no recommendations. "With 85 to 90 percent of parents automatically choosing disposables, our concern is that they haven't been exposed to the alternatives and haven't thoughtfully considered them," says Greenstreet.[27] She is convinced that once parents learn about the social and environmental effects of their diapering decisions, they will choose to use throwaways more sparingly.

This past June, Procter & Gamble made news across the country by announcing two pilot programs designed to test the feasibility of recycling its millions of disposable diapers and to show that composting "is a viable disposal method for municipal solid waste." The testing sites are of particular interest. It is no coincidence that the recycling test, involving 1,000 households, is being conducted in Seattle, where the King County Nurses Association has been trying to get hospitals to "educate" parents about cloth diaper alternatives. The composting demonstration project is to take place in St. Cloud, Minnesota, a city that already recycles two-thirds of its trash.

After explaining how concerned the company is about the nation's solid waste crisis, a Procter & Gamble executive noted: "Our aim is not to get into the recycling business on a permanent basis. Rather, we want to demonstrate that the technology is feasible and encourage entrepreneurs to get involved in this business."[28] It remains to be seen if these projects move beyond a stage of providing fodder for company press releases.

The extreme visibility of the disappearing diaper means it is time for a new ethic. Throwaway is not go-away, and what appears to be immediately advantageous also has long-range consequences. As informed consumers, we need to remember that the earliest lessons our children learn may be the first ones they pass on to their children. Diapering is not a quick-change undertaking; it is an act of love.

Notes

1. *Physicians Management* (1987).
2. M. A. Shapiro et al., *Preliminary Study of the Environmental Impacts from Processing and Disposal of Diapers* (Pittsburgh, PA: University of Pittsburgh, July 1971).
3. Author's coverage of the arrival of the Marcoses, Hickman Air Force Base, Hawaii, for the *Honolulu Advertiser* (Jan 1986).
4. Telephone interview with Joe Kozloff, market analyst for Drexel Burnham Lambert, Inc., New York (10 March 1989).
5. Jane Seybolt, "Wear It and Toss It," *Paper Sales* (April 1987): 8.
6. "Dear Doctor," a brochure enclosed in Procter & Gamble's *Medigram* (7 Nov 1986).
7. Steven Greenhouse, "Innovation Key to Diaper War," *New York Times* (25 Nov 1986).
8. Estimate by the Rhode Island Solid Waste Management Corporation (undated).
9. Brooke Gladstone, "Diaper Wars," *Boston Globe Magazine* (18 Oct 1987).
10. Quoted in *Nan Scott's Newsletter* (Aug/Sept 1986), a South San Francisco diaper service publication.
11. Carl Lehrburger with Rachel Snyder, "The Disposable Diaper Myth," *Whole Earth Review* (Fall 1988): 61.
12. William V. Driscoll (Executive Secretary, Diaper Research Committee of the American Paper Institute), "Letters to the Editor," *American Journal of Public Health* (Sept 1974): 846.
13. United Press International, "U-M Researcher Says Disposable Diapers Environmentally Safe" (28 July 1988).
14. Telephone interview with Procter & Gamble spokesperson Scott Stewart (10 March 1989).
15. Telephone interview with EPA officials, San Francisco (9 March 1989).
16. Telephone interview with Patricia Greenstreet, King County Nurses Association (10 March 1989).
17. W. L. Rathjie et al., "The Phoenix Recycling Project," City of Phoenix, Department of Public Works (June 1988): 16.
18. Carl Lehrburger, *Diapers in the Waste Stream* (Sheffield, MA: Carl Lehrburger, 1989), p. 3.

FUTURE EVENTS

[1] WOMEN'S SEXUALITY

20-21 April 1990
Auckland Education Unit, NZ Family Planning Assn
214 Karangahape Road
Auckland Phone: (09) 796-182

Cost : $85:00

This is a one and a half day workshop allowing women to examine personal issues in sexuality. It looks at influences on sexuality - parents, peers, media, societal attitudes - and how these affect sexual experiences.

[2] MIDWIVES WORKSHOP

28-29 April 1990
Manawatu Polytechnic (Hokowhitu Site)

Topics include: Midwife Autonomy
Legislative Update - Nurses Act
Young Mothers and Childbearing Process
Cultural Aspects of Maternal and Child Care
Current Trends in Breastfeeding
Homebirth - Boundaries of Practice
Homeopathy

Contact : The Secretary
Continuing Education Section
Nursing & Health Studies Department
Manawatu Polytechnic
Private Bag
Palmerston North Phone : (063) 65-030

[3] 1990 NZ NATIONAL HOME BIRTH CONFERENCE

11-13 May 1990
Whangarei

Theme : Birth Figures

Contact : Agnes Hermans
24 Pah Road
Onerahi
Whangarei

[4] 1990 NATIONAL NURSES FORUM

18-20 May 1990
Victoria University
Wellington

Theme : Partnership in Health - The Future is Now

Contact : Nursing Education and Research Foundation
P O Box 2128
Wellington

[5] AUSTRALIAN 11th NATIONAL HOME BIRTH CONFERENCE

19-21 May 1990
Adelaide

Theme : Unity in Birth

Contact : GPO Box 703
Unley
South Australia 5016

[6] INTERNATIONAL WOMEN'S DAY FOR PEACE & DISARMAMENT

24 May 1990

[7] INTRODUCTION TO FAMILY PLANNING

12-15 June
31 July-03 August
16-19 October

Cost : $220.00

Auckland Education Unit, NZ Family Planning Assn
214 Karangahape Road
Auckland Phone: (09) 796-182

A four day programme introductory course covering all contraceptive methods and aspects of fertility and sexuality.

Environmentalists are concerned that the current marketing hype about "biodegradable" single-use diapers will divert attention from the real problem by promoting what a *New York Times* headline calls "Diaper Disposal with a Conscience."[6] Will it divert well-intentioned parents from a viable solution to the solid waste crisis? Will it impede the environmentally sound 3Rs—reduce/reuse/recycle—approach to waste management?

The stakes are high. Each family that chooses natural, recyclable cotton diapers for their child prevents 1 ton of waste from entering the solid waste stream each year? Hopefully, this reality is more compelling than the ads promoting the disposal of a "biodegradable" ton.

Notes

1. Carl Lehrburger, in conversation with Dr. William Rathje of the University of Arizona.
2. Colin Isaacs, *Probe Post* (Fall 1988): 42.
3. Jeanne Wirka, *Wrapped in Plastics* (Washington, DC: Environmental Action Foundation, 1988).
4. See Note 2.
5. Carl Lehrburger, *Diapers in the Waste Stream* (Sheffield, MA: Carl Lehrburger, 1989).
6. *New York Times* (10 Dec 1988).
7. See Note 5.

For More Information

Environmental Action
1525 New Hampshire Avenue, NW
Washington, DC 20036

National Association of Diaper Services
2017 Walnut Street
Philadelphia, PA 19103

Ann E. Beaudry (42) lives in Washington, DC, with her daughter Kate (3). Her firm, Beaudry Communications, specializes in public policy issues.

in place, seated—[connoting] passivity, gentleness, and receptivity. Throughout childhood, it is difficult enough to work against such pervasive gender stereotyping so that boys can learn to be more gentle and girls [to be] more active and effective. We certainly do *not* need products that reinforce such unequal distinctions."[24]

Consumer Reform

The hazards of single-use diapers are wide-ranging, and the remedies rest squarely with the consumer. The question is, what exactly influences consumer buying decisions?

Whether the rapidly increasing fees to dispose of throwaways—combined with the inevitable increases in the cost of the diapers themselves—will have any effect on purchasing decisions is anyone's guess. If past experience is any guide, it won't. The traditional American aversion to matters concerning human excreta is so strong, and the marketing of throwaway diapers so pervasive, that parents may be willing to pay many times what they are paying now for single-use products.

A more likely stimulus for consumer reform is education. Concern about the environmental and health hazards posed by throwaways has prompted plans to educate parents of newborns about alternative diapering methods. One such program, designed by the King County (Washington) Nurses Association, has attracted a good deal of attention from Procter & Gamble. Patricia Greenstreet, an attorney and registered nurse with the association, says she has been visited by Procter & Gamble executives three times since November, while a county task force was compiling a brochure on alternative diapering.

Meanwhile, of the 14 hospitals in King County that have nurseries, two have switched from throwaway to cloth diapers and six more are considering a change because of health and environmental concerns.[25] Greenstreet, who is soon to be a mother, says that she does not favor efforts to ban throwaways by passing laws against them. As she puts it, "I think we've got to make sure that people have good options open to them that are going to work for them in their lives."[26]

The brochure for parents, which Greenstreet refers to as a "teaching

expensive alternative. Assuming an initial cost of $63.00 for seven dozen diapers, and figuring 3¢ per diaper to wash[22] and eight changes per day, purchasing diapers and home laundering them costs under *$9.50 per month* over a period of 30 months. Human waste is sent into sewage systems, and the diapers are eventually recycled as rags, which are completely biodegradable.

The biodegradable option. Some companies, in an attempt to capitalize on concerns about throwaways that are slow to break down, have begun offering so-called biodegradable diapers—single-use items that are said to "disappear" two to five years after being dumped in a landfill. (See sidebar.) These sell for between 26¢ and 39¢ each, somewhat more than the products offered by Procter & Gamble and Kimberly-Clark.[23] Critics note, however, that biodegradable throwaways consume as much paper and plastic as do the major brands, contribute to overly burdened landfills and disposal fees, and carry large amounts of human waste into groundwater.

The gender-specific option. Another marketing innovation in single-use diapers is customized boy/girl diapers with different forms of "night-guard protection"—in front for boys and in the middle for girls. Diane de Mauro, director of Program Services for the Sex Information and Education Council of the U.S. (SIECUS), finds these diapers particularly disturbing from a sex educator's point of view. In a letter to Procter & Gamble, de Mauro expressed her concern as follows: "While I am not totally convinced that gender-specific diapers are necessary from an anatomical point of view, I am very certain that we do not need any more sex-role stereotyping in product marketing.

"The choice of typically male blue vs. female pink colors and the distinctive male/female trim chosen for these gender-appropriate diapers...reinforces traditional sex-role stereotyping at a very early age. The boy's diaper has a 'functional' blue belt around the box, and each one is individually trimmed with Sesame Street figures riding a moving train—[connoting] activity, direction, and effectiveness. The girl's diaper box is surrounded by a soft, pretty pink ribbon, and her individual trimmings are the same Sesame Street figures, but [they are]

BIODEGRADABLE DIAPERS:
A PSEUDO SOLUTION

Ann E. Beaudry

Playing on the growing public concern about the critical solid waste problems created by single-use "disposable" diapers, marketers have recently begun to promote single-use "biodegradable" diapers. Their ecomarketing strategies, including introduction of the product in natural food stores and environmental catalogs, are targeting environmentally conscious parents. Contrary to the ads' assertions, however, these cornstarch, plastic, and paper concoctions do little, if anything, to solve the landfill crisis or to mitigate potential public health concerns caused by human waste entering landfills.

Let's look at the facts *not* mentioned in the ads. The outer layer of "biodegradable" diapers is composed of a mixture of cornstarch-based resin and plastic. Theoretically, the cornstarch component is to be broken down by the bacteria and fungi in landfills, leaving a residue of polyethylene particles. But environmentalists say the promoters' claims about the speed of this organic breakdown are highly debatable, due to the compaction of garbage, the lack of air and sunlight, and the variability in landfill temperatures and composition. Indeed, Dr. William Rathje, an anthropologist at the University of Arizona, has found 10-year-old newspapers still intact in Tucson landfills.[1] In spite of the time-factor controversy, one thing is certain: even the eventual breakdown into small pieces of plastic offers no solution to the landfill capacity crisis, because "the breakdown products of every throwaway diaper, disposable or biodegradable, take up just as much room in the landfill as the original."[2]

Far from being environmentally neutral, biodegradable plastics may pose a serious threat to the environment. In her recent book *Wrapped in Plastics*, Jeanne Wirka writes, "Little is known about what happens during and after the degradation process to chemical additives, toxic heavy metals and other plastics ingredients."[3] Other environmentalists, such as Dr. David Wiles, director of the National Research Council of Canada's Division of Chemistry, suspect that plastic breakdown will worsen the "already serious problem of gas and leachate production, possibly adding [to the environment] toxic chemicals [that are] much more damaging...than the plastic wastes themselves."[4]

In addition to the environmental costs, the new "biodegradable" diapers continue the cycle of public costs associated with the pervasive use of throwaway items. The truth is that *no single-use diaper offers any respite from the escalating disposal fees faced by most communities.* Even if all 18 billion of the single-use diapers disposed of annually in the United States were biodegradable, the public would still be spending $300 million each year for their disposal.[5]

[8] INTERNATIONAL BOARD OF LACTATION CONSULTANT EXAMINERS CERTIFICATION PROGRAMME

Exam Date : 11 July 1990
Christchurch

For Health Care Providers who are:
- Involved in Infant Feeding
- Encouraging and Promoting Breastfeeding
- Seeking a Challenge

Contact : Rachel Walker
41 Halton Street
Christchurch 5

Closing date for Fees : 15 May 1990

[9] PELVIC EXAMINATION COURSE FOR NURSES 1990

30-31 May
18-19 July
19-20 September
21-22 November

Nursing Administration, NZ Family Planning Assn
214 Karangahape Road
Auckland Phone : (09) 775-049

Cost : $150.00

A skills based course involving a one and a half day theoretical component followed by clinical experience in the taking of cervical smears and bi-manual examinations.

[10] NZ COLLEGE OF MIDWIVES BIENNIAL CONFERENCE

17-20 August 1990
Knox College
Dunedin

Theme : Women in Partnership

Speaker: Marsden Wagner
Director Maternal and Child Health, WHO

Contact: Conference Committee
Otago Region of NZCOM
P O Box 6243
Dunedin North

[11] NZ ASSOCIATION OF NATURAL FAMILY PLANNING NATIONAL CONFERENCE

24-26 August 1990
Lincoln College
Canterbury

Theme : Breastfeeding

Contact : National Secretary
NZ Association of Natural Family Planning
P O Box 38-406
Howick
Auckland

[12] INTERNATIONAL CONFEDERATION OF MIDWIVES 22ND INTERNATIONAL CONGRESS

7-12 October 1990 [NOT August as advised in last
Kobe, Japan issue]

Theme : A Midwife's Gift - Love, Skill and Knowledge

Full Papers : Deadline 30 June 1990

Registration Fee : Y50,000 - before 15 June 1990
($581.00)
Y55,000 - after 15 June 1990
($640.00)

Estimated Total Cost to attend Conference including registration, all fares, accommodation, food : $3,600

Information and enquiries : Regional Chairperson or
Board of Management
P O Box 21-106
Christchurch

[13] FOURTH INTERNATIONAL CONGRESS ON WOMEN'S HEALTH ISSUES

8-10 November 1990
Massey University
Palmerston North

Theme : Women as Health Providers within a Context of Culture, Society and Health Policy

Enquiries : Fourth International Congress on Women's Health Issues
Department of Nursing Studies
Massey University
Palmerston North

"It's distressing to me just how lazy people are! They think no further than closing the garbage lid. . . . If a diaper service was only one-quarter the cost of 'plastic' diapers, I would bet any money that those diapers would still continue to increase in sales."[10]

The Many Costs of Expedience

Health costs. Concerns that the buried human waste in diapers can carry more than 100 types of viruses into groundwater across the country have been widely publicized. For years, critics have warned that leachate from landfills can carry viruses such as polio, hepatitis A, Norwalk, and dysentery into aquifers.[11] However, single-use diaper defenders are quick to point out that there has never been a documented case of someone getting sick as a result of pathogens emitted from soiled diapers in landfills.[12] Although arguments over these hazards have been raging for more than a decade, definitive scientific studies of the dangers posed by human waste in landfills have yet to be done.

Procter & Gamble has paid $120,000 for a three-year study, now under way at the University of Michigan, to determine what happens to the sodium polyacrylate in diapers once it enters a landfill.[13] However, the company has not funded any research into the hazards posed by the 100 or so viruses known to be carried in babies' excrement. Company spokesperson Scott Stewart says that Procter & Gamble relies on published scientific studies that have looked into the virus hazard from landfill leachates—none of which has shown a link to human illness.[14]

Solid waste costs. The Environmental Protection Agency (EPA) estimates that single-use diapers account for 2 percent of all solid waste in this country's landfills.[15] Some critics of the agency say the EPA is underestimating the size of the diaper deluge, but private studies tend to support the government's figures. A Seattle, Washington, study found that 1.8 percent of its municipal garbage was made up of diapers,[16] and a Phoenix, Arizona, examination of its waste found the average to be 3.8 percent. The Phoenix research further revealed that whereas wealthy families tend to produce more garbage in general, lower-income families contribute significantly to the flow of diapers into the trash stream.[17]

According to Carl Lehrburger of Energy Answers Corporation, a resource recovery company in Albany, New York, parents pay about 10 cents in disposal costs for every dollar spent on throwaway diapers. With an estimated 18 billion soiled diapers being hauled to landfills each year in this country, Lehrburger figures that American mothers and fathers are shelling out an astonishing $300 million annually just to bury the mess.[18]

In many parts of the country, especially the well-populated urban areas—where most babies live—landfills are virtually full. As a result, those who have studied America's garbage crisis are unanimous in their predictions that tipping fees (costs charged to dumpers by landfill operators) will skyrocket from their current average of $27 per ton to as much as $100 per ton by the turn of the century.[19] Thus, the $50-per-year fee that a family now pays for disposing of one infant's throwaways is likely to reach nearly $200 by the year 2000.

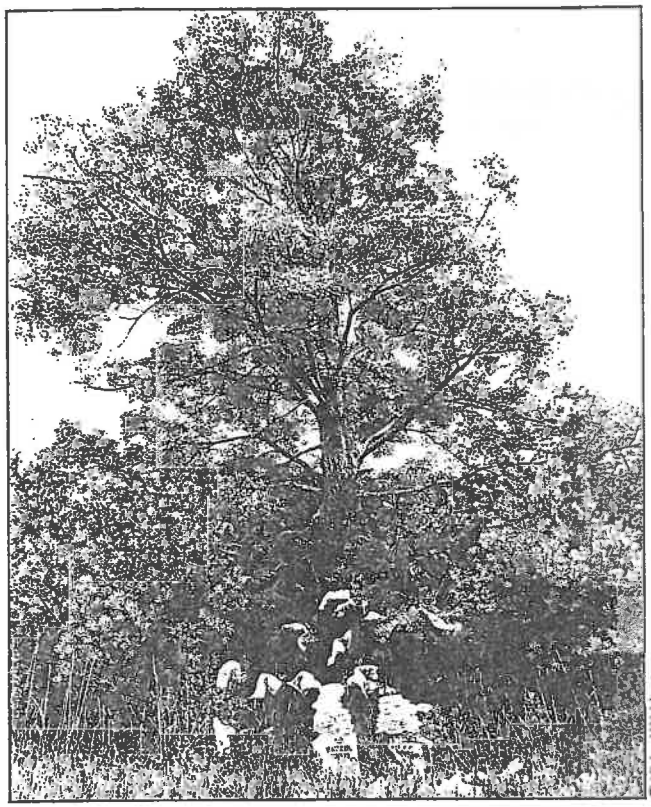
Financial costs. Millions of parents across North America, Japan, and Europe are paying dearly for the convenience of throwaways. A box of Procter & Gamble Pampers contains between 32 and 96 diapers, depending on their size, and sells for about $11 plus tax in California supermarkets.[20] For older infants, this works out to about 35¢ per diaper change, or *$84 per month*, based on eight changes per day.

Diaper services are less expensive than all types of throwaways. They are sometimes hard to locate, however, especially for families living in rural or semirural areas. According to a 1987 *Consumer Reports* study, services charge between 7¢ and 11¢ per diaper.[21] Based on the 11¢ figure and eight changes per day, it costs approximately *$26 per month* to keep a child in cloth diapers.

Diaper services are also less costly in terms of resources—especially paper, oil, and chemicals. Because the services send human waste into sewage systems, where it is treated, the impact of this option on landfills and environmental health is negligible. Some environmentalists, however, worry about the safety of chemicals used by laundry services, including chlorine bleach.

Purchasing cotton diapers and washing them at home is the least

"Why would anyone think that it's easier to throw a diaper in the garbage can than put it in a diaper hamper?"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ancient diapers. I have personally seen excrement-filled diapers floating in the lagoons of Kwajalein and Majuro, two of the Marshall Islands in the western Pacific; on smoldering garbage heaps near towns and villages across Alaska and the northern Yukon Territories; in the gutters of Manila; and along the roads of Northern California—not to mention the back stacks of a bookstore in Honolulu, Hawaii. In 1986, when Ferdinand and Imelda Marcos arrived in Honolulu in exile from the Philippines, they were carrying jewelry, cash, and other booty in recycled Pampers boxes removed from Malacanang Palace.[3]

Why do we do it? Why do more than 18 billion diapers, containing millions of tons of excrement and urine, get tossed into the trash each year in this country alone?

One obvious answer is that single-use diapers are an immensely profitable product for the world's two leading manufacturers—Procter & Gamble and Kimberly-Clark—who together control 80 percent of the diaper market.[4] According to a report published in the trade journal *Paper Sales*, annual United States consumption of "disposable non-woven" baby diapers totaled $3.2 billion in 1987. By 1991, the publication predicts, sales will reach $4.2 billion.[5]

That kind of money is hard to ignore. Both Procter & Gamble and Kimberly-Clark spend hundreds of millions of dollars annually in advertising and sophisticated market promotions, including hospital giveaways to parents of newborns and campaigns aimed at medical professionals. In one Procter & Gamble *Medigram*, sent to physicians in November 1986, professional services technical manager Arnold P. Austin asserts: "Over 40 percent of newborns in U.S. hospitals are diapered in Ultra Pampers. In addition, the diaper has received a highly favorable response from pediatricians. In fact, within the first five months of introduction, over 25 percent of your colleagues reported that they had recommended Ultra Pampers to parents of diaper-age children."[6]

Throwaways are a source of profits for the timber, chemical, and oil industries as well. The outer layer of most diapers is made of waterproof polypropylene. The inside is filled with absorbent material made from wood pulp. The newer, superabsorbent varieties also contain sodium polyacrylate, a Japanese-licensed chemical agent that can absorb up to 100 times its weight in urine.[7] It is estimated that 82,000 tons of plastic and 1.3 million tons of wood pulp (about a quarter of a million trees) are consumed each year in the United States *just to keep our young children's bottoms dry.*[8]

Another major reason throwaways are so successful is that parents like them. A vast majority of today's parents were diapered in single-use products, and most of these parents see no reason to change. As for convenience, the appeal is obvious. Brooke Gladstone, a self-confessed user of throwaways, writes in the *Boston Globe*: "In an age of working mothers and 'quality time,' it's worth almost any price not to be pinning and slinging eight times daily. With disposables, changing a baby is so easy that two enterprising 2-year-olds could probably change each other."[9]

However, not every parent is convinced that throwaways are better. Here are some thoughts from a mother in Tiburon, a wealthy suburb in Marin County, California: "Why would anyone think that it's easier to throw a diaper in the garbage can than put it in a diaper hamper? What is the difference?...One only has to put the diapers out for pickup once a week, put a new plastic bag in the hamper, fold the newly delivered clean diapers, and put them away for use.... [But] you have to use pins with real diapers, or if you have diaper covers, you...have to fold and place [the diaper] into the diaper cover.

"How much easier the diaper manufacturers make it when they are prefolded for you and all that is to be done is to put the baby's bottom on it, stick the tape across and you're done.

[14] AUSTRALIAN COLLEGE OF MIDWIVES 7TH BIENNIAL CONFERENCE

16-18 September 1991
Perth
Western Australia

Theme : Birthdays, Birthways

[15] 2ND INTERNATIONAL HOMEBIRTH CONFERENCE 1992

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ANNOUNCING

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In recognition of the special character of the year 1990 for New Zealand, La Leche League will present an award for the best original manuscript on breastfeeding.

La Leche League New Zealand is a voluntary organisation which provides support and information to women who wish to breastfeed their babies. It is affiliated to La Leche League International and has been active in New Zealand for 25 years. Through monthly meetings, telephone counselling and publications, and with the backing of a Board of Consultants drawn from the medical and scientific communities, La Leche League Leaders have encouraged thousands of women to breastfeed and to meet the needs of their babies.

Rules for Preparation and Submission of Papers

1. The paper must not have been previously published and must be the original work of the author/s. It may relate to any aspect of breastfeeding, including original research, review of scientific literature or commentary on cultural aspects.
2. Five copies of the manuscript should be submitted to the Board of La Leche League New Zealand, Box 13383, Wellington 4 by 31 January 1991
3. Manuscripts should be double spaced and include the author/s name, address, telephone number and the name of any institution with which the author/s is associated.
4. All papers will be considered by a panel appointed by the Board of La Leche League New Zealand.
5. La Leche League New Zealand reserves the right to withhold the award if no papers of sufficient merit are submitted.
6. La Leche League New Zealand reserves the right to publish papers if appropriate.

NURSES ACT AMENDMENT BILL

NURSES ACT AMENDMENT BILL SELECT COMMITTEE

On March 14, 1990, the Parliarmentary Social Services Select Committee began hearing verbal subsmissions to the Amendment to the Nurses Act re midwifery autonomy. Select Committee members present were *Judy Keall - Chair*
Judith Kirk
Don McKinnon
Kathryn O'Reagan

Submission were heard from the New Zealand College of Midwives, Wellington Region NZCOM, Domiciliary Midwives Society, Homebirth Association, Royal College of Obstetricians and Gynecologists and the Northland Area Health Board.

College members will be pleased to know that midwives and consumers were well represented. It was very exciting to be there to hear their articulate and coherent submissions. The Committee commented on the number of submissions received, approximately 93 in all, with the majority in favour of the proposal. The Committee had been impressed by the presentation and depth of both midwives and consumers submissions.

The National Committee and Wellington Region presented their comments together and although we weren't sure if going first would be to our benefit, we were given a long hearing and a chance to answer quite a few questions.

The Committee appeared to be quite supportive of the proposal but were mainly concerned with issues of competency of midwives and possible legislative changes needed to enable midwives some prescribing rights. These two points took up a lot of time and energy but I feel midwives were able to explain their position clearly. It was pointed out that both the College and Domiciliary Midwives Society had establishment and evaluation of standards well in hand with the formation of Standards of Practice, Service and Education and the setting up of Standards Review Committees with wide consumer involvement.

The Royal College of Obstetricians and Gynecologists and the Northland Area Health Board both felt that their interests should be represented in standards reviews although they've generally never shown much interest in seeking consumer or midwifery input into their own competency evaluations. Obstetricians felt the need to urge that all women should be assessed by a medical practitioner in early pregnancy before they could be "allowed" to have total care by midwives. You can be assured that we have written to the Select Committee with further comments on this and other points that arose.

HEALTH

THE ETHICS OF DIAPERING

Robert W. Hollis

An American baby's first lesson in life often derives from our culture's pervasive throwaway ethic. The lesson is hidden in baby's first clothing—usually a high-tech, paper-and-plastic concoction manufactured by one of the nation's two largest consumer products companies. This superabsorbent marvel—mislabeled by corporate marketeers as "disposable"—is put on baby's bottom shortly after baby has emerged from the womb.

For the next three years or so, the infant will wear these throwaway diapers continually. With expanding awareness, the child will learn that once a diaper is soiled with urine or excreta, it gets tossed into the garbage and disappears. It is a powerful lesson: that which is new and clean comes in a box from the store; that which is dirty and foul-smelling is simply thrown away. Where is the concept of cleaning and reusing?

The buy-and-toss lesson is reinforced in countless ways as the child grows. Hands are washed with liquid soap from disposable dispensers; food is packaged, heated, and served in microwaveable paper containers or on disposable dishes; fast-food fare comes enclosed in polystyrene boxes; drinks, sweet and bubbly, come in toss-away pop-top cans; and school lessons are performed with disposable pens or felt-tipped markers. Then, as an adult, the individual acquires the ultimate disposable: a ton-and-a-half automobile that is apt to find its way to the scrap heap after 10 years or so.

It is during the first years of a child's life that the throwaway culture really flowers. The average baby, prior to learning to use the toilet, will use up 6,600 diapers, costing parents who purchase disposables about $1,300, according to one estimate.[1] Other studies arrive at higher figures. Research conducted in 1971 for the University of Pittsburgh's Graduate School of Public Health concludes that the average child can run through 8,000 to 10,000 diapers before becoming "fully toilet trained."[2]

Don't blame the infant. She or he obviously has no choice in the matter. Parents—usually the mother—make the decision. And for more than nine families in 10, the choice is single-use diapers.

The Popularity Factor

Since the Procter & Gamble company introduced Pampers in 1961, hundreds of billions of single-use diapers have been manufactured in the United States and overseas. The legacy of this 28-year disposable-diaper age—buried in landfills, heaped in vast garbage pits, and tossed on the shoulders of our roads—will scar our planet for centuries. Researchers believe that many of these bundles of soggy paper, plastic, and excreta will take as long as *500 years* to decompose. It is interesting to think that 24th-century anthropologists may excavate our dump sites, examine these bundles, and determine what we ate and what ailed us.

Actually, future scientists will not have to look very far to find piles of

High technology: the case of obstetrics

Brigitte Jordan

Obstetric high technology is eagerly received in developing countries, where hospitals in which it is enthroned assume a disproportionate amount of the health care budget. In Senegal and Tanzania, for example, high-tech hospitals absorb more than half of the total money available for health care, while serving only five per cent of the population.

The benefits of the new technology need to be weighted against the hazards of obstetric intervention and invasive procedures which may prove harmful for mothers and babies. In Yucatan the traditional method of treating the newborn baby's umbilical cord is to cut it with a fresh slice of bamboo and then to slowly and carefully cauterise the stump in a candle flame. Now indigenous midwifes are instructed to cut it with scissors and to use alcohol and thiomersal. But in a hut without boiling water it is impossible to sterilise scissors properly and dabbing on alcohol is less effective than burning the stump.

An important characteristic of low technology is that it is simple and easily obtained, interchanged and replaced. It is enmeshed in the cultural matrix. Yet it is much easier to transport the high technology, and the procedures which go along with it, than this low technology that is anchored in culture. In Africa, for example, a woman may hold a rope slung from the rafters during labour, but no-one is going to transport ropes from Africa so that women in the West can do the same. There is no fortune to be made out of selling them.

The introduction of high technology has profound effects on the social system. In agriculture, development projects have benefited men, but have led to reduction in women's status and a narrowing of the range of options open to women. In childbirth, high technology is associated with a hierarchical system of power and decision-making, since the information necessary to make decisions is embedded in the technology itself, and only experts control it. When low technology is available, decisions about the right course of action are made by everyone involved in the process of childbirth.

Appropriate technology - though central to the theory and practice of primary health care - has never been clearly defined. There is a need to question the effects of all new technology on the social systems into which they are introduced.

Abstracted with permission from World Health Forum, vol 8, 1967, pp 312-33.

Both Domiciliary and Hospital midwives made it quite clear that midwifery autonomy would benefit the consumer in either the home or hospital setting by providing the opportunity for Domino and other continuity of care schemes, along the lines of the Know Your Midwife Schemes, to be set up. Hospital based midwives will especially benefit from being able to practice midwifery totally and alter the segmentation of midwifery as happens now in many hospitals.

The Select Committee appeared to have a good grasp of the issues and acknowledged that much of this was due to the persistent lobbying of midwives and consumers in the past. We can all take heart that our efforts have been recognised and well worthwhile. Well done everybody!

The Committee took care to let us know that any further comments we have would be welcome. As time overtook us, it became clear by our reactions to some comments by the other health professionals that we had plenty more to say and the Committee recognised this.

I was very proud to have witnessed the impressive representations of both midwives and consumers and came away with very positive feelings for the future of midwifery in New Zealand.

Submissions from the NZNA, NZMA, NZ Council of Women and the Nelson Area Health Board will be heard at a latter date. Hopefully, we will be able to keep you informed of the comments from these groups.

– *Jacqui Anderson*

WHAT AUTONOMY MEANS FOR MIDWIVES

Many of the comments made regarding midwifery autonomy have focused on the benefits for domiciliary midwives without any apparent awareness of how it will affect midwives working in other settings. It is very important that all midwives are aware of the potential changes to their scope of practice by the probable acceptance of the Nurses Act Amendment Bill.

Probably the most rewarding aspect of autonomy will be the ability to provide continuity of care in its true sense. This continuity should be possible at home or in hospital. This would be aided by limited prescribing rights up to six (6) weeks post partum (yet to be decided).

Consultation could occur with another midwife, GP or obstetrician, with referral to an obstetrician if the woman's pregnancy became abnormal.

Those women who choose to birth in hospital may be involved in "Dominio" or "Know Your Midwife" Schemes. Midwives may either be employed by the Area Health Board or be independent. having a contract with the AHB for use of beds. Antenatal care could be carried out at home or in hospital based midwives clinic, depending on the individual needs.

Midwives working in the community may choose to work individually or in teams. Domiciliary midwife contracts for payment will hopefully remain with the Health Department. Some midwives may set up in practice with a GP or obstetrician with emphasis on maintaining autonomy of care.

Ultimately, the most important aspect of midwifery autonomy is accountability. We will take full responsibility for our actions during the time we care for a woman and her baby. It is understandable that many midwives presently working in a disempowering environment will not feel prepared for autonomous practice. To meet this need, it is anticipated that NZCOM run refresher courses will be available in all regions by the end of 1990.

The opportunities are there but it is up to us to make them happen.

-Julie Hasson

The Immunisation Awareness Society is a group of people who have become concerned that the information provided by the Health Department is not sufficient to allow parents to make an informed choice. We feel the information is insufficient and often misleading. This group has made a commitment to help other parents become informed about ALL aspects of the immunisation issue. We are a collective organisation rather than a consumer service.

AIMS

- To collate and disseminate information in relation to immunisation.
- To encourage parents to take responsibility for their families health and their medical records.
- To set up a register of vaccine damaged children and provide a network of support.
- To provide detailed information whereby parents can make informed decisions about immunisation.
- To seek support from within the medical profession and other interested bodies.
- To make people aware of other alternatives available.
- To bring together all those concerned about immunisation and its affects.

BELIEFS

In the implementation of these aims, the Society relies on the following beliefs:-
- Immunisation is the individual's choice and responsibility.
- Parents in consultation with their medical advisor, have the right to choose whether or not to immunise their children.
- We are for informed choice about immunisation; we are not anti-immunisation.
- To maintain good health, a high standard of nutrition and lifestyle are essential.
- Every individual should have unrestricted access to all available information about the pro's and con's of immunisation to enable an informed choice to be made.

IMMUNISATION PAPERS

Papers produced by IRONI (Independent Research on Non-Immunisation) are available at the following prices:-

- Paper 1 - A Dissenting View	$7
- Paper 2 - Immunity and Immune System	$7
- Paper 3 - Vaccines, Diet and Immunity	$10
- Paper 4 - Meningococcal Meningitis	$10
- Paper 5 - Hepatitis B	$10

Available from:
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Blockhouse Bay
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Please include a self addressed A4 size envelope with a $1 stamp.

THE IMMUNISATION AWARENESS SOCIETY INC. - Newsletter Subscription Form.
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MIDWIFERY PRACTICE:

AN URGENT NEED

Marsden Wagner

In every European country, there is a large group of practicing midwives. They far outnumber obstetricians. *In no European country do obstetricians provide the primary health care for most women with normal pregnancy and birth.* This pattern of having the midwives provide the majority of pre- and postnatal care, as well as being the principal birth attendants at uncomplicated births, is fundamental to the entire perinatal care system in the European region.

The implications of midwifery practice in Europe for the situation in the United States are profound. Every single country in the European region with perinatal and infant mortality rates lower than the United States uses midwives as the principal and only birth attendants for at least 70 percent of all births; that is, there is no physician in the room at the birth. This fact alone should dispel any notions that obstetricians are safer than midwives as birth attendants at uncomplicated births. There is also evidence that a strong independent midwifery profession is an important counterbalance to the obstetrical profession in preventing excessive interventions in the normal birth process.

Consequently, it is perhaps not surprising that in the United States one finds the highest obstetrical intervention rates as well as a serious problem with malpractice suits. The European experience and our data strongly support the urgent need for the introduction of widespread independent midwifery practice in the United States as a most important counterbalance to the present situation.

[Reprinted with permission from Marsden Wagner's testimony before the US Commission to Prevent Infant Mortality, delivered February 2, 1988, at the United Nations in New York City.]

Marsden Wagner, MD, (59) is a pediatrician, neonatologist, perinatal epidemiologist, and father of four. A native Californian, he has been living in Copenhagen, Denmark, and working for 12 years with the Maternal and Child Health Division of the World Health Organization, as regional officer for 32 European countries. His current work focuses on the demedicalization of human reproduction, pregnancy, childbirth, and childhood.

ARTICLES OF INTEREST

Taking the positive approach to childbirth

Learning how to cope with labour isn't enough, says Sheila Kitzinger: expectant women also need to learn how to cope with doctors

IT IS difficult to say what you want lying flat on your back, pants off, exposed from the waist down, with a strange man in a white coat towering over you.

All you can see is the top of his head as he prods with gloved hands inside your vagina. Many women find it impossible to be assertive in the hospital antenatal clinic and come out feeling depressed and anxious, and sometimes as if they have been violated. Learning about what happens in labour and how to breathe and relax is not enough. A pregnant woman also needs assertiveness skills so that she can say what she wants and not be side-tracked, patronised, cowed or emotionally blackmailed into submitting passively to whatever kind of care is routine and whatever the obstetrician decides to do to her.

Yes, of course there are pleasant, humane, friendly obstetricians, but even they are part of a power structure in which women are objects over which authority is exercised and rights asserted. It is the system which is at fault. In antenatal classes women often learn techniques for labour and receive doses of warm reassurance and hints on how to wheedle concessions from hospital staff by employing feminine wiles (most obstetricians are men).

This is not what many women are looking for from classes. They would like to know how to avoid being sucked into the medical system and turned into patients who are unable to make informed decisions about their own bodies. They want to be treated as intelligent adults.

Many doctors confuse assertion with aggression, do not know how to react to assertive women and turn hostile. An article in the

Even midwives can side with the system

Journal of the American Medical Association describes how doctors haven't the faintest idea what to do when a patient refuses an investigation or treatment. The trouble is that there is usually very little in their training which prepares them to cope. A sociologist, Diana Scully, asked doctors in obstetric training schools in Boston what they thought of as "a good patient".

One doctor put it in a nutshell: "She understands what I say, listens to what I say, does what I say, believes what I say."

Even midwives, who might be expected to understand what other women want and protect them against unnecessary intervention, sometimes side with the system against those who ask for something different from what is routinely provided. Margaret Miles, author of the major midwifery text-book, writes: "To the expectant mother labour is a very personal experience which engenders the presumption that she ought to participate in professional decisions and dictate regarding her obstetric care."

She warns: "If she knew more she would realise the wisdom of having faith in professional experts and allowing them to make decisions regarding her own and her baby's wellbeing and safety." Many midwives would dissent from that authoritarian point of view, but there are still some around who wish that women having babies would behave like obedient little girls and do what they are told.

Though we may think there have been great strides towards freedom and choice in childbirth, women are often prisoners of a system which pays mere lip-service to choice.

A World Health Organisation report about maternity care in Europe published a few months back disclosed that women can sometimes choose who can be with them at the birth in only 10 out of 23 countries, may have choice about pain relief in 10, can sometimes choose whether or not to be shaved in five, may be allowed to decline electronic foetal monitoring in five, can sometimes choose the position they are in at delivery in only three and may have some choice about episiotomy — the cut to enlarge the vagina at birth — in just one (which must be Britain). When a woman is assertive there is at least a chance of building a relationship in which she can work in equal partnership with those giving her care rather than being at the receiving end of treatment about which she is not consulted.

Yet many pregnant women find it especially hard to be assertive because they have been programmed since they were little girls to behave in an acceptably "feminine" way — being polite and charming, smiling when the doctor smiles, and avoiding at all cost being thought demanding.

It is true that more and more doctors are willing to discuss and explain the care and treatment they are proposing. They sometimes complain that women just don't want to know. Obstetricians and gynaecologists are the self-appointed guardians of women's bodies. They do not — usually — live in them but study them from the outside. Women may not have medical information but have other, equally or more important, knowledge about their bodies.

"I don't want to make them angry in case it goes down in my notes that I'm a difficult patient. They might have it in for me when I am in labour — or take it out on the baby." The more women speak out in a commonsense way about what they want, the more hospital staff will learn how to offer the right kinds of care. If a woman acts as if she expects to be bossed about the more likely it is that she *will* be.

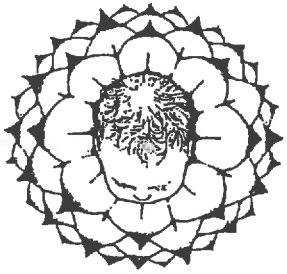
"I don't know all the arguments so I couldn't explain why I didn't want to be induced." Though it helps to have as much information as possible beforehand, if an intervention is proposed that a woman does not want she can simply say: "No thank you."

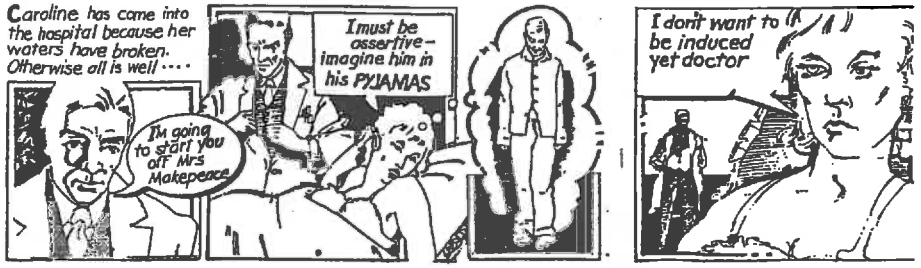
There is always a price to pay for being submissive in childbirth. A woman avoids conflict but afterwards feels that birth was done *to* her, not something she did herself. I get hundreds of letters from women who have suffered a sense of complete powerlessness in birth, and who go on feeling this long after the baby is born. It often leads to them feeling incompetent with the baby too.

Being assertive can change conditions for other women, not just for you. Improvements in human care given to women in childbirth, do not, for the most part, come from inside the medical system. They come from outside, from pressure by parents who band together to take action and those women who have the courage to jump off the conveyer belt and say what they want.

National Childbirth Trust,
9 Queensborough Terrace,
Bayswater,
London W2 3TB
Tel: 01-221 3833
Association for Improvement in Maternity Services,
163 Liverpool Road,
London N1 ORF
Tel: 01-278 5628

Always a price to pay for being submissive





EXCERPTS FROM WOMENS INTERNATIONAL NETWORK NEWS

BASIC TRAINING FOR VILLAGE MIDWIVES OVERCOMES TRADITIONAL TABOOS

Nius bloag Meri, PO Box 7254, Boroko, NCD

"In many Papua New Guinea cultures, touching the birthing mother, her afterbirth or the newborn child are taboos. It takes a special woman to become a midwife. About 80 strong-willed village women in the Southern Highlands have conquered their fear of blood. They are midwives trained to help their village sisters give birth safely without leaving their villages...."

PAPUA—NEW GUINEA

"There is some tradition of home delivery. Some men will not allow their wives to leave the village to give birth. Some villagers are two or three days rugged walk from the nearest health centre. Some women do not have the strength for the long walk ... There may be no one to care and protect her garden and her children if an expecting mother goes to a health centre for several days. In many health centres there is no food. This prevents many women from coming long distances ... Even after getting safely to the clinic, a village woman may be frightened or confused. There may be no one who speaks her language ..."

"The village midwife programme is based on two realities. That there will continue to be many births in the villages. And, that in most cultures, there are not traditional,birth attendants. Often women go off to the bush alone to bear their child. In some villages, their sister or mother may be there for comfort but be unable to give much more than emotional support."

"A 1980 World Health Organization report exposed South Highlands as the province with the highest number of maternal deaths."

"When Health Centres identify a village where the deathrate is high, Sister Gari meets the village headman and community leaders. She explains that many lives can be saved if the village has a skilled midwife. Sister Gari's program was funded for the initial five years primarily by the Asian Development Bank. It offers the village a four week training course for two women. The villagers choose the women. 'They must be mothers and older respected community women who will stay in the village.' ...

"In their four weeks at Nipa Health Centre, the trainees each observe three births and deliver five babies. They must pass an oral test before being awarded their certificate in village midwifery by the Department of Health."

PAPUA—NEW GUINEA

"The community's contribution is to build and maintain a bush-material birthing hut, a rubbish pit where the afterbirth can be safely buried and a toilet. Some villages build a birthing hut and a separate hut nearby for the new mother and baby to rest for five days before returning to their family. After the midwives are trained, Sister Gari or her assistant Sister Suzie Tol go to the village to inspect the huts and to help new mothers get set up. They also follow up with inservice training..."

"Since 1986 the village women trained on this program have delivered about 600 babies. First priority for training goes to remote areas and villages with high maternal death rates. The training has focused on two of the province's seven districts and is now expanding into two more..."

VILLAGE MIDWIVES

"It is difficult for a midwife to help a mother. Many say that once she touches the blood or the afterbirth, she is not allowed to touch food..."

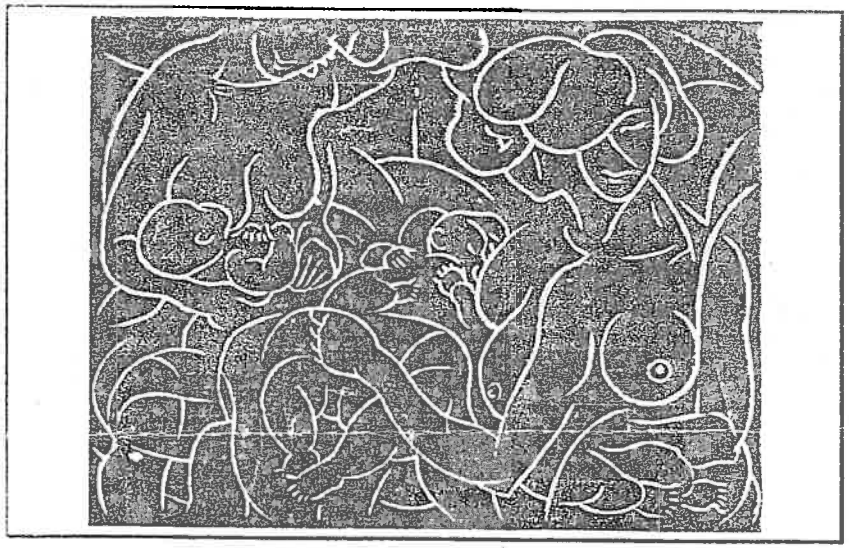
"'Some still believe they must compensate for the midwife touching blood with her bare hands.' Because of this, compensation also becomes a problem. Sister Gari doesn't want any women left without care because her husband cannot afford compensation."

"In fact, the midwife's services are free. The programme calls for two midwives in each village to work together. One attends the mother. The other prepares the fire, sterilizes the knife, etc. The pregnant women's relatives are only expected to help supply food and firewood, or to give a few kina to the midwives to make up for the time lost in their gardens."

"In spite of the low cost of this service, many villages are now insisting that the health department pay for the midwife service and for building the birthing huts..."

"The programme is a genuine success. The big problems of the past have been overcome."

NIN NEWS 16-1 winter 1990



"A Nursing Mother" Etching by Harold Hawkins
Weaver

GENITAL and SEXUAL MUTILATION of FEMALES

ESTIMATE OF

TOTAL NUMBER OF WOMEN AND GIRLS OPERATED IN CONTINENTAL AFRICA

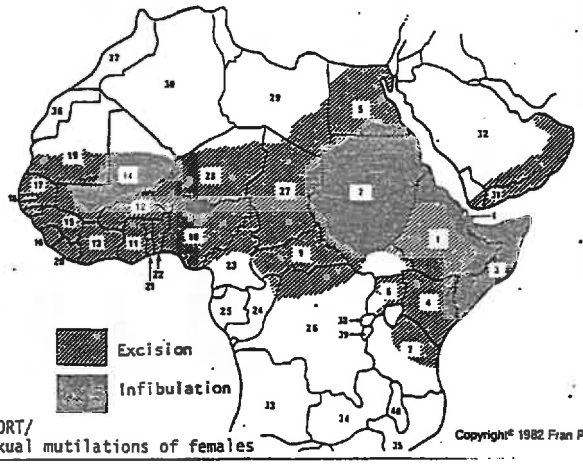
Countries w. Case Histories in Hosken Report	Total Population (in millions)	No. of Women (50% of total population)	Percent Operated (Estimate) **	
East Africa				
Sudan	17.40	8.70	80%	6.96
Somalia	3.90	1.95	100%	1.95
Egypt	44.00	22.00	50%	11.00
Ethiopia	31.00	15.50	90%	13.95
Kenya	15.80	7.90	60%	4.74
West Africa				
Nigeria	100.00	50.00	50%	25.00
Mali	6.70	3.35	80%	2.68
Upper Volta	6.90	3.45	70%	2.41
Senegal	5.60	2.80	50%	1.40
Ivory Coast	8.20	4.10	60%	2.46
Sierra Leone	3.50	1.75	80%	1.40
		Subtotal in millions:		73.95
Countries Where Information/Operations Limited				
East & Central Africa				
Djibouti	.29	.14	100%	.14
Tanzania	17.40	8.70	10%	.87
Uganda	13.20	6.60	small	small
Chad	4.30	2.15	20%**	.43
Niger	5.20	2.60	20%**	.52
Central Africa	2.50	1.25	20%**	.25
Zaire	27.10	13.55	small	small
West Africa				
Benin	3.30	1.65	20%**	.33
Togo	2.80	1.40	20%**	.28
Ghana	11.30	5.65	20%**	1.13
Liberia	1.90	.95	20%**	.19
Guinea Conakry	5.30	2.65	50%	1.32
Guinea Bissau	.80	.40	50%	.20
The Gambia	.58	.29	60%	.17
Mauritania	1.52	.76	25%	.19
		Subtotal in millions:		6.02

TOTAL NUMBER OF MUTILATED WOMEN AND GIRLS IN CONTINENTAL AFRICA ABOUT 80 MILLION (1980)

These population figures are from 1980 (latest available official figures). Average growth of polulation is about 2.5 - 3% per Year. Therefore about 2 Million girls need to be added annually. Decrease due to organized efforts against mutilations is yet too small to count.

Therefore a conservative estimate for the 1990ties is MORE THAN 98 MILLION MUTILATED GIRLS AND WOMEN!

1. ETHIOPIA
2. SUDAN
3. SOMALIA
4. KENYA
5. EGYPT
6. UGANDA
7. TANZANIA
8. DJIBOUTI
9. CENTRAL AFRICA
10. NIGERIA
11. GHANA
12. UPPER VOLTA
13. IVORY COAST
14. MALI
15. GUINEA
16. SIERRA LEONE
17. SENEGAL
18. THE GAMBIA
19. MAURITANIA
20. LIBERIA



21. TOGO
22. BENIN
23. CAMEROON
24. CONGO
25. GABON
26. ZAIRE
27. CHAD
28. NIGER
29. LIBYA
30. ALGERIA
31. SOUTH YEMEN
32. SAUDI ARABIA
33. ANGOLA
34. ZAMBIA
35. MOZAMBIQUE
36. SAHARA
37. MOROCCO
38. RWANDA
39. BURUNDI
40. MALAWI

From: THE HOSKEN REPORT/
genital and sexual mutilations of females

OPERATORS/TOOLS/ENVIRONMENT:

In most of Africa and the Middle East, old women, traditional birth attendants, do the operations. In some countries special castes are involved (blacksmith's wives in Mali). Sometimes men do the operations, such as barbers in Egypt and Northern Nigeria. Often it is an inherited trade (Sudan/Kenya). In West Africa, villages have special "excisors". Many of the operators are paid for their services (for instance, male excisors in Nigeria). It is a very profitable trade. Even though in many areas (especially among Moslems) only women are present at the operations, men (fathers) order the operations and pay for them.

At present, the operations are also performed in the cities in the modern sector by trained midwives (dayas) as well as trained male nurses, also in clinics and hospitals. Stripped of all traditional myths the operation is exposed as the sexual castration it is. Girls who are not excized are refused for marriage; therefore, fathers, afraid to lose the bride price, have them 'done' at an ever-younger age before they can resist. Operators in many countries make a good living from the operations; physicians are also becoming increasingly involved.

In case of complications or death of the child, neither the operator nor the operation are held responsible. The tools used are mainly special knives or razor blades or any available sharp instrument. Asepsis is unknown. The operations are often performed on the ground, on the floor of huts, under trees, etc. In West Africa, dirt and ashes are thrown on the wound to stop the bleeding. Usually several people hold the child down. Anesthetics are not used in the traditional environment; instead the child is threatened and persecuted for crying.

Excision/Clitoridectomy are traditionally practiced as a coming-of-age rite; recently, it is performed on much younger children. Infibulation is traditionally performed on girls 4-8; recently also at younger ages. Among some populations (Amhara, Ethiopia and Yoruba, Nigeria) the operations have always been done on babies a few days old.

COUNTRIES/AREAS (GEOGRAPHIC DISTRIBUTION):

Excision:

Excision is practiced by many ethnic groups all over East, West and Central Africa in a broad area along the equator, from Somalia and along the Red Sea Coast to Senegal (Atlantic Coast). According to the literature published, these operations are documented in more than 26 African countries among hundreds of tribes and millions of people. According to a conservative estimate at least 84 million women are mutilated today in continental Africa alone.

Due to population growth in Africa, today more children than ever before are operated on, though the operations have been practiced for 2000 years. See map and list of countries/ethnic groups. Excision is also documented in the Southern part of the Arab Peninsula and around the Persian Gulf.

A less damaging genital operation is practiced only on Moslem children in Indonesia and Malaysia.

At present there are no medical records available of genital operations in any other areas, though it is possible that it exists among some isolated groups (which has no public health significance as the operations in Africa do).

Infibulation:

Infibulation is practiced in Southern Egypt (Nubia) - hence the name pharaonic circumcision - all along the southern Nile Valley, in the Sudan (on a majority of women) including Khartoum and Omdurman; and on almost all the female population of Somalia and Djibouti. Infibulation is also practiced among the Moslem population of Ethiopia in Eritrea and all along the Red Sea Coast; in Northern Kenya (ethnic Somalis); in West Africa in Mali and in Northern Nigeria according to one medical source.

PURPOSE/REASONS GIVEN:

The real purpose is to reduce or extinguish sexual pleasure and keep women under male sexual control. Therefore, men refuse to marry girls who are not operated on.

The reasons given are: morality; faithfulness to the husband (who has several wives); the preservation of the family. It is believed that women who are not operated on cannot have children - a woman's worth depends on the number of children she has. Many people believe excision is a custom decreed by the ancestors, therefore, it must be complied with. Without excision, a girl cannot become an adult member of society. The clitoris in West Africa is considered a dangerous organ that can kill a baby at birth, and make a man impotent.

Infibulation is practiced to guarantee virginity (visibly) - a bride is inspected before the bride price is paid to assure that she is well closed. Infibulation is done by Moslem population groups because of the importance they attach to virginity and chastity. Traditionally, infibulation is performed on much younger children than excision. Wives are re-infibulated when their husband leaves for an extended time. In Sudan and South Egypt, the procedure is called Tahur "cleansing". In West Africa (Mali) it is practiced by Moslems for the same reasons - to guarantee a virgin bride.

The reasons given for all operations are contradictory and always incompatible with the biological facts; they are however, believed by the people involved, who have no access to health facts and modern information.

"The CHILDBIRTH PICTURE BOOK - a Picture Story of Reproduction from a Woman's View" has Additions to Prevent Excision and Infibulation with the English/French/Arabic editions (also available in Spanish) - by Fran P. Hosken, pictures by Macia Williams published by WIN NEWS / 187 Grant st. Lexington MA 02173, USA.

The CBPBs have been successfully introduced all over the world and especially in countries affected by FC/GM in Africa / Middle East: WIN NEWS welcomes sponsors and contributions to make more CBPBs with Additions to prevent EX/IN available.
WOMEN'S INTERNATIONAL NETWORK is a non-profit charitable organisation.

GENITAL AND SEXUAL MUTILATION OF FEMALES

DEFINITION OF OPERATIONS (According to Medical Literature):

1. Sunna Circumcision (Sunna means "Tradition" in Arabic)
   Removal of the prepuce and the tip of the clitoris (mildest form).
   This delicate operation is rarely performed in Africa and the Middle East, given the lack of anatomical knowledge of the operators, the crude tools used, and the environmental conditions (operations are done on the ground).

2. Excision/Clitoridectomy
   Removal of the clitoris and also often adjacent parts including the labia minora and sometimes all exterior genitalia.
   In some areas, additional cuts into the vagina are added (to make childbirth easier - the opposite is true). Excision is the most frequent operation.

3. Infibulation (Pharaonic Circumcision)
   After the removal of the clitoris and labia minora as well as parts of the labia majora, the two sides of the vulva are closed over the vagina. This is done by fastening together the bleeding sides of the labia majora with thorns or catgut or some sticky paste. A small opening is created by inserting a splinter of wood to allow for elimination of urine and later menstrual blood. The legs of the child are then tied together, immobilizing her for several weeks or until the wound is healed.

THE HEALTH RESULTS (SUMMARY):

Immediate Results: Hemmorhage and infections, severe shock due to loss of blood and pain; tetanus (which is fatal); blood poisoning, gangrene and other infections due to septic conditions and dirty tools; difficulties in passing urine; damage to adjacent parts, urethra, perineum, etc. In W. Africa, dirt is often thrown on the wound to stop the bleeding.

Childbirth: Infibulation requires cutting of the vulva to make delivery possible; if no one can help, both the mother and baby may die. The often hardened scars of the excision operation prevent dilation, especially with the first child; brain damage may result; also tears of the perineum.

Long-range Results: Painful menstruation and difficulties in passing menstrual blood; painful intercourse; infibulation often requires cutting the scar for intercourse which results often in infections; cysts, keloid formation, urinary tract infections and infertility. In later life, women may become incontinent due to fistula formation (rupture of the vagina) which is very difficult to repair.

Psychological Problems: Only some limited studies have been made. The psychological trauma from prolonged pain (anesthetics are not used), from coital problems and acute childbirth complications due to the operations, have not been studied; the damaging effects of sexual castration (frigidity) have been ignored so far.

The WORLD HEALTH ORGANIZATION held a Seminar in Khartoum (Feb. 10-15): "Traditional Practices Affecting the Health of Women and Children". The following resolutions were made by the Africa/Middle Eastern participants:

- Adoption of a clear national policy for the abolishment of female circumcision.
- Establishment of national commissions to coordinate and follow up the activities of the bodies involved, including where appropriate, the enactment of legislation prohibiting female circumcision.
- Intensification of general education of the public, including health education at all levels, with special emphasis on the dangers and the undesirability of female circumcision.
- Intensification of education programmes for traditional birth attendants, midwives, healers and other practitioners of traditional medicine, showing the harmful effects of female circumcision, with a view to enlist their support along general efforts to abolish this practice.

Report available from: WHO REGIONAL OFFICE/P.O. Box 1517, Alexandria, Egypt.

Continued on Page 19

MEDIA WATCH

PICTURE: TIM MACKRELL

Sea Storks plan to deliver win

A group of Auckland midwives are hoping to deliver a win when they take to the water in a dragon boat on Sunday.

The women, from St Helens Hospital, entered the dragon boat festival race on Auckland Harbour to boost morale at the soon-to-be-closed maternity hospital.

Enthusiasm of the organisers caught on and now 21 employees calling themselves "the Sea Storks" plan to paddle their way to victory.

One of the organisers, Miss Joan Pierson, said raising the profile of midwifery, rather than winning, was the most important goal.

With the closure of St Helens, more than 100 midwives will be looking for

"St Helens was the last of the midwifery hospitals left in New Zealand," she said.

Of the 22-strong crew, 18 are midwives and two are nurse aids, one is a husband of one of the crew and there is also a physiotherapist who doubles as an exercise instructor.

The crew will be accompanied on a march up Queen St tomorrow, before the festival, by a large polystyrene model stork.

The team has been in training since December, and Miss Pierson said it had been "a great morale booster."

"People have been able to allay their [illegible] about the hospital closing."

Couple facing prosecution after birth

20-3-90 Press

PA Whangarei

A Whangarei woman may be prosecuted because she chose to have her baby at home without medical help.

Anu Sparx's daughter was born five weeks ago at her Whau Valley home.

Ms Sparx delivered Raven Ariel herself and says the birth is none of anybody else's business.

But the authorities do not agree. Whangarei's Medical Officer of Health, Dr David Sloan, said it was illegal for women to deliberately have children without a doctor or midwife present and it was up to the Northland Area Health Board to enforce the law.

Dr Sloan visited Ms Sparx at the week-end and later said he was investigating the case to determine whether an offence had been committed. He would then decide what action should be taken.

Ms Sparx and the baby's father, Rain Gobi Hawk, are furious about the intervention in what they say is one of nature's most natural and personal experiences.

"What right have they to tell me how I should have my baby?" Ms Sparx said.

The couple reject the scientific view of birth and say it is ludicrous that women have to submit to someone else's idea of childbirth. Ms Sparx, who has one other child, says she saw her first birth at 18 on a bus in Mexico. Since then she had been at 200 births, only one of which was in hospital.

"It was awful — clinical — there was nothing human about it. In the end the woman asked me to take her away from there."

She laughs at claims by the medical profession that they must deliver babies.

"All they can do is take it from the woman's body as she delivers it. It's her birth. It's nothing to do with them.

She says Raven's birth was smooth and uncomplicated and she was in labour for only 1¼ hours.

Raven was born in water in the bathtub (something the medical professional frowns on) but reports of the birth were exaggerated so much it was described as a "horror story," Ms Sparx said.

Somebody complained to Dr Sloan, who sent Ms Sparx a letter informing her she could be prosecuted.

She said it would have been easy to pretend she did not deliberately plan to have the baby without medical help, but she did not want to compromise her principles by bowing to the system.

"Of course something could go wrong, but that's life. Things go wrong in hospital too, but they (doctors) are covered against that. What gives them the exclusive right to life and death?" she said.

Sandra Coney

Rules for men of influence

D.S.T. 25-2-90

THIS week the Medical Council announced that it had struck a young Auckland GP off the Medical Register. He had been charged with excessive prescribing of prescription drugs. Snip, snap. End of Dr Gilgen (for at least for six months, when he can reapply to go back on the register).

The Medical Council has always been gung-ho about doctors who over-prescribe drugs or diddle the GMS benefits. Doctors cynically point out that if you're a relatively claim-less GP, especially if working in the provinces (or in Dr Gilgen's case, with drug addicts in Karangahape Road), and you commit some sin, you're probably for the high jump, as an Example For All To See. If you're a Big Boy, different rules can apply.

In the same week came the announcement from the Medical Council that "charges will be laid against some of the doctors investigated" in the wake of the Cartwright inquiry. Who the doctors are, what the charges are and when they will be heard was not revealed then. We are told that "further announcements will be made at the proper time concerning the outcome of the tribunal's decisions". My estimate is that that will be some time in the next century, but don't hold your breath.

These charges relate to events going back a quarter of a century. In the early 1960s, a doctor or doctors (in the spirit of the council's announcement, they shall remain nameless) began deviating from orthodox medical treatments and conducting experiments without patient consent. Twenty-nine women died.

In May 1987, Phillida Bunkle and I re-raised all this. a judicial inquiry was established within a month and in August 1988, the report of the Cervical Cancer Inquiry validated what we had said. Shortly afterwards, after some prodding, the New Zealand Medical Association asked the Medical Council to investigate. The council's Preliminary Proceedings Committee took over and now, 17 months later, the council has reached a decision to reach a decision at some point in the future . . .

This sorry process is displaying (once again) the inadequacy of the doctors' self-policing system to provide protection and satisfaction for health consumers. Its faults are brought into particularly stark relief because of the enormity of the complaints, and the consequences for the women.

The inquiry into the National Women's Hospital doctors is going through exactly the same process all complaints about medical practitioners follow. Failing to recognise the great public interest in this case, the council apparently saw no need to deviate from its normal procedures. They are going by the book and the book says that the public will know nothing of the identity of the doctors involved, or the charges, OR after a judgment has been made and the doctors given a month to appeal.

The hearings, at both Medical Council level (the only body that can strike off) and Medical Practitioners Disciplinary Committee level, are conducted in secret, the public being entirely excluded. All this means that doctors are given far more protection than an ordinary old citizen who may have done nothing more than neglect to put money in a newspaper honesty box. The rest of us have our names published when charged, the public gets a blow by blow description of the case, and the judgment and sentence immediately becomes public information. The public can then kick up a fuss if it doesn't like the outcome, as it has had its own chance to assess the evidence and the punishment. These mechanisms are in place to protect the public interest. They will be entirely absent from hearings of NWH doctors. The reason for this is that these bodies do not exist to serve the public; they exist to protect the image of the profession and channel and control complaints from disgruntled consumers.

The composition of the various committees is also biased and self-protective. Nine doctors and one lay person could hear the complaints at council level; a similar ratio applies at MPDC level. The doctors will be judged by their peers, and who can have faith in that? It failed in 1978; what has changed since?

New Zealand is too small a country to guarantee an objective inquiry. It's highly likely that some of the doctors on these various committees will have worked with the doctors concerned, gone through medical school with them, or served on the same committees and professional associations. Already, the chairperson of the Preliminary Proceedings Committee, which framed the charges, has been put in the uncomfortable position of investigating doctors in her own medical school.

There's a strong feeling among the profession that the doctors concerned have suffered enough. For example, at the Royal College of Obstetricians and Gynecologists a motion expressing "sympathy for the women involved" was lost, but the college decided a letter should be sent to Professors Green and Bonham "expressing hope for their and their families continuing well-being". In this climate, committee members may come under pressure to ease up. On the other hand, there are probably some who would like to see the doctors concerned hung, drawn and quartered, for bringing the profession into disrepute.

My prediction is that we will continue to see extremely slow progress — call it justice on the never, never. Very expensive, but the company still owns the goods. And of course, there are merits in tardiness. The hearings may well outlast its protagonists, which would indeed solve a few problems.

Fears over birthing unit

Replacement of Elderslea Maternity Hospital with a two-bed birthing unit would be a disaster for the women of the Upper Hutt Valley, Dr Nora Duffield says.

Dr Duffield, who has been active in the campaign to retain a full maternity unit at Upper Hutt, said a birthing unit was a hopelessly inadequate substitute.

It was designed for very low-risk mothers who would be discharged six to eight hours after delivery.

Dr Duffield said she had surveyed doctors practising at the Upper Hutt Health Centre, and only two were prepared to use a birthing unit.

Mothers would be faced with either arranging their prenatal care through a Lower Hutt doctor who would deliver them, or arranging local prenatal care.

"It can be a highly unsettling situation for one GP to care for a mother until the time of birth, with another doctor stepping in to do the delivery," she said.

The cost-cutting was a panic measure being imposed without adequate backup for women discharged within hours of giving birth.

She predicted there would be many more sick babies at home whose problems were going to be diagnosed late.

"I fear we are going to see neonatal deaths as a result of this policy."

These women need midwives!

12 NZ Herald, Thursday, January 4, 1990 ★ SECTION 1

The telephone rings at 3 am.

It is cold and raining, but Sian Burgess gets out of bed and into the car.

The Welsh-born midwife sometimes wonders why she does it, but once at the house where the birth is to take place, "the light switches on, so to speak."

"It has never failed to be exciting."

After working in Europe, Thailand and East Africa, the 36-year-old has been delivering babies in New Zealand homes for nine years.

An increasing number of women are opting to give birth at home.

"Birth is a lot less complicated than it is made out to be," she says.

"If things ever go wrong, the signs are obvious very early.

"As a hospital charge nurse I might be looking after 10 to 12 women at one time, and wouldn't notice as early."

Of 63 babies delivered in 1963, only four involved a transfer to hospital.

Sian Burgess continues to visit the mother for two weeks after the birth, and often develops lasting relationships with families.

Living in Mt Albert, she travels throughout greater Auckland at all hours of the day and night, even to the Waitakeres, where tiny Sian Cottrell-Davies was born two weeks ago.

"It totally disrupts my private life, but that is what you take on. It is just great."

More women turn to home births

ODT 1-11-89

By Joelee Thomson

Home births are on the increase in Dunedin, according to a member of the Dunedin Domiciliary Midwives Collective, Ms Sally Pairman.

"A year ago we were averaging one home birth a month and we now average five," she said.

Out of 1184 babies born in Dunedin, 5% would have been home births, she said.

This figure did not include births in the province.

The Dunedin collective, which started a year ago, receives bookings and inquiries every week.

They were already booked into the New Year, Ms Pairman said.

She said home births seemed to be on the increase nationwide.

"I think women are beginning to see home birth as a safe choice for them."

Law on Medical Council hearings not clear

D.S.T. 25-2-90

By ROB DRENT

THE Medical Practitioners Act of 1968 contains no clear ruling that charges brought against doctors by the Medical Council have to be heard behind closed doors.

Herbert Green and Dennis Bonham have been charged by the Medical Council this week with disgraceful conduct in relation to the treatment of cervical cancer at National Women's Hospital.

A controversy has raged over whether the charges should be heard in private or in public.

The Medical Council has said it wants to hold the hearings in private because they always have been to protect the confidentiality of patient witnesses.

However no decision has been made and the council has called for a legal opinion to see if the hearings can be held in public.

Two other doctors, Otago Medical School professor Richard Seddon and semi-retired Auckland obstetrician and gynecologist Bruce Faris, face lesser charges of professional misconduct arising from their membership of a National Women's Hospital committee in the mid 1970s.

Sandra Coney, who co-wrote the article The Unfortunate Experiment, which sparked the Cartwright inquiry into the cancer treatment, puts her view on page 8.