Our survey showed a high level of morbidity among the respondents. Half (513) believed that their sex life was "less good" than it had been before the birth of their child. Pain was the most quoted reason for this (116 women) and had often persisted a long time after the birth. The respondents thought that doctors either dismissed or failed to recognise their problems, and comments about untreated morbidity were common (for example, "penetration now makes me feel like I'm about to inadvertently pass a stool" and "a major episiotomy made sex impossible for over a year"). Loss of libido and vaginal dryness associated with breast feeding were also common problems, about which the women believed that they (and their doctors) had little knowledge.

The women were largely unprepared for the sexual problems and physical changes they had experienced—an interesting finding, given that the respondents were largely middle class and educated and had attended additional antenatal classes run by the National Childbirth Trust. Only a small minority of the respondents had been given information about postnatal sexual health by health professionals before the birth of their baby, and after the birth discussion about resuming their sex life revolved mainly around contraception.

We agree with the author of the personal view that there are many times in the postnatal period when women come into contact with health services and could be helped with postnatal sexual difficulties. Our concern, however, is that maternal and child health services focus more on the child than the mother and that health professionals do not always have the awareness, knowledge, and skills to deal with problems with postnatal sexual health.

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1 New baby? How wonderful. *BMJ* 1994;309:815-6. (24 September.)

2 Welch A, Chapple J, Beard R. *North West Thames regional annual maternity figures 1992: St Mary's maternity information system*. London: North West Thames Regional Health Authority, 1992.

Payment for blood donations

EDITOR,—John D Cash is worried about the German policy regarding payment for blood donations.¹ I join him in his concern. The Council of Europe defines voluntary unpaid donations as follows: "Donation is considered voluntary and non-remunerated if the person gives blood, plasma or cellular components of his/her own free will and receives no payment for it, either in the form of cash, or in kind which could be considered a substitute for money. This would include time off work other than that reasonably needed for the donation and travel. Small tokens, refreshments and reimbursements of direct travel costs are compatible with voluntary, non-remunerated donation."² Some European Union documents use the same definition,³ which is generally accepted by international organisations.

Last October, at a meeting of the committee of experts on blood transfusion and immunohaematology of the Council of Europe, the German delegate indicated that the German minister of health had accepted this definition, but the interpretation was such that "small tokens" and "reimbursement of direct travel costs" allowed payment of a lump sum of up to DM50 (£20) per donation. Moreover, he was prepared to accept the report of the committee only on the condition

that the German interpretation was approved and accepted by the rest of the committee.

We are on a slippery road if such playing with words is generally accepted. The paid plasma donors in the United States receive less than £20, hence they are unpaid according to the German interpretation. Who would then be a paid donor? We must be vigilant that the European Union keeps unpaid donors unpaid in the spirit of the directive 89/381/EEC.

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1 Cash JD. Payment proposed for blood donations in Germany. *BMJ* 1994;309:1160. (29 October.)

2 Council of Europe. *Guide to the preparation, use and quality assurance of blood components*. Strasbourg: Council of Europe Press, 1992.

3 Van Aken WG. *The collection and use of human blood and plasma in the European Community in 1991*. Brussels: European Commission, 1994.

Nestlé's donation

EDITOR,—The letter from the Honorary Secretary of the British Paediatric Association states that the Nestlé donation was accepted under the policy of taking money from companies "whose products are not harmful and whose marketing practices obey the ethical standards set by the codes of the countries in which they operate." Recent monitoring of Nestlé's activities shows that the British Paediatric Association has contravened its own policy.

A new report, *Breaking the Rules 1994*,² compares the activities of 74 manufacturers of breast milk substitutes with the requirements of a World Health Organisation marketing code.³ Every country in the world has voted to support this code, and many have adopted all or part of it as national legislation. Information from 62 countries shows that all companies violate the code and indicates that Nestlé violates it more than twice as often as its closest competitor. On the issue of giving free or subsidised supplies of baby milk to hospitals—now generally recognised as the most detrimental practice inducing mothers away from breastfeeding—a sample survey found Nestlé free supplies in 13 countries where they have been banned by governments. Unicef field officers reported free or low cost supplies by Nestlé in a further seven countries where governments have acted to end the practice (unpublished data).

The British Paediatric Association appears to have simply taken Nestlé's word that it abides by the WHO code. The association's council should look into the matter more carefully and reject donations from manufacturers of breast milk substitutes.

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1 Dodd KL. Nestlé's donation. *BMJ* 1994;309:414. (6 August.)

2 International Baby Food Action Network. *Breaking the rules 1994. A worldwide report on violations of the WHO/Unicef international code of marketing of breast milk substitutes*. Cambridge: Baby Milk Action, 1994.

3 World Health Organisation/Unicef. *International code of marketing of breast milk substitutes*. Geneva: WHO, 1981.

Reform of GMSC needed

All GPs should have right to vote

EDITOR,—At the British Medical Association's annual representative meeting this year a motion proposing reform of the General Medical Services Committee was put down for debate. As it was placed too low in the order, debate was not possible despite an appeal to suspend standing orders. The

motion, proposed by Mid Surrey, Kingston and Esher division and Leicester division, read: "That this meeting believes that members of the General Medical Services Committee should be elected by a direct vote of all general practitioner principals arranged into large constituencies rather than by [local medical committee] members."

Not all members of the BMA are aware that members of the GMSC are indirectly elected and that ordinary general practitioners have no part in their election. An analogy would be parish councillors electing members of parliament. There is a strong feeling throughout Britain that now is the time for reform. The morale of general practitioners is low, recruitment is minimal, and early retirements are increasing. All these are examples of the failure of the present system and leadership. Under the proposed system general practitioners would be enfranchised for the first time, there would be a larger choice of general practitioners (rather than the present "time servers") for places on the GMSC, and the GMSC would take greater note of what general practitioners said.

The GMSC has agreed that this is an important issue but has refused to sponsor a referendum of all general practitioners through the Electoral Reform Society, preferring that the motion should be proposed for possible discussion at next year's annual representative meeting or the conference of local medical committees. The annual representative meeting declined to take the matter seriously this year, and debating it at the conference of local medical committees would be akin to asking a condemned man to debate whether he wished to be hanged. The only alternative, unless the GMSC reverses its decision, is for the many hundreds of supporters of reform to call extraordinary general meetings of the BMA until the GMSC permits such a referendum.

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BMA's reply

EDITOR,—The tone of David Roberts's letter makes it seem that there has been some systematic attempt by the BMA to deny him the opportunity to raise this important question. This is not the case. The order of business for the annual representative meeting is decided by the agenda committee, and it is wrong to suggest that there was any deliberate attempt to place Roberts's motion "too low" in the order. In addition, it is open to any member to seek the support of his or her colleagues to get a motion not previously accorded priority placed in the position of a "chosen motion." This Roberts failed to do. He furthermore failed to move the annual representative meeting to suspend standing orders to get his motion debated.

Since the annual representative meeting Roberts has been in correspondence with the council's secretariat, and as a member of the council he raised the matter at the meeting on 11 October, when the subject was extensively debated. At that point Roberts did not seek to put a motion seeking a referendum or bring forward any list of signatures calling for an extraordinary general meeting. He was, however, assured by the chairman of council that, although this year's annual representative meeting had not found it possible to discuss the motion, the matter would be discussed at next year's meeting. He was also reassured by the chairman of the General Medical Services Committee that the matter would be debated at the conference of local medical committees next summer. Roberts has subsequently written to me again on the issue; and further time will be devoted to it by the council at its meeting on 14 December.

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