



# JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, OCTOBER 1997







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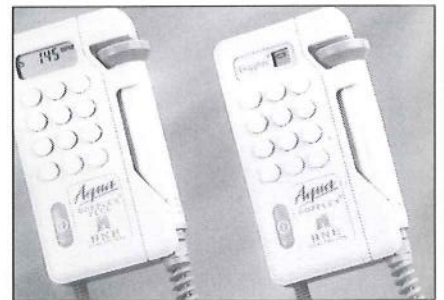
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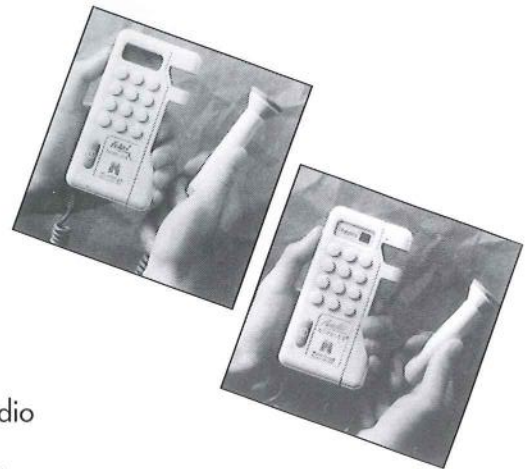
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Helen Manoharan  
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**Printed by:**  
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**Editorial Advisory Committee:**

Anne Barlow – Auckland  
Rea Daellenbach – Christchurch  
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**Philosophy of the Journal:**

- \* Promote women's health issues as they relate to childbearing women and their families.
- \* Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
- \* Provoke discussion of midwifery issues.

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**Information for Authors**

These notes are intended as a brief guide for contributors.

**Articles**

Manuscripts submitted for publication should not have been published previously in any form. Ideal length is between 1,500–4,000 words plus figures, tables and references. Authors should use concise headings and subheadings to identify sections of the article. Diagrams should be supplied as computer generated or as high quality line illustrations drawn in black ink. Photographs should be of high quality. All illustrations and tables should be captioned. All pages should be numbered consecutively, beginning with the title page. Manuscripts should be submitted typewritten and double-spaced on A4 paper (one side only) with 2.5 cm margins all around.

Abbreviations should be written in full followed by the abbreviation in brackets for its first use, e.g. World Health Organisation (WHO).

Preferably the manuscript should be accompanied on a computer disk either Macintosh or IBM compatible.

All submitted articles are peer-reviewed within the subject area of speciality.

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Please provide the following details:

- Name(s)
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- Address for correspondence (this is not printed).
- Current telephone and fax numbers where the author can be reached.

**References (Harvard system)**

In the text, cite the authors' names followed by the date of publication, e.g. Bowers and Thompson (1996). Where there are three or more authors, the first author's name followed by *et al.* will suffice. Style should follow:

Bowers, A.C. (1996). *Clinical Manual of Health Assessment*. 4th ed. London: Mosby.

Bloch, S. and Harari, E. (1990). Family therapy: conceptual empirical and clinical aspects. *Current Opinion in Psychiatry*, 3 (3), pp. 359–367.



## Midwifery – The People Profession

Midwifery is a people profession – women becoming mothers, babies, fathers, families and midwives, and the relationships between the people. The consumers and midwives of New Zealand have exemplified this belief and attitude in the development of a way of working that emphasises relationships. This has been further borne out by the development of a philosophy of practice that is based on a partnership relationship between women and midwives (Guilliland and Pairman 1995). The initiative to bring about changes in legislation which enabled midwives to work in a partnership relationship with women in settings of the women's choice was a model which other professions have still to emulate. Midwifery in New Zealand has come a long way since 1990 and certainly made an impact on me when I came to New Zealand at the end of 1993. It would be unfair to compare a developed country with a developing one where the politics, the needs, standards of living and the populations are so different. Yet there are aspects that warrant comparison, not as a criticism of one country or as a point of praise for the other, but rather as a critique of practices so that the good and bad points of each system can be assessed. One hopes then too that past mistakes will not be repeated or allow detrimental health/economic policies to affect the way one is able to practise in the future.

Prior to the change in government in 1994, South Africa had a health system that was largely dominated by the medical profession but where nurses and midwives formed the largest health professional workforce. Each nurse was also a midwife by education but not necessarily by practice. Midwifery was promoted as a profession that deals primarily with normal childbirth and the detection of deviation from the normal and secondarily with illness or deviations from the normal when these occur. Yet our language emphasised the deviations or the abnormal experience of pregnancy more than the normal. We called pregnant women 'patients', the majority of women were delivered in hospital, were passive recipients of care and had little choice. Even midwives had little choice about the way they could practise. Most of the midwifery education was focused on hospital-situated care and most midwives expected to work in a hospital once they had graduated and registered. The sanctions placed on South Africa because of the Apartheid system effectively separated midwives from a lot of the change that was happening in midwifery around the world – it was difficult to access books, to attend

conferences, to promote change. Despite this there were a few innovative midwives and women who wanted to do things differently, their way. However, much of such difference was fragmented. Some midwives offered antenatal classes, others only postnatal classes; some provided postnatal care while a few worked as self-employed practitioners offering a comprehensive service. The latter was often a difficult situation to be in as midwives were seldom covered by the major health insurance policies that families had taken to cover the anticipated health costs for their families.

Coming to New Zealand opened up a whole new world of possibilities. Some of the possibilities for practice are: a new way of childbearing and birthing available to all women, not just those who could afford it; a variety of birth settings; an emphasis on the woman being an active participant in her pregnancy and birth. Midwives do not have to be nurses and nor do they have to work in a hospital setting only. Midwifery education is community-centred and pregnant women are called women, not patients. These differences made a profound impact on the way I began to view my past practice and my future teaching, writing and researching. I would say that I wrote my thesis differently from what I would have done had I completed it in South Africa. I discovered an amazing infrastructure that had been set up to provide guidance to midwives as they practise in new ways. The New Zealand College of Midwives had set standards for practice, developed a code of practice and a philosophy for practice and guidelines for supporting and promoting breastfeeding. Standards Review Committees function in various areas of New Zealand and encourage and support practising midwives as they assess their practice on an annual basis.

Despite all these wonderful innovations, I have discovered midwives who are desperately unhappy, critical, who feel unsupported and are just waiting for a lawsuit to be taken out against them or to have to appear before the disciplinary committee of the Nursing Council of New Zealand. I have also heard women and fathers and families who are very critical of midwives. The media seems to pick up on the negative publicity related to midwives and every midwife seems to be painted with the same brush. Some doctors appear not to want to work with midwives and vice versa, some hospital-based midwives are critical of self-employed midwives and vice versa. Midwives are becoming tired and despondent and wonder what they are doing the job for. Some are

afraid to debrief on situations they experienced in case their comments are used against them in a court of law or a disciplinary tribunal. What has happened to this people profession? What has happened to relationships and partnerships? Have we moved to a total business and competitive focus? Are we not prepared to support each other, help each other learn to be better midwives for the benefit of the women and children and families of New Zealand?

It is seven years since the amendments were made to the Nurses Act. We have come a long way and it is time to reassess where we are and where we are going. Change is a fact of life and will continue to occur. We cannot afford to merely react to the changes that are occurring. We should be developing our vision for the future of midwifery in New Zealand and acting to ensure it happens. If we do not, someone else's vision will be forced upon us. What areas should we be addressing? Strengthening our relationship with women, strengthening our relationships with each other, putting an end to horizontal violence. It is time we reaffirmed our maturity as a profession and developed working relationships with members of the other health professions on negotiated terms, not to be subservient again but to work in a co-operative relationship for the good of the women we serve. Student midwives are educated to work in a self-employed situation in the community: how can we help them become confident safe practitioners without having to send them into the hospital to first gain experience there? How can we get to know what is happening in practice in the whole of New Zealand and not just in the area where we live, or the practice or hospital in which we work? We need to start working with each other and not against each other. We don't always have to agree – there cannot be total consensus on all issues. But when a decision is made on a majority vote and we have taken time to participate in the decision-making or the discussion of issues, let us consider ways we can work to make decision come to fruition rather than break things down.

Statements such as 'United we stand, divided we fall', 'A house divided against itself cannot stand' are still apt. Let us move forward into working with each other, for the good of the women of New Zealand and for benefit of the midwifery profession.

*Cheryl Benn PhD  
Associate Professor  
Dept of Nursing and Midwifery  
Massey University, Palmerston North*



# Female Genital Mutilation

*Nikki Denholm*

*Midwife Manager  
FGM Project Co-ordinator*

Nikki is  
currently co-ordinating a  
Female Genital Mutilation (FGM)  
Education and Research  
Programme in the  
Auckland area for  
North Health.

With the recent rise in North East African refugees settling in New Zealand, FGM has become a health issue for New Zealand – particularly for Women's Health Care Services. In response to the increase in immigrants, FGM was made a criminal offence in January 1996. Following this, the Ministry of Health distributed an information leaflet stating that it would introduce an education strategy for communities affected and for health and child care protection professionals. My role is to initiate this as a pilot project and then forward recommendations for further work needed.

I am currently undertaking the research component of the programme with the African community in Auckland and training local health and child protection professionals working with genitally mutilated women.

Globally, at least two million girls a year are at risk of genital mutilation – approximately 6,000 per day. An estimated 130 million girls and women in the world are genitally mutilated. Most live in Africa, a few in Asia and increasingly there are more women in Europe, Canada and the United States who have suffered female genital mutilation. These women and girls experience pain, trauma, infections, or even death. Long-term physical complications are numerous and there appears to be substantial psychological effects on women's self image and sexual lives. For those with the severest form of FGM, infibulation, the trauma of mutilation is repeated with each childbirth.

Dr Nahid Toubia (1995)

Female genital mutilation is an emotionally and culturally charged issue is shrouded in mystery and taboo. Whilst most Western governments and citizens hold very indignant views on the issue, because of the controversial 'cultural' nature of the practice few have translated their concerns into providing health care services and education programmes to assist the women affected.

With the recent civil wars in North Africa, there has been an increased number of refugees entering New Zealand, bringing FGM with them. Over the last year 39 genitally mutilated women have been cared for at National Women's Hospital and FGM has become a significant issue for our Women's Health Service. Most of the women affected in New Zealand are from the Horn of Africa and have undergone the most severe form of genital mutilation – infibulation (Type 3 – see definition). Subsequently, cases are appearing of scar tissue shattering extensively at delivery, chronic anaemia, women having posterior episiotomies instead of being de-infibulated at delivery, women refusing necessary caesareans, women being unable to consummate their marriage because of a lack of services available to open up their scar tissue, women with recurrent urinary tract infections, women becoming pregnant immediately postpartum because of misbeliefs regarding family planning, and much more.

The increasing number of African refugees settling in New Zealand has also resulted in wider public consideration and concern given to the issue of FGM and the New Zealand Government responded by making FGM a criminal offence under an amendment to the Crimes Act in January 1996. Following the law changes, focus groups were held for genitally mutilated women in the Auckland area to identify their health needs and get general feedback on issues surrounding FGM. The feedback very clearly focused on difficulties with Women's Health Services in Auckland. It highlighted a considerable lack of knowledge, training, understanding and sensitivity among health professionals and indicated a very clear need for a specialised service to be established for women who have undergone genital mutilation.

From a health care perspective, FGM is clearly a complex reproductive health issue with multiple obstetric, gynaecological, sexual and psychological consequences. With the difficulties of FGM being highlighted in pregnancy and childbirth, many other gynaecological and sexual health issues frequently arise during a woman's care and need to be addressed. As midwives and doctors are often the first New Zealand health professionals the women have dealt with on this issue, it is therefore imperative that professionals within our services are educated to provide sensitive and specialised care to genitally mutilated women.

FGM is not a simple issue that can be addressed on a purely physiological level. It is a complex, multifaceted practice embedded in deep traditional and cultural beliefs. In order to provide the best possible care for affected women it is vital we understand some of the complexities surrounding it. This paper therefore does not simply focus on the clinical aspects of FGM, but in order to provide deeper insight



and understanding it addresses some of the wider issues surrounding the practice. The paper also focuses largely on FGM from a Somali perspective, as although FGM is practised among a number of ethnic groups, the Somali community is currently the most prominent community affected by the practice in Auckland.

The paper begins by defining FGM and looking at the practice itself; its origins, prevalence, how and when it is performed; describing the consequences of FGM; short-term, long-term, problems in pregnancy and childbirth, sexual consequences and psychological and social consequences. The beliefs and issues that sustain FGM are examined, followed by feedback on our Health Care Services. Finally, it makes recommendations for our Health and Child Protection Services for improved and more effective care and education for genitally mutilated women and protection and monitoring of at risk girls.

## Definition

Female genital mutilation (FGM) is defined by the World Health Organisation (WHO) as all procedures which involve partial or total removal of the external female genitalia and/or injury to the female genital organs whether for cultural or any other non therapeutic reasons (WHO 1996).

FGM is classified into four main types:

### Type 1 – Circumcision (also known as Sunna Circumcision)

This is the mildest form of circumcision and consists of the removal of the prepuce or hood of the clitoris only, preserving the clitoris itself and the posterior larger parts of the labia minora.

### Type 2 – Excision or Clitoridectomy

This type is more severe and consists of the partial or total removal of the clitoris together with the adjacent tissues of the labia minora (sometimes the whole of it). The labia majora are left intact and the vagina is not closed. The amount of tissue removed varies widely between communities and is dependent on the skills and eyesight of the operator and/or the struggles of the child.

*Note:* Approximately 85% of all women who undergo FGM have either Types 1 or 2.

### Type 3 – Infibulation (also known as Pharaonic Circumcision or Gudniin in Somali)

This is the most extreme form of FGM and causes the most damage to girls' and women's health throughout their life. It involves the removal of the clitoris and labia minora as well as the inner surface of the labia majora. The two sides of the vulva are finally attached to each other, either by stitching with silk or catgut sutures, or by thorns. This reduces the size of the orifice of the vulva

and leaves only a very small opening at the lower end to allow for the passage of urine and menstrual flow. The girl's legs are bound together from thigh to ankle and she may be immobilised for several days and/or up to two weeks. Traditional herbs and local medicines believed to enhance healing are often applied to the wound. If the vulva does not heal successfully or the opening is too big, the girl is often operated on again. Since a physical barrier to the vagina has been created, recutting often has to take place prior to intercourse and with childbirth to allow exit of the fetal head.

Although only an estimated 15% of all women who experience FGM have this type of operation, in certain countries like Sudan, Somalia and Djibouti, 80–90% of FGM is infibulation.

### Type 4 – Unclassified

This includes other procedures such as; introcision (the enlargement of the vaginal opening by tearing or cutting the perineum), pricking, piercing, incising or cauterising by burning the clitoris and/or labia, the scraping of surrounding tissue of the vaginal orifice (angurya cuts), or the cutting of the anterior and sometimes posterior vaginal wall (gishisi cuts).

## The Practice

We can't afford being different. We found our mothers circumcised; we learned that our grandmothers and great-grandmothers were circumcised and we have to carry the tradition for our children and grandchildren. We can't think of anyone who is not circumcised. Once a man divorced his wife as soon as he discovered that, out of negligence, one of her two leaves was not cut off. This man told his wife: 'What have I married? A man or a woman?' News of the incident spread and the woman did not know where to hide because of the scandal.

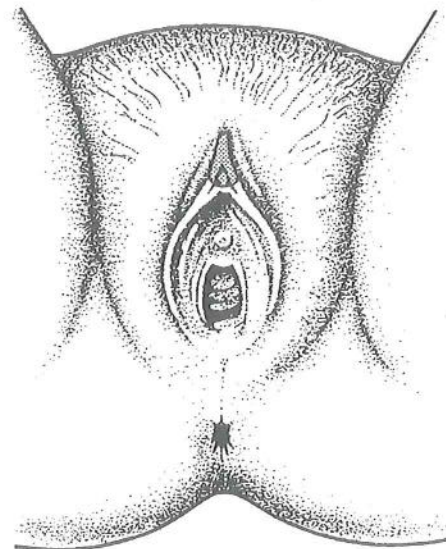
M. Assad (1994)

To understand the complexity of FGM, it is necessary to look at the practice and the historical context within which it occurs.

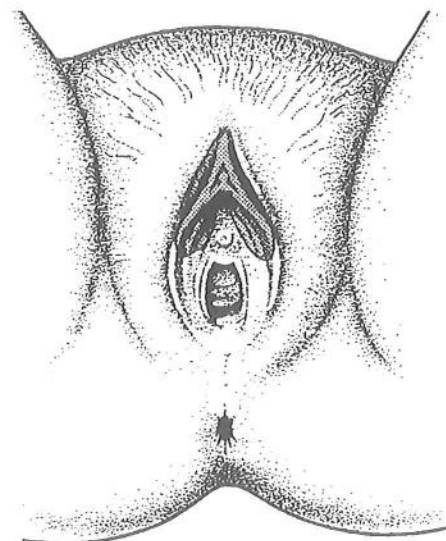
## Origins

The customs and beliefs surrounding the origins of FGM vary greatly. Two predominant schools of thought are that it originated in ancient Egypt and spread to East Africa (Assad 1994) (hence being termed 'pharaonic circumcision' by the Sudanese) or it was an old African rite that came to Egypt by diffusion (Dorkenoo 1994) (being referred to as 'Sudanese circumcision' by the Egyptians). There is, however, no confirmed documentation on the exact date and place the practice originated, but it is believed to spread by dominant tribes and civilisations often as a result of tribal, ethnic and cultural allegiances (Deco 1982).

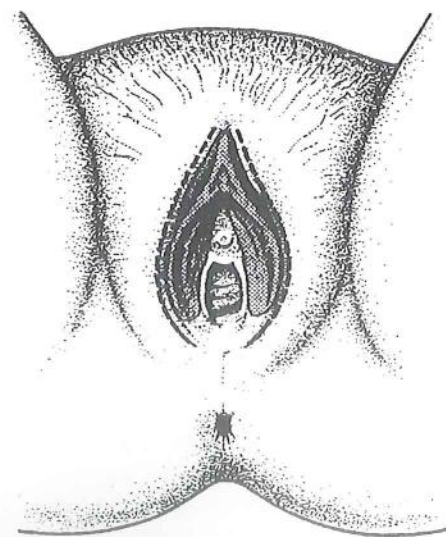
Type 1



Type 2



Type 3





## Prevalence

At present it is estimated that there are 127 million girls and women who have undergone some form of genital mutilation (Hosken 1995) and that at least two million girls per year are at risk of mutilation (Toubia 1995). However, information available on total prevalence and rate is only based on anecdotal reports and is not complete. One or more forms of FGM are practised in more than 26 African countries and also by many ethnic groups in the southern part of the Arabian Peninsulas and along the Persian Gulf. It is also reported to be practised by some Muslim groups in Malaysia and Indonesia (Hosken 1995). Because of recent civil wars in the Horn of Africa, many refugee communities have resettled in Western countries and it is thought to be increasingly practised in refugee camps and some Western countries (Hosken 1995). Based on government reports and limited surveys the prevalence of FGM in countries where it is practised is estimated to range from 5 to 98%. See Table 1.

**Table 1: Estimated prevalence of Female Genital Mutilation in Africa**

Country	Estimated % of women and girls operated on	Estimated number (millions)
Somalia	99%	4.49
Djibouti	99%	0.28
Sierra Leone	90%	1.98
Ethiopia	85%	24.05
Eritrea	80%	1.38
Sudan	85%	11.63
Mali	75%	3.92
Gambia	80%	0.43
Burkina Faso	70%	3.52
Chad	60%	1.85
Guinea	70%	2.28
Egypt	80%	18.49
Kenya	60%	8.20
Liberia	70%	1.03
Mauritania	40%	0.44
Nigeria	60%	32.54
Ivory Coast	60%	4.13
Guinea Bissau	70%	0.37
Benin	50%	1.32
Ghana	30%	2.54
Togo	50%	1.00
Niger	20%	0.88
Senegal	20%	0.81
Cameroon	15%	0.98
Central African Republic	10%	0.15
Tanzania	10%	1.49
Uganda	5%	0.49

Information source: Credit to Fran P. Hosken for the original estimates of prevalence of FGM in Africa. All other information is from *Africa Today*, Population Concern, 1994, *The State of the World's Children*, UNICEF, 1996.

## Age FGM is Performed

The age at which FGM is performed varies widely, depending on the ethnic group and geographical location. In some groups, for example among the Ethiopians, FGM is performed as early as infancy, while in other groups the ceremony may not occur until the girl

is of marriageable age – approximately 14 to 16 years old. The most typical age for infibulation seems to be between four and eight, although the age is generally falling – indicating FGM is having less and less to do with initiation into adulthood (Taba 1979). It is reported for example, that refugees seeking asylum in Western countries are performing the procedure on their children at a much younger age so as to avoid laws in recipient countries prohibiting FGM (Dorkenoo 1994).

## How the Practice is Carried Out

FGM is most frequently performed by traditional midwives (birth attendants) or 'circumcision operators'. The procedure is carried out using special knives, scissors, razor blades, scalpels or pieces of glass. Anaesthetics and antiseptics are not generally used and pastes containing herbs, local porridge or ashes are frequently rubbed on the wounds to stop bleeding. There is often unintended damage due to crude tools, poor light and septic conditions. The girl is held down by female relatives to prevent her from struggling. In some regions at certain points in the procedure, the women begin an ululation chorus of chants of victory and encouragement. This helps to quieten and drown the cries and screams of the child. It is also thought to be symbolic of the act of purification of the girl. For most girls, the procedure is marked by pain and fear. In *Sisters in Affliction* (Abdalla 1982) a young rural Somali woman describes the day she was circumcised in her village:

I was excited and happy when my mother agreed, but when I saw the woman operator and her razor blade, I felt frightened. When it was my turn, I was already trembling but forced myself to sit down so that my mother would not see that I was afraid. When the woman held me tight and the midwife parted my legs, I was full of fear and when she started the cutting, I screamed loudly and fought to free myself. One of the women filled my mouth with cloth and another one closed my eyes and they kept me tight and suffocated me with their bosoms until I nearly ran out of air.

By the time the operation was over, I was exhausted and hardly breathing. My mother told me that the operator used six thorns to sew up my wound, three on each side. I did not know what was happening to me except that I felt severe pain. After the operation I stayed in bed for two days without moving, as I was afraid to do so. On the fourth day my legs were tied up for several days and I was walking with the support of a stick for another few days. It took me about two weeks to resume any other activities.

Abdalla (1982)

In urban areas, however, FGM is being performed much more frequently with anaesthetics in hospitals, by trained doctors, nurses and midwives.

(According to *The Progress of Nations*, a report published by UNICEF in 1996, 12 nations in the world have estimated maternal mortality rates of 800 or more. Nine of these are in the areas in Africa where FGM is widely practised.)

## Consequences of FGM

There is no single practice which has such a dramatic negative effect on health in the broadest sense as female genital mutilation.

Dr Mark Belsey (WHO 1996)

FGM causes grave damage to girls and women and frequently results in long-term health consequences. The effects on health depend on the extent of cutting, the skill of the operator, the cleanliness of the environment and the physical state of the girl or woman concerned. The most detrimental health consequences occur with infibulation.

## Short-Term Complications

### Haemorrhage

This is the most common and almost unavoidable immediate complication of FGM, as excision of the clitoris involves cutting across the high pressure clitoral artery. Attempts to stop bleeding may not be effective and this can lead to excessive haemorrhage. Acute extensive bleeding can lead to haemorrhagic shock or even sudden death in the case of cataclysmic haemorrhage.

### Shock

This may occur because of blood loss and the severe pain and trauma of the procedure. Both haemorrhagic and neurogenic shock can be fatal.

### Pain

The majority of mutilation procedures are performed without anaesthetics and cause the girl severe pain. Even if a local anaesthetic is used, multiple insertions of the needle are required.

### Urinary Retention

This is very common and may last for hours or days. It is commonly due to pain, tissue swelling, inflammation, injury to the urethra and fear of passing urine on the raw wound.

### Injury to Adjacent Tissue

Injury to the urethra, vagina, perineum and rectum can result from the use of crude instruments, poor light, careless techniques or from the struggles of the girl.



## Infection

This commonly occurs for a number of reasons; unhygienic conditions, the use of unsterilised instruments, applications of traditional herbs or ashes to the wound which provide an excellent growth medium for bacteria, contamination of the wound with urine and/or faeces, or binding of the legs following infibulation which prevents wound drainage. Infection may spread internally to the uterus, fallopian tubes and ovaries causing chronic pelvic infection and infertility. Septicaemia and tetanus may also develop.

## Fracture or Dislocation

Fracture of the clavicle, femur, humerus or hip joint can occur if heavy pressure is applied to a struggling girl during the procedure, as often occurs when several adults hold her down.

## Failure to heal

Wounds may fail to heal quickly because of infection, irritation from urine, underlying anaemia or malnutrition.

## Long-Term Complications

We will keep doing it because of our tradition, but it brings many, many problems.  
Faduma, Somali refugee, N.Z. (1997)

The long-term complications from both excision and infibulation are detailed below. However, those resulting from infibulation occur more frequently and are more severe.

## Difficult Micturition

This is due to damage to the urethral opening, obstruction of the urinary opening or scarring of the meatus and can lead to chronic incontinence.

*Note:* For many infibulated virgins, urinating takes up to 15 minutes.

## Recurrent Urinary Tract Infections

This is often a result of the damage caused to the lower urinary tract during the mutilation, or infection near the urethra resulting in ascending UTIs. As the normal flow of urine is deflected, the perineum remains constantly wet and susceptible to bacterial growth – retrograde UTIs commonly result, affecting the bladder, uterus and the kidneys.

## Chronic Pelvic Infections

Partial occlusion of the vagina and urethra increase the likelihood of infection. The infections are often painful and may be accompanied by a noxious discharge spreading to the uterus, fallopian tubes and ovaries. These infections frequently become chronic.

## Infertility

This is a risk due to infections causing irreparable damage to the reproductive organs.

## Vulval Abscesses

These can develop due to deep infection resulting from faulty healing or an embedded stitch causing the formation of an abscess.

## Neurinoma

This can develop where the dorsal nerve of the clitoris is cut or trapped in a stitch or in scar tissue. The surrounding area becomes hypersensitive and unbearably painful.

## Keloid Scars

These result from slow and incomplete healing of the wound and the production of excess scar tissue. The scars may obstruct the vaginal orifice and be so extensive that they prevent penile penetration.

## Dermoid Cysts

These result from inclusion of the epithelium during healing, leading to swelling or pockets producing secretions. The cysts vary in size, are extremely painful and can prevent sexual intercourse. They are the most common complication of infibulation.

## Calculus Formation

These develop due to menstrual debris or urinary deposits in the vagina or in the space behind the bridge of the scar tissue.

## Fistulae

Vesico-vaginal or recto-vaginal fistulae can form as a result of injury during mutilation, de-infibulation, re-infibulation, sexual intercourse or obstructed labour. Urinary and faecal incontinence may be lifelong, with severe social consequences.

*Note:* Fistulae are a very common complication of infibulation and clinics have been set up in parts of Africa solely to repair fistulae, many of which have resulted from FGM.

## Bleeding

Repeated events of de-infibulation and re-infibulation during childbirth may cause large amounts of blood loss, which may lead to the development of long-term anaemia. Bleeding also occurs if the wound becomes infected.

## Difficulties in Menstruation

This often occurs because of partial or total occlusion of the vaginal opening and may result in dysmenorrhoea. Haematocolpos may result from the retention of menstrual blood due to the almost complete coalescence of the labia.

## HIV Transmission

The use of the same unsterile instruments in group mutilations, repeated cutting and stitching during labour and the higher incidence of lacerations and abrasions during intercourse, increase the risk of HIV transmission.

## Difficulties with Sexual Health Screening and Family Planning

- Screening for some STDs such as chlamydia (endocervical) is often very difficult to perform in infibulated women, resulting in undiagnosed and untreated STDs.
- Providing a comprehensive family planning service for women who are infibulated is also difficult as some methods of contraception such as diaphragms and IUDs may be precluded.
- Cervical smear-taking of infibulated women is often not possible, preventing early detection of cervical cancer.

## Problems in Pregnancy and Childbirth

Problems during pregnancy and childbirth are very common, particularly following infibulation. The extent of the complications varies depending on factors such as the size of the opening, parity and the nature of the scar tissue. The most common complications following infibulation are as follows:

- In the event of a miscarriage the fetus may be retained in the uterus or the birth canal and performing a dilation and curettage may be difficult.
- Incorrect assessment of the stage of labour, cervical dilation and/or fetal presentation due to the inability to perform vaginal examinations.
- Inability to perform an induction with prostaglandins due to a very narrow vaginal opening.
- Difficulty with urinary catheterisation due to a very narrow urethral opening.
- Prolonged and obstructed labour due to tough scar tissue causing partial or total occlusion of the vaginal opening.
- Increased risk of uterine inertia, rupture or prolapse, tearing to the perineum, haemorrhage and fistula formation due to prolonged and obstructed labour. The baby may then suffer brain damage or death as a result of birth asphyxia.
- Increased risk of bleeding, wound infection and damage to surrounding tissues due to



repeated de-infibulation – particularly if it is not performed correctly.

- Difficulties applying fetal scalp electrodes or performing a fetal blood sample due to a very narrow vaginal opening. An inability to provide adequate fetal monitoring in the case of a compromised baby may hasten the decision to perform a caesarean.
- Difficulty identifying some obstetric emergencies such as cord prolapse due to an inability to perform vaginal examinations.
- Repetition of de-infibulation and re-infibulation (which commonly occurs 8–10 times) weakens the scar tissue and at the beginning of menopause, a woman can be left with a mass of fibrous tissue. Incontinence and prolapses of the vaginal wall may result.

## Sexual Consequences

With Pharaonic (infibulation) women don't ever experience sexual pleasure because they can't feel anything.

Asha, Somali refugee (1997)

After 15 years of marriage I still don't like the sexual act. I don't know whether my cold feelings are due to circumcision or to other factors ...

Sahra, Somalia refugee (1997)

We are always very scared about sex the first time and don't enjoy it much. In New Zealand we also don't have anywhere where we can be cut open.

Saneb, Somali refugee (1997)

Few studies have been done on the sexual consequences of FGM. However, it is reported and most authors confirm, that FGM significantly decreases the sexual pleasure and fulfilment of women (Hosken 1995). Most women who have undergone genital mutilation experience various forms and degrees of sexual aberration.

Painful intercourse is a common consequence of FGM because of scarring, the reduced vaginal opening and other complications. Vaginal penetration through reduced and damaged genital nerve and scar tissue can be difficult without further tissue damage and recutting is often necessary. This is done occasionally by the husband using fingers, a razor or a knife, or more commonly by a traditional midwife. In some communities husbands are expected to penetrate the opening with their penises, which can be extremely painful and consummation of marriage may take months if the scar tissue is not cut open. Consequently many women complain of great fear associated with initial intercourse. For immigrants/refugees settling in Western countries, accessing health professionals familiar with cutting open infibulated scar tissue is not easy.

Mutilations that involve injury to, or removal of, the clitoris result in damage to the concentrated nerve complex responsible for clitoral erection

and erection of a partially mutilated clitoris can be a very painful and mentally inhibiting ordeal. The few studies that have addressed the area of sexuality report the absence of orgasm in genitally mutilated women to be extremely common. In a study involving 4,024 women in Sudan, 80% of the women who had undergone infibulation reported they had never experienced orgasm (Abdalla 1982). Smaller local studies also concur with the view that many genitally mutilated women experience sexual frustration and frigidity (El Saadawi 1982).

*Note:* Despite such sexual difficulties, it is important to understand that women with mutilated genitals can experience sexual desire (which is largely psychological) and enjoyment is still possible (Lightfoot Klein 1989).

## Psychological and Social Consequences

For many girls FGM is an experience marked by fear, submission, inhibition and suppression of feelings. The experience becomes a vivid landmark in their mental development, with feelings of deep anger, fear, bitterness and betrayal at having been subject to such severe pain. Older women have reported that nothing they have subsequently gone through (e.g. childbirth) equals the painful experience of FGM (WHO 1996).

FGM is commonly performed when the girls are quite young and uninformed and the procedure is often preceded by acts of deception and coercion by trusted parents and relatives. In most cases an anaesthetic is not used, the girls are conscious and need to be physically restrained as they struggle against the pain. For some girls and women, the physical and psychological experience of genital mutilation is extremely traumatic and its aftermath is similar to that following rape. In *Sisters in Affliction* (Abdalla 1982), a Somali woman clearly illustrates this when recollecting her mutilation:

I was very much afraid of the circumcisor when she opened her dirty bag and produced the knife. I was held firm and tight and my back was pressed by some women friends of my aunt and relatives. When my legs were parted the midwife started to perform the operation, I felt great pain and I screamed and fought wildly, but it was not possible to free myself.

When it was over, I could hear the ululations of the women and they broke an egg on the wound which they said would cool down the pain. In spite of this, I started to bleed and they were not able to stop it until the midwife took out the thorns. I was left like that for four days.

On the fourth day the midwife came again with her knife, I was held tightly

again and then re-infibulated with several thorns. I was shocked and shivering with fear and pain.

After all these years, I still remember the pain and how frightened I was.

In 1977, Dr T.A. Baashar conducted one of the first studies on the long-term psychological effects of FGM (Baashar 1979). The study concluded that the numerous physical consequences of FGM have subsequent psychological effects and that the two are inseparable. He identified that a genitally mutilated woman faces agony at many stages of her life; a painful and traumatic mutilation in youth, continual difficulties with urinating, severely painful monthly periods, sufferings during marriage due to infibulation, forceful penetration and sometimes physical assault in intercourse with the husband and excruciating suffering during childbirth. He suggested that the memories of all these ordeals can lead to severe psychological trauma for women. There is often no acceptable means of expressing these fears and pains and the women suffer in silence.

It needs to be emphasised however, that despite the severe physical and emotional trauma of the practice, FGM also has an important psycho-social role in the lives of young girls in affected communities. FGM is often shrouded in mystery and magic rituals and celebrations with special clothes, food and gifts for the girl. The ritual marks the young girl's entry into womanhood and she carries a new and vital sense of 'identity' after the procedure. An unexcised or uninfibulated girl is often despised, alienated and made the target of ridicule, thus facing severe psychological anxiety of another nature. In *The Hosken Report – Genital and Sexual Mutilation of Females* (1995), the following account of a midwife's dilemma over whether to subject her daughter to FGM clearly illustrates this.

I cannot sacrifice my child. Either way, she suffers. What am I to do? As a midwife I know the terrible health results. As a mother I know how the child suffers from being teased, insulted and excluded by her friends. She will face even worse problems later when the family of the man to whom she will be given in marriage will turn her down as 'unfit'. How can we stop these operations as long as we know that if our girls are not circumcised, they will not find husbands and they will blame their mothers: their lives will be ruined either way!

## Beliefs and Issues Sustaining FGM

It is a deep-rooted custom in our culture and people think it is an important operation for women because it prevents them from being oversexed. Uncircumcised girls are not accepted among our society. As you know infibulation is a



prerequisite for marriage because no man wants to have an oversexed woman who becomes unfaithful after marriage. No family wants their daughter to have loose ways and bring shame to the family. Because of this, mothers make sure their daughters are properly circumcised and infibulated.

Ardo, Somalia (Abdalla 1982)

FGM is a culturally embedded, multifaceted practice that must be understood from the context of the society within which it is practised. The beliefs surrounding FGM are such a deeply entrenched part of the society's framework and held on to with such tenacity that despite the fact that it is medically harmful, painful and extremely dangerous, women who have themselves been subjected to so much suffering submit their daughters to genital mutilation.

To prevent its occurrence and provide the best possible care for genitally mutilated women in New Zealand, it is important to understand the function and powerful role FGM has within affected communities, however harmful it may look to us from our personal and cultural viewpoint. The beliefs surrounding FGM vary greatly from one ethnic group to another. However, there are many common themes. The following outlines some of the most common beliefs sustaining the practice, focusing particularly on examples from Somalia.

### The Position of Women

One of the most important factors to consider when trying to understand FGM is the position of women within societies practising FGM. While a woman's role varies with the diversity of history and culture in each ethnic group, a common theme running through all the groups is that they are patriarchal and patrilineal-based societies, i.e. cultures dominated by males where resources and power are passed down and held solely under male control (Hosken 1995). A woman's access to land and to economic resources is therefore entirely through the male members of the family and through a husband.

In order for a woman to be eligible for marriage in Somalia, Sudan and Muslim areas of Ethiopia, it is absolutely essential that she is a virgin. The importance attached to the concept of premarital virginity and genital mutilation in these societies cannot be overemphasised. The association between premarital virginity and genital mutilation is so strong, that an uninfibulated girl has virtually no chance of marriage regardless of her virginity. The following account of a young Somali girl's need to be re-infibulated illustrates this:

At the age of 12 I was told that my infibulation was not tight enough and I had to have another operation. I was very unhappy about it, but I was told I would not be regarded as a decent girl if I was

not tightly infibulated and there would be no hope for me to marry. It was a horrible, painful and sickening experience for me, but I had to force myself to undergo it.

(Abdalla 1982)

Another important concept upheld in Somalia, is that of the bride price (Hosken 1995). A Somali girl is sold by her father to her husband and to his family for a bride price, which usually consists of money, cattle or other goods. The girl is always inspected by the husband's family to ensure she has been infibulated prior to paying the bride price and if a woman divorces her husband, part of the bride price must be returned to the husband. FGM therefore also has significant economic value, as a fundamental prerequisite for obtaining a bride price for a woman's family.

FGM clearly does not stand alone, but is an intrinsic part of patrilineal familial practices in Somalia. It is the key to securing a woman's position in marriage and the family, preserving family honour and the modesty code and maintaining a woman's social role. Abdalla (1982) describes this in *Sisters in Affliction*, by likening the infibulation scars to 'a seal attesting to the intangible but vital property of the social group's patrimony, the honour of the family and patrilineage'.

### Role of Men

While the practice of FGM remains in the female sphere and women are considered both the excisors and the perpetrators of the practice, the underlying role of men cannot be overemphasised. FGM is universally considered a practice resulting from patriarchal societies and subsequent women's powerlessness. It is considered to be rooted in male-dominated societies that have attempted to subjugate women and repress their sexuality. As discussed, FGM is strongly linked to virginity and chastity and a man will usually refuse to marry – or reject a woman that has not been excised or infibulated. In the Horn of Africa, FGM is also considered to play a significant role in men's sexuality: a narrowed opening is meant to enhance a husband's sexual pleasure and the challenge of penetrating a tight opening is often considered to indicate a man's virility. (Most women seek re-infibulation after childbirth for these reasons – simply to please their husbands.)

### Lack of Education and Traditional Myths

The majority of African women in the societies practising FGM are illiterate, poor and rural women with no access to broad health education. Many myths surrounding FGM have been passed down from generation to generation and are *genuinely* believed and held onto with tenacity, thus sustaining the practice.

For example:

- The Mosi of Bukin Faso, the Bambar and the Dogon in Mali believe that the clitoris is dangerous during childbirth and when in contact with the baby's head, can cause death (Epelboin 1979).
- In some areas, notably Ethiopia, people believe that if the female genitals are not excised, they will grow and dangle between the legs like a man (Hosken 1995).
- The Tagouna of the Ivory Coast believe that an unexcised woman cannot conceive (Aminata 1979).
- The Dogon and the Bambara in Mali believe that both the female and the male sex exist within each person at birth – the foreskin and the clitoris must be excised to clearly demarcate the sex of the person (Assitan).
- In Egypt, Somalia and Ethiopia the external female genitals are considered dirty, ugly and disfiguring. For example, an unexcised girl is called 'Nigsa' in Egypt meaning unclean. The aim of infibulation is to produce a smooth clean skin surface. In areas where infant mortality is so high and fertility so important, FGM is promoted as a prerequisite for the cleanliness of a woman and the good health of her baby.  
(*Yet, in practice infibulation has the exact opposite effect to this, promoting poor hygiene and an increased risk of infection, infertility, health complications and child-bearing difficulties.*)

### Sexuality

For many societies FGM is quite clearly about curtailing women's sexuality. The most universal reason offered for FGM is 'for the attenuation of sexual desire' (Baashar 1977). In 1980, a survey on the attitudes towards uninfibulated women was conducted among members of a Somali community in Mogadishu. The feedback indicated that both men and women considered uninfibulated women to be loose, oversexed and impure, with questionable sexual morals and fidelity (Abdalla 1982).

In the context of societies where virginity is an absolute prerequisite for marriage and any type of promiscuity or extramarital relationship provokes the most severe penalties, FGM is believed to protect a woman against her oversexed nature, saving her from temptation, suspicion and disgrace – while preserving her chastity (El Saadawi 1982).

In some societies where a man has several wives, it is said that since it is physically impossible for him to satisfy them all, genital mutilation helps by making the wives less sexually demanding.

Another very important concept which prevails strongly in the Horn of Africa is that of family honour. If a woman loses her honour, an entire family is dishonoured. The most dishonourable experience for a man is the sexual impropriety of a female member of the family –



and once lost, it cannot be restored. Coupled with the belief that women who have not undergone genital mutilation are oversexed and prone to temptation and disgrace, 'honour' is supported and sustainable only through FGM.

*Note:* Although the intention of genital mutilation may be to diminish a woman's desire, from a medical point of view, excision of the clitoris reduces sensitivity, but it cannot reduce desire, which is psychological. Another point to note is that while infibulation is offered as being 'the preservation of virginity and prevention of immorality', re-infibulation can easily be made to look like original infibulation.

## Religion

FGM is practised by followers of many different religions: Muslims, Catholics, Animists, Christian Coptics and non-believers. It is important to stress that there is no basis in the various religious texts for FGM. The relationship between FGM and religion has been built up by the way in which texts have been interpreted and taught by male religious leaders from generation to generation. For example, FGM is commonly construed as a Muslim tradition and while it is practised by many Muslim communities in the genuine belief that it is demanded by Islamic faith, it is not mentioned in the Koran. The Koran does, however, encourage women's chastity and modesty as important virtues and various religious leaders have used this to support and sustain FGM.

## Role of Circumcisors

Another significant factor in the continuation of the practice of FGM is the role and vested interests of excisors or 'circumcisors'. The role of circumcisors varies within the ethnic groups practising FGM. In Somalia, for instance, they have no special respect, while in West Africa they wield a lot of power and have considerable status within traditional power structures. In Sierra Leone the circumcisors control the traditional 'secret societies' and are considered to be priestesses by their followers (Toubia 1995). They commonly have extended roles as counsellors and consultants in mother and child care. In Mali, they are often the gatekeepers of traditional power bases for women, feared and respected by women and the community at large. FGM is an irreplaceable source of revenue for the circumcisors and any challenge to FGM not only threatens this revenue, but is perceived as an attack on the respected older women of the community.

## Sociological Pressures

In many societies the practice of FGM is a tradition or ritual signifying a young girl's

development into womanhood and part of her initiation rites. In areas such as Northern Sudan, Kenya and Mali the practice is surrounded with ceremonies, celebrations and coming-of-age rituals. Specific periods of the year, such as after harvest, are designated for the event and there are songs, dances and chants intended to teach a young girl her duties and the desirable characteristics of a good wife and mother. The event is rich in ritual and symbolism and can last up to two to three weeks with special convalescent huts for the girls, where they remain until they are healed and then emerge to be adorned with special clothes and gifts.

The ceremonial aspects of FGM, however, are diminishing with urbanisation, and with FGM being performed at a much younger age, it is having much less to do with entry into adulthood, undermining the hypothesis that it is an initiation rite (Hosken 1995).

Whether the practice is shrouded in rituals and celebrations, or it simply involves a visit to the local midwife, throughout Africa it is an inherent part of a girl's social development. The practice is deeply embedded in the social norms of the community and there is immense pressure on all young girls to be 'made like everyone else'. It can be very traumatic for a young girl to be withheld from 'her circumcision'. The unexcised girl is often despised, taunted and made the target of ridicule. No one in her community will want to marry her and what is clearly understood to be her life's work, marriage and childbearing, is denied her. In *Female Genital Mutilation: A Call for Global Action* (Toubia 1995) this account of a young Somali girl's experience clearly illustrates this social pressure:

When girls of my age were looking after the lambs, they would talk among themselves about their circumcision experiences and look at each others' genitals to see who had the smallest opening. If there was a girl in the group who was still uninfibulated, she would always feel ashamed since she had nothing to show the others. Every time the girls showed their infibulated genitals, I would feel ashamed that I was not yet circumcised. One day I could not stand it any more. I took a razor blade and went to an isolated place. I tied my clitoris with a thread and while pulling at the thread with one hand I tried to cut part of my clitoris. When I felt the pain and saw the blood coming from the cut, I stopped and went to my Aunt. After some weeks I was infibulated together with seven other girls. I was seven years old, but some of the other girls were older. After a few days the wounds healed and the thorns were removed. When I was able to resume my normal work, I felt proud and whenever some girls asked me if I was infibulated, I did not have to hide my genitals.

(Toubia 1995)

In summary, for a woman living in a patriarchal society, with no access to resources, no education and no effective power base, marriage is her main means of survival and access to resources. With the beliefs surrounding FGM deeply embedded in her from childhood and the practice being a fundamental prerequisite for marriage, the benefits of FGM, social approval, being eligible for marriage, maintaining the family line and preserving family honour far outweigh the difficulties. It can clearly be understood, therefore, why women continue to cling to and uphold the tradition, colluding in their own daughter's mutilation.

## Feedback on Women's Health Services

What the Somali women in Auckland need is midwives and doctors who understand circumcision and who they can feel comfortable with. Many women feel afraid and too shy to go back to some doctors and midwives who have been shocked and angry at what they've seen.

Jama, Somali refugee (1997)

Somali ways and New Zealand ways around childbirth are very different and New Zealand doctors don't seem to understand about looking after circumcised women ... sometimes we are very afraid ...

Asha, Somali refugee, N.Z. (Jama 1996)

I am afraid for the young girls who are getting married here. They are refugees and very shy to get help about their circumcisions. Some married women are still virgins even though they have been married for two years, because they don't know where to get the type of help they need.

Shukri, Somali refugee, N.Z. (1997)

## Feedback From Somali Women

The following is the feedback on our Women's Health Services which came from focus groups and forums held with genitally mutilated women in Auckland. The women expressed the following concerns:

- A lack of knowledge and/or training among New Zealand health professionals about FGM.
- A lack of medical staff that knew how to relate to and care for women who had been circumcised.
- A lack of knowledge and sensitivity among doctors, midwives and nurses about the Somali culture and a lack of understanding that for Somalis FGM is a very 'normal' practice.
- The unavailability of female doctors in certain services, for example, in delivery suites. The women considered male doctors



inappropriate for gynaecological and obstetric examinations.

- The inappropriate solutions being offered by professionals to unmarried Somali women for severe menstruation pains, such as the contraceptive pill and reopening of the circumcised area – both these solutions would mean rejection from Somali men and the girls would be considered 'promiscuous'.
- Difficulty accessing health services where single women can be cut open prior to consummating their marriage. In many cases husbands were simply having to penetrate the scar tissue with their penises.
- The shocked reactions from health professionals when women were being vaginally examined. Many doctors were 'horrified' and the comments that followed examinations often left the women feeling shy and too embarrassed to return to the professional.
- Difficulty accessing family planning services that understand the needs of circumcised women – as some forms of contraception such as the diaphragm may be precluded with infibulation.
- Concern that midwives and delivery staff do not know how to deliver circumcised women and that many women were being cut down (episiotomy) instead of being recut open (upwards).
- Fear of not being restitched correctly (to suit their husbands) after delivery.
- Fear of isolation during the postnatal period. Somali women are usually attended closely by family during the childbirth period in Somalia – but this is often not possible here as separation from the family is common.
- Concern at the high number of caesareans that were being performed on Somali women that had previously had normal vaginal deliveries in Somalia.
- Concern at the haste to induce postterm pregnancies in New Zealand. Somali women are not familiar with induction and most women keep no record of their last menstrual period. The women were concerned that their due dates were often not accurate and doctors were 'pressuring them into inductions' when they feel 'it is best to have it naturally'. Women stated they were purposely not turning up for 40-week antenatal appointments for this reason.

### Feedback From Health Professionals at National Women's

- There was an overall lack of understanding and access to information on FGM for all staff throughout the Women's Health Services.
- Antenatal midwives found that, in addition to the physical complications associated with FGM, there were a large number of social problems prevalent in many of the refugee women that were heightened by pregnancy and required referral and support. For

example, many of the women had only recently moved to New Zealand and were struggling with immigrant/refugee issues such as language difficulties, marriage difficulties, culture shock, feelings of isolation and post-traumatic stress syndrome.

- Antenatal midwives also indicated that there was a significant need for education surrounding reproductive health issues among many of the women. For example, many women had no knowledge of their menstrual cycle, believing that bleeding occurred to release 'bad blood' from their body. Most women had no knowledge of family planning, believing some forms of contraception offered to them such as the depo provera injection would make them permanently infertile.
- Difficulty caring for women when there is an urgent need for a caesarean section. Some women were adamantly refusing, hours of negotiating ensued and the baby was endangered.
- Concern that circumcised women were arriving in delivery suite unexamined with no documentation in their notes on their of circumcision or their choice for resuturing the scar site versus being de-infibulated. Sometimes no professional interpreter was available to determine these requests.
- Most staff lacked training and skills at delivering genitally mutilated women and there was no guarantee who would be available in the delivery suite when the women arrived in labour. There were many reported incidents of women having *posterior* episiotomies – instead of being de-infibulated during a vaginal delivery.
- Difficulties suturing up ruptured scar tissue that had been severely damaged during the initial FGM procedure.

### Child Protection

Legislation (against FGM), as the record shows, is essential if we want to protect the health and lives of the younger generation. These laws are also supported by international conventions signed by most countries around the world. But laws are ineffective if they are not enforced or if the people are unwilling to support them. To really implement change, a well planned information and education process is necessary to reach the hearts and minds of people. To convince people that change is in their own best interest we need to reach their personal lives.

Hosken (1995b)

### FGM in New Zealand

In response to the increased settlement of refugees from areas where FGM is practised, performing FGM and sending a child overseas for the procedure were made criminal offences under an

amendment to the Crimes Act in January 1996 (see Appendix 1).

The historical and social context of FGM however, is barely understood in New Zealand. FGM is totally alien to the New Zealand culture and knowledge that it is practised by African people on girls often provokes racist remarks and paternalism towards the people who practise it. This, along with media sensationalism by exposing the physical horrors of FGM, is often interpreted by African community members as attacks on their already marginalised culture and community.

Few aspects of a refugee's life are not threatened or lost with civil war and resettlement in a foreign country. Almost all refugees in New Zealand have lost their homes, their lifestyles, their social role and status, their family unit, their profession, their cultural structure, their religious identity and much more. So for a community that has already faced so much loss, FGM – a ritual that reinforces such important cultural values as chastity, purity and fidelity takes on even greater importance when settling in New Zealand.

The risk of FGM being performed on young girls settling here is therefore an important issue to New Zealand, as there is immense pressure on young girls from their families and communities to continue upholding the tradition. An example of this pressure has been highlighted by incidences of genitally mutilated adolescents who have sought medical assistance in New Zealand for severe menstruation and micturition difficulties. When offering the only effective solution – to slightly open the scar tissue the girls have adamantly refused for fear of being teased and alienated by their African peers and no longer being eligible for marriage. The following statements made by two Somali refugees highlight this attitude:

It is part of our religion and we must do it. We will get all the community to write a petition to the government, explaining that it is part of our culture and required by our religion and they need to change the law to allow us to do it.

Mohammed. Survey (1997)

Of course we must do it, it is part of our culture and our religion.

Fadum. Survey (1997)

The attitudes toward FGM among the African community vary however, as some are strongly opposed to the practice.

The practice of FGM within the community is a very closely guarded secret. Cases of FGM would only ever come to national attention if there were physical complications and medical attention was sought, or if a complaint was made to the police – but as the practice is condoned by adults and the community at large, a formal complaint is unlikely. While no documented accounts have been given of the practice being



performed here, there has been suggestion that a few mutilations have occurred. In other countries there are many examples of it becoming public, but only when medical attention was sought. For example in France, four babies died and many others have been brought haemorrhaging to medical emergency centres following mutilations performed in homes.

FGM could be performed on young African girls in New Zealand in several ways. First, parents could save money to send their daughters overseas for the mutilation. Second, there may be private doctors who offer their services to the community on an illegal and highly confidential basis. And third, traditional circumcisors in the community may be willing to perform the operation. As most of the African communities in New Zealand are made up of refugees as opposed to immigrants, the likelihood of saving enough money to travel is scarce. Because FGM was illegal in New Zealand, the penalty for doctors performing FGM is high and it seems unlikely that anyone would be practising it here. If FGM was to occur in New Zealand, it seems most likely, therefore, that it would occur in homes, by traditional circumcisors – usually older women.

## Prevention

The prevention of FGM should not be left to a few refugee services or women's groups to deal with, but be brought into the mainstream child health and child protection services and prevention strategies and policies developed. Prevention should involve the following three areas:

### 1. Health Education and Promotion Education

Education is the key to prevention and should take a sensitive health promotion approach. Education on FGM and its harmful effects can be easily incorporated into routine childbirth care by midwives.

Family doctors can also provide health education and be aware of any at-risk girls during mother and child follow-ups during the girl's first five years.

### 2. Identification and Monitoring At-Risk Children

Age five to ten years is when little girls are most at risk of FGM. School nurses, schoolteachers and public health nurses have a key role in identifying at-risk girls. Schoolteachers should also be aware that girls who have already been excised or infibulated have special needs and may require extra support. For example, girls frequently take a long time urinating (up to 30 minutes) or may be off school with severe menstrual problems. School nurses in particular should have a good knowledge of FGM so young girls can confide in them and feel comfortable seeking assistance. In cases of an imminent

mutilation, the child should be reported to an experienced social worker, who can be attached to the family and monitor the child closely.

### 3. Child Protection and Law Enforcement

When legal intervention is necessary, it is important to acknowledge that FGM is a deeply rooted custom and is seen as very beneficial by the family. FGM is community approved and is performed by loving parents generally to make their daughters marriageable and acceptable in their community. FGM is a complex type of child abuse and it is a *one-off* abuse. For these reasons, the responses to FGM by child protection professionals need to be sensitive and care must be taken to guard against aggressive intervention. Police should work in a collaborative way with social workers, leaving social services to undertake education, i.e. counselling on threatened genital mutilation. Police and legal involvement should always be a last resort.

*Note:* Clear guidelines and protocols for intervention strategies and interagency co-operation need to be developed.

## Recommendations

Countries should be aware that immigrant survivors who have undergone FGM may need special medical help. State resources should be set aside for the education of immigrant groups and research into the health needs of immigrant women and girls. FGM should be perceived as a public health issue and activities for its prevention and elimination should be incorporated into existing institutional budgets and health education curricula, including reproductive health packages, safe motherhood programmes and school health programmes.

WHO (1996)

The following are recommendations for improving our Health Care and Child Protection Services in Auckland. The recommendations come from extensive experience working with genitally mutilated women in Auckland, models of FGM Programmes used by other Western countries, research and feedback from focus groups and surveys with North African women and communities upholding the practice in Auckland.

### 1. Health Care

#### Training

- Provide training to all professionals dealing with genitally mutilated women: midwives, nurses, doctors, family GPs, public health nurses and plunket nurses.
- Training should focus on knowledge on FGM, cultural understanding and awareness,

obstetric and gynaecological care and rehabilitative care.

- Develop and introduce educational modules on FGM into nursing, midwifery and medical school curriculums.

#### Models and Guidelines for Practice

- Develop clear national guidelines on antenatal/postnatal care, delivery care and de-infibulation.

#### Specialised Service for Genitally Mutilated Women

It is evident that genitally mutilated women have very specialised needs requiring a specialised service. This should be provided by trained professionals in the form of a weekly clinic or in a more flexible fashion. The service should include the following components:

1. *Continuity of Antenatal, Intrapartum and Postnatal Care* by a specialised team of midwives and doctors.
2. *Comprehensive Childbirth and Health Education* covering antenatal, delivery and postnatal care of mother and baby, anatomy and physiology of normal reproductive organs versus infibulated genitalia, the health consequences of FGM and nutrition.
3. *De-infibulation Counselling* offered by trained and sensitive health care professionals involving the woman's husband.
4. *Sexual Health Screening and Family Planning* providing cervical smear-taking, STD screening, breast examinations and appropriate family planning advice.
5. *Referral/Assessment Service* where women can come for referral when FGM related health problems – such as women needing to be cut open prior to marriage.

*Note:* Because of the trust that is often established between a woman and her midwife/doctor during pregnancy and childbirth, women are often very open to education on FGM. It is therefore an ideal opportunity to educate women on the harmful effects of FGM and provide support and options such as de-infibulation.

### 2. Child Protection

#### Training

- Provide comprehensive training for child protection professionals; CYPS, social workers, school teachers, school nurses, refugee services and police.
- Training should focus on knowledge and understanding of FGM, identifying and monitoring at-risk girls and developing skills for working with families.



## Identification and Monitoring 'At-Risk' Children

- Develop an interagency at-risk register so girls can be referred to key social workers for monitoring and care.

## Protection

- Police to work in collaboration with social workers in the case of a suspected imminent mutilation.

## Guidelines and Protocols

- Develop clear guidelines for interagency collaboration, referral and intervention strategies.

## 3. Community Education

- Incorporate health education and promotion into already existing health education programmes, targeting childbirth education and care.
- Develop culturally appropriate educational resources and aids.
- Establish community education programmes focusing on health promotion, the harmful effects of FGM and the New Zealand law and FGM. The programme should use African educators and community workers.
- Liaise closely with New Zealand Refugee services and support groups to incorporate FGM education into resettlement programmes.

## Conclusion

FGM is unnecessary. It is a violation of women's rights to preserve the integrity of their bodies. FGM is an issue that concerns women and men who believe in equality, dignity and fairness to all human beings, regardless of gender, race, religion or ethnic identity.

We must empower women all over the world to preserve their bodily integrity and their reproductive and sexual health and rights. The Global action calls upon all peoples of all nations to come together in empathy, solidarity and compassion, to create an environment where people feel safe to change their old ways without threat to their dignity, independence and cultural integrity.

Toubia (1995)

FGM is clearly a harmful practice. It causes grave damage to girls and women and frequently results in long-term physical, psychological and sexual difficulties. The reason why such a tradition continues to be upheld with such tenacity can only be understood from the context of the societies within which it is practised.

FGM is deeply rooted in a complex social and economic framework. The practice is embedded in local customs and superstitions around marriage, health beliefs, childbearing, family honour and the role of women in society. Despite all its harmful effects, in the patriarchal societies where it is practised it provides a woman with many benefits, access to economic resources and family security.

As African immigrants and refugees have moved throughout the world, taking FGM with them, FGM has become an international issue. In *Female Genital Mutilation: A Call for Global Action*, Dr Nahid Toubia (1995) states, 'FGM will not be eradicated unless those people who are fighting for change, understand the deeply felt beliefs of the people who practice it'.

It could be argued that we can *also* only provide the most effective Health Care and Child Protection Services for these women when we understand these deeply felt beliefs and the complexities surrounding FGM.

From a human rights perspective, the abolishment and prevention of FGM within Africa needs to be actively supported by New Zealand and other Western countries. Within New Zealand, our challenge, however, is to provide effective education and support for already genitally mutilated women and for young girls at risk. FGM is a women's reproductive health issue and the door to providing this education and care is through effective and sensitive health services.

Clearly, as health professionals we need expert knowledge of the physiological effects and clinical care of FGM. But it is only when we marry this knowledge with deep understanding and sensitivity, that women will be best cared for. It is only when a genitally mutilated women feels her midwife or doctor has a knowledge and understanding of FGM and when she is being treated with dignity and respect, that she will feel comfortable to share and discuss problems surrounding this very sensitive issue. From my experiences, it is in this environment of understanding and respect that women then feel able to unlock the difficulties and complications that they have often been tolerating for years.

It is also from within this 'environment' that we are able to teach women the harmful consequences of FGM, explore options such as deinfibulation and identify at-risk children. My hope is that through a more comprehensive and improved service, women's attitudes and understanding of FGM would eventually change and that their daughters and daughters in generations to come will not be subjected to female genital mutilation and its harmful sequel.

## Appendix 1

### New Zealand Crimes Act Amendment 1995

The following amendment came into place as from 1st June 1996:

#### Section 204A Female Genital Mutilation

1. Female Genital Mutilation (FGM) is defined as any medical, surgical procedure of mutilation of the vagina or clitoris of any person.
2. Only medical and surgical procedures done by a *Registered Medical Practitioner* for the benefit of the person's mental and or physical health are acceptable.
3. Medical and surgical procedures may *NOT* be performed for reasons of culture, religion, custom or practice.
4. Punishment for breaking the law – may be imprisoned up to a maximum period of seven years.

#### Section 204B – Further References Relating to FGM

1. You may *NOT* take or send any child out of New Zealand for FGM to be performed on them.
2. You may *NOT* make arrangements for any child to leave New Zealand for FGM to be performed.
3. You may *NOT* assist or encourage any person inside New Zealand to perform FGM on a New Zealand Citizen or resident outside New Zealand.
4. You may *NOT* whilst in New Zealand, convince or encourage any other New Zealand citizen or resident to go outside New Zealand to have FGM performed on them.

Punishment for breaking the law may be imprisonment up to a maximum period of seven years.

#### Note:

- A child is defined as under the age of 17 years and a citizen or resident of New Zealand.
- A person on whom FGM is performed cannot be charged with an offence.
- It is *no defence* to a charge that 'consent' was obtained or believed to be obtained from the person on whom FGM was performed.





## Appendix 2

### Organisations, Initiatives and International Instruments

#### Organisations

##### Inter-African Committee

The largest group working to promote the eradication of FGM is the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children in Africa. The IAC is an umbrella organisation that co-ordinates the work of government and non-government institutions working towards the reduction of morbidity and mortality rates of women and children through the abolition of FGM and other traditional harmful practices.

The IAC have committees in 26 African countries and affiliates in four Western countries and work closely with WHO, UNICEF, UNFPA and the UN Centre of Human Rights. The IAC's work involves the sensitisation of health workers, community and religious leaders, policy-makers and the general public by means of information and education campaigns, media networking and research and advocacy at national, regional and international levels. The IAC run training workshops and seminars and produce information and educational materials for use in Africa and in Western countries.

##### FORWARD (Foundation for Women's Health and Development)

FORWARD is a women's health activist movement based in London aiming at promoting good health among African women and their families in the U.K. FORWARD is funded largely by the Department of Health and has acted nationally and internationally against FGM. FORWARD has developed health, education and training programmes both for African immigrant families and British social services and health professionals working with the African community. They have developed FGM prevention programmes and resources and co-ordinated specific policies for Western countries to use with immigrant groups practising FGM.

##### RAINBOW (Research, Action and Information Network for Bodily Integrity of Women)

RAINBOW is an American organisation advocating the sexual and reproductive health and rights of women. At an international level the organisation has initiated a project called 'Global Action against Female Genital Mutilation' directed specifically at integrating the activities against FGM into existing national health programmes in order to counteract and prevent narrow and marginalised approaches to FGM. RAINBOW

has started an Inter-Agency Working Group (IAWG) comprising relevant UN experts in the field. The aim of IAWG is to assist with the setting of FGM guidelines, exchanging information and experiences and co-ordinating FGM projects and research on an ongoing basis.

##### WIN (Women's International Network)

WIN is a participatory network in the U.S. linked through *WIN NEWS*, a quarterly comprehensive journal reporting on women's development and rights world-wide. Mrs Fran P. Hosken (a veteran on the issue of FGM) is editor and publisher. *WIN NEWS* has had a section devoted to FGM since 1975 and has produced a wide range of teaching materials and international and local publications on FGM.

The Childbirth Picture Books (CBPBs) are books developed by *WIN NEWS* following the 1979 WHO seminar recommendations for developing education tools to use at a grass-roots level. The books contain a reproductive picture story from a woman's viewpoint and provide basic information on reproduction, childbirth and family planning. The pictures are accompanied by a text to read out loud and are available in English, French, Arabic and Somali. There are special books with sections on excision and infibulation, which graphically show the harmful effects of FGM, especially in childbirth. The books have been extremely successful in African communities both in Africa and in Western countries.

##### GAM'S

GAM'S is a French women's group set up to assist with the abolishment of sexual mutilation of women. It is headed by paediatrician Dr Marie Franjou, who works with African immigrant women in Paris. GAM'S works alongside the government-funded 'Well-Baby Clinics' that provide antenatal care, family planning and childcare consultation in the community. Using the CBPBs GAM'S works with midwives, social workers and doctors providing health information on FGM and identifying at-risk children. They have also established a documentation centre, a standby telephone service and a media campaign for the public.

##### Initiatives in Western Countries

A number of FGM programmes have recently been initiated in Western countries such as France, Italy, Sweden, Holland, Denmark, England, France, Canada and Australia. The following are a few examples of these programmes:

##### Sweden

In 1996 Sweden established a Mother and Childcare FGM programme under the Swedish Board of Health and Social Affairs. The aims of the programme are to assist health professionals

with the care and rehabilitation of genitally mutilated women and to prevent FGM in Sweden through education on the harmful effects of the practice. The project works closely with health professionals running workshops, developing guidelines for child protection and providing media education.

##### Canada

Canada has initiated an FGM Education Programme through numerous private organisations with the support of the Canadian Health and Welfare Department. The department purchased 2,000 Somali Childbirth Picture Books which have been used by various NGOs for community education. The Maternal Infant Reproductive Health Unit in Toronto is currently undergoing an 18-month research project looking at the childbirth healthcare needs of genitally mutilated women and developing guidelines for obstetric care.

##### Australia

The Australian Commonwealth has funded a three-year FGM Education Programme, to be implemented by each separate state. The programme is three-pronged focusing on health care and rehabilitation, community education, and child protection. The New South Wales' programme is the most established programme and is being co-ordinated through the Ethnic Affairs Commission, working closely with state health and child protection services.

##### Denmark

Denmark established an FGM Education and Protection Programme in 1996. Its programme focuses on research, community education and sensitisation at a grass-roots level. It also aims at developing health services and national policies and strategies to prevent FGM in Denmark.

#### International Instruments

New Zealand is a signatory to the following international instruments and conventions that both encourage and oblige us to action against FGM.

1. The universal declaration of human rights. Article 25.
2. The convention on the elimination of all forms of discrimination against women. Articles 2f, 5a, 12.
3. The convention on the rights of the child. Articles 2, 19.2, 24.1, 37a, 24.3.

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# Pushing: A Spectator Sport?

G. Davis, RGON

Midwifery Degree Student  
Wellington

I was pleased when our group decided to look at second stage as our inquiry project and I gladly volunteered to investigate pushing.

Since my introduction to midwifery practice my naiveté has been shattered. I had placed 'coached pushing', which has been likened by some to yelling at a rugby match, into the birth archives where I felt it well and truly belonged. But much to my amazement I have found it alive and well and fair bursting out of the delivery rooms.

'Oh, dear! How terrible,' I thought. 'How degrading, how patronising, how can this still be happening in the '90s?'

The first birth I attended as a student midwife in the hospital was shared care with a GP who, during the woman's labour, chatted with colleagues in the corridor, leant on the desk by the nurses' station and occasionally stuck his head in the door to see if it was nearly time for the 'real' work to begin. This doctor does not feel comfortable with labour care, I thought to myself. He can't be here for the beer! Sure enough second stage ensued and in he came larger than life, grabbed the woman's leg and instructed me to do the same with the other. I wanted to say 'No!' He looked at me oddly, probably wondering at my lack of initiative or maybe he could see the smoke pouring out of my ears!!

Anyhow, away he went, with the well rehearsed litany:

Come on, now chin on your chest  
Big breath in, hold it. Push, push, push, push.  
Come on, you can do better than that.  
Don't waste it!  
You can get three good pushes out of that one – good girl and again, big  
breath ...

and on it went!!!

I thought I had heard and seen it all ... but I hadn't.

A different doctor at the next birth counted, 'Push now 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 – big breath in, push 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.' Gosh!

And at yet a different birth another doctor shouted at the woman who was doing a great job of moving her baby down the birth canal, 'Look, you're just letting it go back up again!! Don't tense up'.

Give me a break! What woman in her right mind would want her baby to go back up again after all that hard work? I don't know! Perhaps they need the odd rugby ball for breakfast!

\*\*\*\*\*

This enquiry follows on from the oral presentation of 'pushing' as portrayed at recent births I attended.

In the April issue of the *New Zealand College of Midwives Journal*, I read an article by Tricia Thompson called 'The Second Stage of Labour – Whose Urge to Push'. Whose indeed?

According to the author, in recent years it has been accepted that the status of women during labour has changed. She is allowed to make choices for herself and this is evident in the first stage of labour when she is allowed to do just about anything she likes for her comfort. Why then does this suddenly change in second stage? To who does the second stage really belong? The women or the support team and caregivers?

I will endeavour to explain coached pushing and instinctive pushing.

Thomson (1995, p. 1) describes the valsalva manoeuvre as the practice of encouraging sustained, directed bearing-down efforts during the second stage. It is widely advocated in most delivery wards world-wide.

According to Bennett *et al.* (1993, p. 230), this manoeuvre was developed in the 17<sup>th</sup> Century (for expelling pus from the middle ear). This valsalva technique has become common practice during birth in an attempt to increase the force of contractions and to speed up the second stage of labour.

The woman is instructed to hold her breath and not let any air escape as she pushed down as hard as she can for 20–30 seconds. If you watch a woman attempting this you can see why it might expel pus from the ears! She becomes red in the face, gets bloodshot eyes and burst capillaries and looks as though she is about to explode (*ibid.*).

Enkin *et al.* (1989, p. 229) say that sustained direct bearing-down effort (with 10–30 second breath holding) does seem to result in a shorter second stage of labour. However, the wisdom of this commonly given advice is questionable.



In addition to respiratory induced alteration in heart rate and stroke volume, these efforts, particularly if the woman is lying flat on her back, are associated with:

- compression of the distal aorta
- reduced blood flow to the uterus and lower extremities
- and therefore compromised fetal oxygenation.

Published controlled trials comparing different approaches to bearing down demonstrate predisposition to:

- fetal heart rate abnormalities and
- depressed apgar score among sustained bearing down groups (ibid).

If the purpose of having a short second stage is to avoid stress for the fetus, then the valsalva manoeuvre is counterproductive.

I would like to mention at this point the view of some authors about pushing in the second stage.

Thompson (1997, p. 26) refers to Sagady's description of the physiology of the second stage as having three phases. The latent or resting phase, an active or pushing phase and a transition or crowning phase. Some women move quickly through all three phases, some have variations. The author refers to Beynon who says that making women push in the latent phase has been shown to increase strain and damage to the muscles of the vagina and perineum and the uterine support ligaments. It may also lead to transverse arrest if pushing is made to start before internal rotation has occurred.

According to Enkin *et al.* (1989, p. 227), however,

... if the women does have an irresistible urge to push, even if there is a rim of

cervix, she may feel better doing so, it is unlikely that any harm will come from this as long as she does not exhaust herself.

One could assume from this that pushing initiated instinctively by the woman is not detrimental, but forceful coached pushing at this stage can be.

The alternative to vigorous pushing and breathholding is to push when and how the woman feels like it.

According to Bennett *et al.* (1993, p. 231), women in a study they described were allowed to push spontaneously. They made several short bearing-down efforts with each contraction of four to six seconds each. Breathholding for short periods occurred in only 24% of women and many of the others made audible grunts, groans and cried out so air was expelled. It appears that the baby is less stressed by this instinctive process even though pushing in short spurts can mean a longer second stage.

An equally important point is that by not intervening loudly with directions for the women, her own pushing instincts will not be disempowered and she will not lose her own birth momentum or get caught up in the great rush and frenzy of what seems like getting the baby out as quickly as possible.

After all, according to Bennett *et al.* (1993, p. 232), as quoted by Roberts, 'contractions provide much of the (expulsive) force and the baby could descend without any pushing at all'.

However, in some situations as suggested by Balaskas and Gordon (1990, p. 110), women may need guidance to help them direct their energy downwards and may need encouragement to make a conscious effort with the contractions, working closely with the midwife.

Enkin *et al.* (1989, p. 228) point out that when an epidural anaesthetic is administered for pain in labour, maternal bearing-down efforts are reduced, delayed or abolished. In this situation

pushing may need to be encouraged, but not loudly or being overly directive or controlling.

In closing I would like to refer to Thompson (1997, p. 26) as she quotes from Sagady: 'We as midwives. ... Wherever we can influence, must give out a loud and clear message: your body knows how to give birth: you can trust your body ... I do'.

## Conclusion

Coached pushing is a common phenomenon in delivery rooms world-wide. It is enforced by caregivers to help speed up the second stage of labour. By its use it seems the carers give little recognition to the ability of women to give birth by their own volition. The wisdom of this technique is questionable for its effect on both the mother and baby.

Instinct-led pushing, by contrast, affirms the woman's ability to give birth naturally as directed by her own body. It puts her on centre stage. There is no danger in this method although it may take longer for the baby to be born.

It is recognised that in some situations there may be indications for active encouragement for pushing to be given.

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# Breastfeeding Management:

The author acknowledges the assistance of Tui Bevin, RGON, Bsc, IBCLC, in the preparation of this article.

## One Breast Per Feed can be a Recipe for Breastfeeding Failure

Jane Wickham, RGON, RM, IbCLC  
Midwife, Lactation Consultant

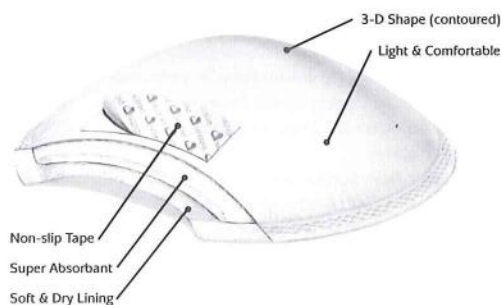
Over the past three years since I started working as a lactation consultant, I have become increasingly aware that women are confused about how best to maintain their breastfeeding.

In particular, they contact me with concerns that they 'don't have enough milk' or that their baby is not gaining weight adequately. They often report that they are feeding for over an hour at each feed. This can occur at any time but cases often cluster around the three-month mark. While taking breastfeeding histories from these women, a common theme has emerged. They have been looked after (in the initial postpartum period) by midwives who have advised them to offer the infant one breast at each feed. Whether or not they have actually been told this (as I am aware that stories can get distorted over time), the overall perception that these women have is that this method of feeding will ensure that their baby gets the 'good' hindmilk.

Since variation in fat content according to duration of a feed was first noted and written about, it seems that some midwives have embraced one sided feeding while not being fully aware of all the facts. The conclusion that Woolridge *et al.* (1990) reached in their discussion was that 'results indicate that the breastfed baby can regulate his fat intake quickly and thus mothers should be encouraged to practice "baby-led" feeding'. This means that mothers need to be taught to observe the cues that their infants give so they can judge best when to change from one breast to the other. Newman (1996) also makes a plea for postnatal caregivers to teach women how to know when the baby is actually getting milk. He emphasises the importance of a baby's jaw action in an open-pause-close fashion as being one of the most important signals of effective suckling. A baby that is not suckling effectively for long periods at one breast is likely to be getting insufficient milk (regardless of hindmilk).

It seems to be widely believed that the milk present in the breast at the beginning of a feed is foremilk and that present at the end is hindmilk. It is not that simple. Daly and Hartmann (1995a, b) demonstrated using a Computerised Breast Measurement System that for some feeds there is little change in volume from the completion of one feed to the commencement of the next. It seems to me that foremilk/hindmilk ratio only becomes significant when breasts are full, firm and leaking. Daly *et al.*

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(1991) found that the fat content rises steeply after 40% of the available milk in the breast has been consumed. This then suggests a practitioner should focus on the degree of breast emptying that occurs with a feed. When questioning the group of women that I referred to earlier, they usually tell me that their breasts are soft before a feed and that by the end of the day they are sure 'there is nothing left'. One-sided feeding in this situation will lead to a continued decline in the mother's lactation.

There is a place for one-sided feeding but mothers need to understand that it is usually short term or for just some feeds. The situation where it would be recommended is one where a mother has an over-abundant milk supply evidenced by full, firm breasts, leaking milk and vigorous swallowing by the baby. Typically, this baby is having six plus very wet nappies per day, frothy explosive yellow or green bowel motions but tending to be miserable and feeding frequently despite excellent weight gains. In this situation I would advise the mother to keep the baby on the first side until it feels soft before offering the second side.

When a mother has any doubt about her milk supply, close observation of her baby's suckling will tell her when to change sides. When the baby is suckling well with frequent swallowing she should leave it at the breast, but as soon as ineffective suckling occurs (e.g. sleepiness, flutter suckling) or fussing at the breast (latching and unlatching rapidly) the mother needs to offer the second side. I have seen mothers express surprise at how their sleepy baby suddenly starts suckling effectively again when changed.

It is interesting to note (Woolridge *et al.* 1991) that when comparing one-sided feeding with two-

sided feeding, there was no measurable difference in 24-hour fat intake for the two methods but there was a significant increase in milk volume for two-sided feeding (8.8%).

While studying to become an International Board Certified Lactation Consultant, I became aware of 'switch feeding'. Subsequently I read Auerbach and Walker's (1994) article on the use of breast pumps. Both of these demonstrated that an infant would receive a greater volume of milk by being changed from one breast to the other when the baby's suckling changed from effective to ineffective suckles. That this would also increase a mother's milk supply is supported by the hypothesis of Daly and Hartmann (1995a, b) that the breast responds to variability in the degree to which the infant empties the breast at a feed, i.e. the less milk remaining in a breast, the greater milk synthesis will be.

Typically, the baby needing to be switch fed is failing to gain weight well, having fewer than six really wet nappies per day (or only damp nappies) and the number of bowel motions may have reduced to one every two to three days or even fewer which is not a concern in an otherwise thriving infant.

For many women who contact me with concern about milk supply, the simple advice to observe the baby's suckling and to switch sides when suckling becomes ineffective is sufficient to turn the situation round. I emphasise that the length of time a baby spends at the breast should be determined by suckling behaviour, not an arbitrary time ('watch the baby, not the watch').

I suggest that mothers think of their breasts as sides. Early in the morning one side may satisfy their baby, early evening it may take five sides to satisfy the same baby.

When Woolridge and Fisher (1988) described a strategy to cope with a breastfed baby with 'colic, "over feeding" and symptoms of lactose malabsorption', they could never have foreseen it being standard advice for all babies in the way I have seen. I fully support the advice 'allow the baby to finish the first side before starting the second' but mothers need more information than this to have successful breastfeeding outcomes.

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# Petrochemical Fragrances:

## Are they Safe for Baby Care?

Joan Donley, OBE

Midwife Manager  
FGM Project Co-ordinator

Since antiquity the volatile oils from flowers and herbs have been extracted and used to calm or stimulate the emotions and to enhance wellbeing. Ayurvedia medicine was founded on such oils. Modern aromatherapy is based on the use of essential oils extracted either by cold pressing or steam distillation. As these are labour intensive processes, essential oils are expensive.

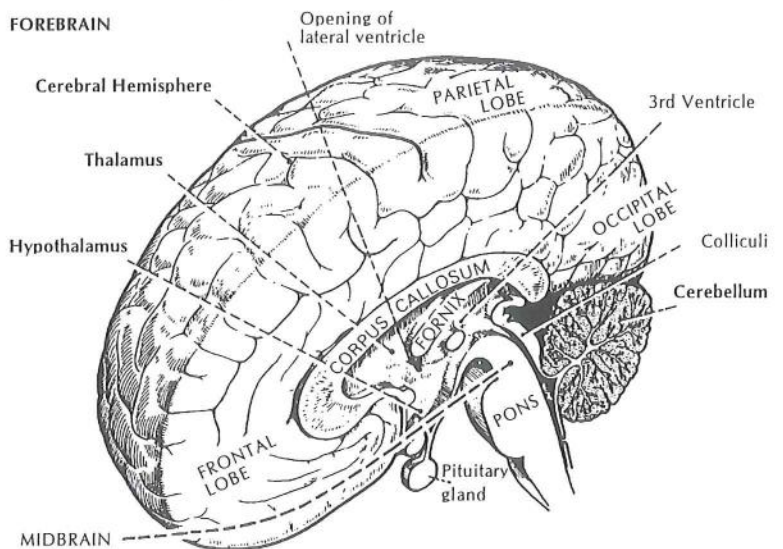
Today, essential oils have been replaced by cheaper petrochemical products promoted by the combined oil and pharmaceutical industries. Referred to as 'cosmeceuticals' (Mindell 1995) these are claimed to be uniform in quality and free from undesirable constituents found in natural oils (Killheffer).

But, how safe are petrochemical fragrances when used in baby products?

When one breathes through the nose, volatile molecules are trapped in the nasal mucosa wherein lie the olfactory receptors. Fine fibres pass from here to the two olfactory bulbs where they synapse directly with the neurons of the limbic system – the emotional switchboard of the brain. The limbic system is a complex network of nerve pathways which is the primitive part of the brain.

It includes the:

- \* hippocampus – the most primitive part, involved in instinct and emotion;
- \* amygdala – involved with regulation of voluntary movements at a subconscious level. It sends fibres from the olfactory system to the
- \* hypothalamus – in the forebrain which is linked to and controls secretions of the pea-sized
- \* pituitary – the master endocrine gland which controls autonomic internal body functions, e.g. hormonal integration, emotional states and sleep cycles, etc.



Mackenna and Callander (1990). *Illustrated Physiology*. 5th ed. London: Churchill Livingstone, p. 224.

The thalamus – two egg-shaped masses – acts as a relay centre for sensory messages entering the brain – *except* the sense of smell. Aromas are therefore able to breach the 'blood-brain-barrier' – the tightly tiled lining of the brain's vascular system. This explains the devastating effect of sniffing petrochemicals, referred to as 'glue sniffing'.

These are the same petrochemicals used in fragrances. They camouflage unpleasant odours and prolong shelf life, but they have been specifically exempted from identification in bodycare products under the U.S. Label Reading Act 1977.

More than 10 years ago (1986) the Committee on Science and Technology of the U.S. House of Representatives noted that 95% of petrochemicals used to manufacture perfumes/fragrances cause toxic reactions. They made reference to benzene derivatives and aldehydes implicated in birth and CNS defects and allergic reactions (Kendall 1994).

In 1991 the U.S. Environmental Protection Agency reported that toluene (in unleaded petrol) was found in every single sample of fragrance the Agency tested. Exposure to toluene has been correlated with increased risk of bone marrow depression, leukemia, birth defects and asthma. It also depresses the CNS (Kendall 1994).



Toluene is one of a number of substances designated as 'hazardous waste disposal chemicals' which are increasingly expensive to dispose of properly. Other hazardous waste chemicals (also found in fragrances) are methylene chloride, methyl ethyl ketone, methyl isobutyl ketone and benzal chloride (Kendall 1994).

The first chemical cosmetic was lauric acid made by Dupont from coconut oil, replacing lauric acid obtained from the European laurel. The

synthetic lauric acid not only replicated the odours of rose, tuberose, iris, violet and incense, it also acted as a 'fixer' replacing musk from the Tibetan male musk deer (Killheffer).

Smell receptors respond to chemical stimuli. Since toxic petrochemical fragrances are able to breach the blood-brain barrier, are they safe to use on babies whose sense of smell is much more acute than that of an adult?

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# LETTERS TO THE EDITOR

## Vaccination Information Network

Dear Editor,

Concerning the current MMR-vaccination campaign (against measles, mumps and rubella) in New Zealand, the British law firm Dawbarns in Norfolk has this to say about the consequences of the 1994 MMR-campaign 'Operation Safeguard' in Britain:

We know of hundreds of children who were fit and well before being vaccinated; but who are now chronically ill or seriously mentally or physically disabled. Of some 600 cases reported as at May 1997, the most common are: autism (287), serious digestive problems (136), epilepsy (132), brain damage (77), hearing and vision problems (81), arthritis (50), behaviour and learning problems (110), ME (41), diabetes (15), paralysis (9), blood disorders (6), SSPE (3), death (18).

We have read and heard many harrowing accounts of the injuries children (and adults) have suffered after the vaccines were administered. We have listened to the dismissive comments from representatives of the government and some members of the medical profession. We are now worried that the safety information about these vaccines may not be entirely accurate.

We are also seriously concerned that safety monitoring for these vaccines appears to fall short of what the public is entitled to expect.

On top of that, information given to parents is certainly lamentably incomplete. We are concerned that risks associated with the actual illnesses may have been exaggerated, perhaps to frighten people into having their children vaccinated.

Rather than create a panic, the health authorities should advise parents to give children with measles vitamin A (e.g. cod liver oil) which according to the medical literature prevents complications.

*Erwin Alber*  
*Vaccination Information Network*  
*PO Box 149, Kaeo.*



## Baby-Friendly Hospital Initiative

Dear Editor,

On 31 July 1997 the College hosted a Baby-Friendly Hospital Initiative (BFHI) workshop in conjunction with the national committee meeting with invited representatives of consumer and health worker groups, providers and the Transitional Health Authority.

One goal of the Baby-Friendly Hospital Initiative is 'To eliminate the most detrimental practice inducing mothers away from breastfeeding: the free and/or low-cost distribution of infant formula through hospitals and maternity facilities'.

It was clear from the participants' responses that free and low-cost infant formula is still being supplied and/or accepted in New Zealand despite many calls since 1986 from the World Health Organisation for this practice to cease. However, the Ministry of Health said in a letter of 5 April, 'The Ministry has not undertaken any surveillance work to see if the practice of free and low-cost supplies on infant formula to maternal and child health services has ceased. It has no plans to do this in future'.<sup>1</sup> Therefore, it remains the responsibility of concerned individuals and their organisations to monitor whether or not such contravention of the International Code of Marketing of Breast-milk Substitutes occurs.

It has proved helpful in the past to produce periodic reports of Code compliance in New Zealand<sup>2,3,4</sup> and it is intended to do so again in the future. Hence, it would be very helpful if any midwives or consumers who are aware of donations of free and low-cost supplies being given or sent to hospitals, community health centres, health workers or parents, etc., would send a record of the details of such contraventions to us for inclusion in future reports.

Such information needs collection in order to hope to facilitate change. Midwives have already been at the forefront of changes in maternity care in New Zealand since 1990. We would very much appreciate your help in this task of protecting breastfeeding. Please send information on free and low-cost supplies of infant formula and other contraventions of the Code to:

Tui Bevin  
129 Signal Hill Road  
Dunedin.

Do remember to also send the information to the Ministry of Health, PO Box 5013, Wellington and copy your letters for your professional organisations.

*Sincerely,*  
*Tui Bevin and Marcia Annandale*

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NEW ZEALAND COLLEGE OF MIDWIVES JOURNAL: BOOK REVIEW FORM

AUTHOR/S *Ian D Graham*  
BOOK TITLE *Episiotomy Challenging Obstetric Interventions*  
PUBLISHERS *Blackwell Science*  
DATE PUBLISHED *1997*  
COUNTRY PUBLISHED *UK*  
ISBN No *0-632-04145-5*  
RECOMMENDED RETAIL PRICE *\$A 39.00*

REVIEWED AS FOLLOWS....

Why do we do what we do?

Have you ever wondered why rates of intervention in childbirth differ between countries, between institutions and between individual practitioners? What is your episiotomy rate or that of your closest colleague or the hospital with which you are associated? What is the rate in different regions of New Zealand? Ian Graham's book sets out to explore these issues and in so doing provides us with insight into how innovations in practice occur.

His proposal is that although science plays a part in medicine, medicine is not a science. The rational-scientific sequential model of advancement in our understanding of pregnancy and childbirth is a fallacy. Instead Graham convincingly explores a model of medicine as fashion, fad, custom or fancy. Innovations in maternity care (and by implication, many other medical practices) rise and fall based on the complex interplay of human and social forces which owe less to strictly scientific endeavours than we may like to imagine.

Ian Graham is a Canadian medical sociologist whose doctoral thesis (*Episiotomy: Challenging Obstetric Intervention*) traces the history of episiotomy in America and Britain. Through a meticulous exploration of this one innovation Graham illustrates why practices introduced to be occasionally used in emergency situations can come to be used almost universally. The first and last chapters of this book are essential reading for every midwife interested in evidence based practice and may even provoke some to question midwifery innovations (such as water birth, homoeopathic remedies and massaging the perineum) which are currently in vogue. This is not merely a book about episiotomy but a riveting exploration of the reasons why evidence based practice rarely occurs in childbirth. It will affirm the reasons why it should.

REVIEWED BY: *Maralyn Rowley*



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# I Am a Midwife

I visit you at home,  
learn your children's names,  
drink tea with you,  
I talk with you,  
hear your hopes and dreams for this child of yours.  
And your fears?  
I hear these also.  
I get to know you and all you care about.

The time has come,  
there is power in your body.  
It slowly builds up,  
then slowly goes.  
Like waves breaking on the beach,  
the power ebbs and flows.  
You welcome each wave but want them to stop.

I am there,  
I hold your hand,  
smile.  
I whisper "you are doing this,  
you are strong,  
I am with you."  
I rub your back,  
help you to the shower.  
I try hot packs,  
I encourage you to change position,  
to swear, to cry, to laugh, to groan.

The waves continue,  
getting stronger and stronger,  
relentless.  
When will this end?  
The energy within scares you.  
You feel lost,  
cast adrift,  
isolated somehow from those so close.  
Soon this energy will leave your body.  
Before then, though, there is more work to do.  
Your family encourage you,  
tell you they love you,  
believe in you.

I am there.  
I say to you,  
"Don't be afraid,  
trust your body,  
do what it is telling you to do."  
You move around, you try to get comfortable.

It is impossible.  
You groan, you scream, you swear.  
Your whanau surround you.  
I am there.  
You have waited expectantly for this moment.  
It is here.



Soft,  
silky hair slowly emerges.  
Breathe, breathe your baby out.  
You reach down and touch your baby's soft slippery skin  
for the first time.

You hold your baby.  
Your baby is wide-eyed,  
taking in his new world.

I am there.  
But this is just the beginning,  
there is so much to learn.  
Your baby feeds hungrily at your breast,  
he has worked hard also.

Slowly you get to know your baby.  
He feeds, he cries,  
he sleeps, he cries.  
You bathe him, you change him;  
he is yours, you are his.

Again I visit you at home.  
I listen to your questions. Are those spots normal?  
Should he be drinking this often?  
Are you sure his pito is supposed to look like that?

You are tired.  
How can a baby possibly take up this much time?  
I express my admiration,  
you are doing so well.  
Your baby is well cared for.  
You are this baby's mother.  
I am with you.  
I am a midwife.

*Annie Hogan – Midwife*



# "When you're pregnant who needs heartburn?"

The problem with heartburn in pregnancy is not too much acid - just too much in the wrong place. In pregnancy this is caused by several contributing factors;

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BOOK REVIEWS

**Book Title:** *My Healthy Child (and How to Keep it That Way)*  
**Authors:** Lynne McTaggart and Bryan Hubbard  
**Published:** 1995  
**Publisher:** The Wallace Press, London  
**Price:** \$19.95  
**Reviewer:** Gillian Eyres White, PhD  
 Massey University @ Albany

The authors of this book state that the book is about avoiding those factors that can jeopardise the health of children. Some of those factors are listed as dietary, environmental, vaccinations and other medications. In 70 pages the book covers topics such as preconception care, breastfeeding and the new born, cot death, vaccination, children's complaints, asthma, eczema, colitis, nutrition, teeth, eye care, hyperactivity and environmental hazards.

The book is written for parents. The authors claim it has been scientifically researched and provides facts which the reader is hard pressed to find elsewhere. This immediately rang alarm bells. A search for the scientific facts revealed poorly referenced material, many assumptions and inaccuracies. For example, a section on X-rays used references from published works in the 1970s presenting information that has been known for years regarding X-rays and the fetus. The authors cite a secondary source that indicates that for every million babies exposed to 'even a single rad of X-rays' in the womb 600 to 6,000 children will develop leukaemia, suggesting that 0.06 to 0.6 exposed children in every 100 exposed children will develop leukaemia. This type of calculation is meaningless within current practice.

Regarding breastfeeding the authors promote the good news that 'breast milk has been proven to make your baby more intelligent'. Although they refer to a study published in the *Lancet* they give no further reference. The study purports to show that children who are breastfed are eight IQ points higher than those who are bottlefed. Anyone who has studied the concept of intelligence will recognise the unreliability of intelligence tests, a difference of eight points being negligible. The section on vaccination was surprisingly sparse which is a shame because the authors gave a reasonably balanced view of measles and the MMR although the referencing was limited. Sensible dietary and hygiene advice was given. Under the section on asthma, the authors pointed out the side effects of current treatments such as inhalers. Although admitting that side effects were the results of inaccurate usage they preferred to recommend homeopathic remedies and herbs than better education in and monitoring of children using inhalers. The section on teeth concentrated on amalgams. There was no discussion of the fluoride controversy, this discussion being left to the chapter on environmental hazards.

The reader is left wondering about the claims being made in the book and wanting to know something about the authors. While history has taught us not to ignore pressure groups attempting to expose unsafe practices we should also be cautious of unsubstantiated 'scientific facts' and critically examine all claims from wherever they are derived.

This book may hold some interest for those who are concerned about the impact of current medications, treatments and environmental developments on the health of our children including trends toward alternative responses. It is not recommended for those who want to study the 'facts' in more depth.

Both of these books are available through the Vaccination Network, P.O. Box 149, Kaeo, Northland. Both were kindly donated to the NZCOM by the NZ Vaccination Information Network.

**Book Title:** *Varney's Midwifery*. 3rd ed.  
**Author:** Helen Varney  
**Published:** 1997  
**Publisher:** Jones and Bartlett Publishers International, Boston  
**ISBN No:** 0-86720-748-5  
**Price:** \$A79.95  
**Reviewer:** Elaine McLardy  
 Midwife, Christchurch

The Preface was personal and heartening, explaining the title change to 'Midwifery' from Nurse Midwifery of the two previous editions. A reflection on the perception and importance of midwifery now emerging in the U.S.A.

This book is American, starting with a brief history of midwifery in the USA, and continually covering the standards and laws governing that country.

It is strongly based on the Management Process, a very definite widely-based set of seven steps creating a framework of care.

Because of its very medical American basis, it covers women and exercise, has a chapter on HIV infection and women's midlife health, as well as lesbian and bisexual obstetric care.

As a text for midwifery sciences, it has many detailed illustrations which are easy to follow, with step-by-step working of procedures, as well as covering obstetrical emergencies with a wide variety of techniques to deal with them as the situation fails to resolve.

I was pleased to read in the introduction to Fetal Assessment, a firm reminder 'One of the hallmarks of midwifery care is the appropriate use of technology. Determining what is appropriate for an individual woman is one of the most complex areas of decision-making the midwife faces' (p. 283). The text overall contains high amounts of scientific data giving it a very medical feel and needs translating from American measurements, but nevertheless, would be helpful for people wanting to expand in this area of knowledge.

I was disappointed to find some important omissions. For example, there is no mention of healing of unsutured perineal lacerations or ways of enhancing this. There is a diagram showing suturing of the perineum by several different methods, but doesn't show how to tie a knot although it does give a reference to this. There is no coverage of breastfeeding is inadequate and unhelpful. I feel that the publishers have made a faux pas with the last chapter. I would like to have seen a positive woman-centred summary. Instead we get male circumcision!

Who would find this book helpful? Student midwives would find it especially helpful - clear explanations for everything done, and probably useful when doing special essays with its extensive use of references. Midwives would find it informative, but it needs to be used alongside other texts that would give balance to the way we practice our midwifery here in New Zealand.



**Book Title:** *What Doctors Don't Tell You (The Truth About Modern Medicine)*  
**Author:** Lynne McTaggart  
**Published:** 1995  
**Publisher:** The Wallace Press, London  
**ISBN No:** 0-7225-3024-2  
**Price:** \$24.95  
**Reviewer:** Gillian Eyres White, PhD  
 Massey University @ Albany

The author states that she has written this book 'because I don't want to be another statistic in my morning post'. She promises that you will not have a comfortable time reading this book and she is right. McTaggart is an award-winning journalist who runs her own publishing company along with her husband, Bryan Hubbard. They edit a monthly newsletter, *What Doctor's*



*Don't Tell You, and Proof!*, a publication for alternative medicine. The research that has been undertaken in order to write this book, while using an investigative journalist approach, is overwhelming. Divided into six parts (12 chapters, 377 pages), the book, is a non-stop nightmare of iatrogenic medical and pharmaceutical practices. To be fair, McTaggart makes it quite plain that although she favours 'natural approaches' such as attention to nutrition, the use of homeopathy and herbs, and praises the body for its ability to deal with many illness and wellness situations itself, she warns that all 'treatments' demand unbiased and critical examination. Interestingly, she supports the Cochrane Collaboration as 'a fresh approach - which might seem the obvious way forward to you and me'.

This book is fascinating yet depressing. Having critiqued most of the current armament of medical tools, techniques, technology, pills and potions the author leaves the reader wondering where to go next. There are no alternatives spelt out - it would appear that we all turn away from the medical doctor and put our faith in other types of healers - who also require access to our bodies, bits and pieces, in order to form their own diagnoses so that they can treat us. This reader wanted some helpful hints and not an address in London.

There is no doubt that this book is a great read and questions need to be asked. It is much better constructed than *My Healthy Child* by the same author (reviewed in this edition). There is one disappointing omission, however, regarding systemic candida albicans. Briefly mentioned in relation to dental amalgam and antibiotics the topic deserves better coverage especially as the author declares that the book was born from her passion to get well (having suffered with polystemic chronic candidiasis).



## VIDEO REVIEW

**Title:** *Expressing Breast Milk - A Guide for Mothers*  
**Producer:** Queen Mary Maternity Centre, Dunedin  
**Price:** \$45 (includes postage)  
**Reviewer:** Robyn Dunning, RM Lactation Consultant

# COMING EVENTS

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Ann Richardson  
Ph: 09-630 9953 ext. 3252

**International Association of Infant Massage**

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*Contact:* IAIM, PO 33997,  
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Executive Officer, ACMI, Suite 23431,  
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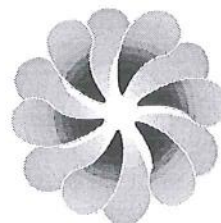
Abstracts should be submitted by  
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6-9 August 1998  
Brisbane

This conference aims to provide a forum to discuss topical issues surrounding birth, breastfeeding and the immediate postpartum period. Pre and post conference workshops will accompany the conference that coincides with *World Breastfeeding Week*.

Abstracts should be submitted by  
30 November 1997.

*Contact:* Margaret Barnes,  
email: mibarnes@ozemail.com.au  
or Jan Cornfoot, CAPERS,  
PO Box 412 Red Hill,  
Qld 4059, Australia  
Tel: 07 3369 9200  
Fax: 07 3369 9299



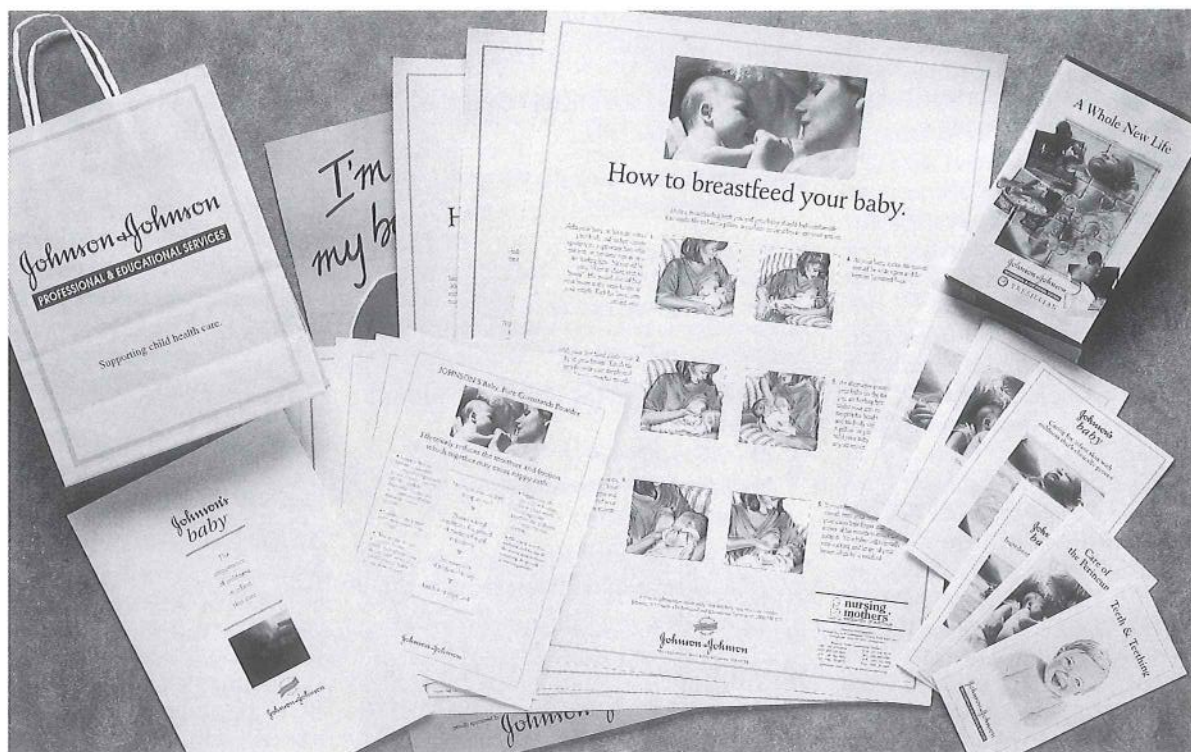
I was pleased to see a video about expressing. Today more and more mothers are choosing to express breast milk for a variety of reasons and it is not an easy subject to explain. This video shows very clearly the different methods of expressing milk, and its storage. More information for mothers who are casual breast milk expressers and perhaps more emphasis on the convenience of hand expressing would have been helpful. My reservation is with the section on sterilisation. Since the video has been produced the sterilising procedure has been revised. Expressing equipment only requires sterilising *once, before it is used*.

After expressing milk the mother should then wash the parts of the equipment that touched the milk, in the dishwasher or with hot soapy water and rinse well. As the video pointed out, if the mother is expressing breast milk for a hospitalised baby she should follow the guidelines for this set out by that hospital. A useful video for a limited market.

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# Good advice.



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