FOCUS ON MATERNAL HEALTH

FIND US ON THE WEB AT: WWW.AFRICAWOMAN.NET

Africawoman

FOR AND ABOUT WOMEN IN AFRICA ● MAY 2004

WANTED: Motherhood is strengthened by the right to health.

TALK IS GOOD, BUT ACTION IS BETTER

By Florence Machio, Kenya

FOR six days, the world's health ministers will be meeting once again to discuss critical issues affecting the world's citizens. For the most part, this is familiar stuff. There's a bonus for women, though: For the first time in the history of the world health assembly, reproductive health features as an agenda for discussion.

By resolution WHA55.19, the health assembly requested the director-general "to develop strategy for accelerating progress towards attainment of international development goals and targets to reproductive health".

It is about time. Maternal health – or the lack of it – is a critical issue in Africa. The women of this continent have had enough of words; they are looking for action. Yet there is no precedent in this area. Some of the treaties our governments have signed that affect women's reproductive health have yet to be implemented.

According to Jacinta Muteshi of the Kenya Human Rights Commission, major international conferences held between 1992 and 1996 were categorical that reproductive health is a human right. "When governments ratify these international human rights treaties, it creates duties that require promotion and protection of rights relating to reproductive and sexual health of girls and women," she says.

How do these rights hold up?

Case One

Wambui: 32-year-old single mother of two and a hawker

With two previous scars, she was admitted for premature rupture of membranes at 28 weeks pregnancy. From her history, conservative management was offered for almost one week. There was no improvement with fever continuing to rise, indicating infection. A decision was made to take her to theatre for a hysterectomy. On opening up the abdomen, a catheter was found.

During an interview, she admitted having gone to a quack for a back street abortion. The quack began the process and referred her to the public hospital for completion.

CONTINUED ON PAGE 2

LOOKING BEYOND DONOR SUPPORT – PAGE 6

It's a dream too far for most

By Eunice Menka, Ghana

GHANA'S dream of encouraging more women to have their babies in hospital may be stillborn because of gender inequalities and poverty. And this despite the Free Maternal Delivery policy launched last year with initial funding of 17.2 billion cedis (US$1.8 million).

The project is designed to encourage vulnerable women in the Upper West, Upper East and Northern and Central regions to choose supervised delivery rather than unassisted home delivery.

"The scheme is a top up for the other exemption policy involving free ante-natal care," says Sam Arko, who is in charge of policy planning and monitoring in the ministry of health. "The government further plans on extending this programme to two more deprived regions."

Traditionally, about 51 percent of deliveries take place at home; 31 percent of these are assisted by families or untrained elders in the community. For this and other reasons, the maternal death rate remains high, with estimates ranging from 214 to 740 per 100,000 live births with considerable disparities in the 10 regions of the country. Between 2000 and 2001, close to 2000 women died in the course of preg-

CONTINUED ON PAGE 2

Inside

It's a dream too far for most women

THE JOY OF LIVING: Women deserve options in reproductive health

FROM FRONT PAGE

nancy and childbirth.

Despite initiatives such as the National Annual Safe Motherhood Week, launched in 2002, pregnancy related deaths continue to rise – essentially because most women remain marginalised, poor and uneducated. It might well be a dream too far for Ghanaian women anxious to see change.

Would pumping lots of money into one programme after another solve the problem? According to the Situation Analysis of Children and Women in Ghana for the year 2000, the care seeking behaviour of women is directly linked with the mother's education and geographical residence. Also, women with secondary and higher education are twice as likely to seek ante-natal and post-natal care. The Greater Accra region reported the lowest rate of home deliveries at 24.2 percent and the Northern region the highest at 90 percent.

Poverty remains at the heart of Africa's high maternal illness and death, and many women are still dying of profuse bleeding, hypertension and abortion complications as well as obstructed labour.

Women who have better earnings are predictably better able to afford health care for themselves and their children, yet many of Africa's women continue to languish in poverty.

Human rights activists therefore had cause for celebration when Theresa Azigi, a steamed maize trader, was freed in March this year after being jailed last November for 10 years for abortion. The Federation of Women Lawyers, African Youth Alliance's Adolescent Project and two male law students filed an appeal on her behalf after extensive media coverage by a state-run weekly.

They challenged the sentence on the grounds that the maximum sentence was five years in jail. In quashing the sentence, the High Court took into consideration mitigating circumstances, including the fact that she was only 22, had three children – the youngest only nine-months-old – and was a first offender. Besides, Azigi was receiving no support from the fathers of the children.

Three months after she started serving her sentence, Azigi was transformed overnight from villain to heroine and is now receiving help from non-governmental organisations in the form of cash and training.

Azigi's predicament reinforces the need for governments to deal with the factors that militate against maternal health. In July 2001, the first ladies of West and Central Africa met in Lusaka, Zambia, and persuaded a meeting of the now defunct Organisation of African Unity to endorse the Bamako Declaration – the result of a two-day forum held in the Malian capital in May of the same year on the reduction of maternal and neonatal deaths.

The forum ended with the first ladies of Benin, Gabon, Ghana, Guinea, Mali, Nigeria and Senegal committing to developing a plan of action to request countries in the two regions to designate an annual day to draw attention to the need to reduce maternal and child deaths.

The Vision 2010 forum argued for policies that would promote the right of every woman to expect that her baby would be born alive and healthy and the right of every baby to be born to a living and healthy mother.

The first ladies would do well to pay attention to unmet contraception needs.

The Allan Guttmacher Institute reports that unmet contraception needs translates into 52 million unwanted pregnancies each year, bringing on 1.5 million maternal deaths and more than half a million motherless infants.

What emerges here is that governments in developing countries must provide options for women when it comes to reproductive health and rights. Had Azigi had easy access to contraception, she might well not have had a pregnancy she did not want.

Talk is good, but action is better

FROM FRONT PAGE

She refused to name the quack.

The reception she received from nurses on admission had been very hostile and had caused her to withdraw and not give more details about her problem.

When asked why she did not use contraceptives, she said she had not given it much thought. After surgery, Wambui's condition worsened and she was wheeled into intensive care for 10 days. She died soon after returning to the general ward.

Wambui's rights: *The right to decide the number and spacing of children and the right to private and family life (CEDAW Art. 16.1 Political covenant Art 17.1)*

"states obligated to inform, educate and provide means that contribute to the exercise of this right. Governments may not control or coerce reproductive choices. The choice of termination of unintended pregnancy remains difficult in many countries, however, especially where abortion is criminalised and thus the state allowed access to health care information that breaches human rights to privacy. Such actions deter women from seeking health care.

Case two

Current studies estimate maternal mortality rates at 1,300 for every 100,000 live births. Maternal mortality refers to women who die in pregnancy and childbirth. One out of every 200 adolescent girls is also likely to die from complications of motherhood and unwanted pregnancies.

Florence Nafula, an attendant at Kenya's Naivasha district hospital, some 90 kilometres west of Nairobi, reported that a 12-year-old in the town recently gave birth after her sister's husband made her pregnant. Her mother refused to sue the man because she felt that her son-in-law might divorce her elder daughter and leave her with children to take care of.

The girl's rights: *The right to freedom from torture or cruel, inhuman and degrading ill treatment.*

Ending sexual violence against women, right to full trial for rape, holding states accountable for rape of women by government officials, denial of abortion services that subjects women to inhuman services, ensure women's access to human and safe health services necessary to protect their lives, dignity, and security in health."

Case Three

In a village in Malawi

The 13-year-old struggles to free herself from the grip of her parents and a few other relatives. They are too strong, however, and soon she is pinned to the ground. They watch as an elderly businessman subdues and rapes her.

The schoolgirl's assailants had gagged her when she tried to shout for help and her parents threaten to kill her if she dares return home. Confused and helpless, she watches her relations bid farewell to the smiling businessman. He has just sealed a deal making the child his wife. It turns out that the "marriage" had been arranged as payment for 4,000 kwacha ($36) that her parents owed the man.

The two parties had agreed that the old man have sex with their daughter and even marry her if he so wished.

The schoolgirl had escaped the old man's attention before and fled back home, where she begged her parents to let her continue going to school. She was forcibly returned to the man's home, her parents making sure that his time she would stay.

The girl's rights: *The right to marry and found a family (Banjul charter Art 18., CEDAW Art. 16, political covenant (Art. 23).*

"Protection of maternal health is central to enjoyment of family life, the protection of daughters from early marriages, states must provide protection to vulnerable women."

We will never achieve the Millennium Development Goals as long as governments do not uphold these rights, which they have signed and ratified. As health ministers deliberate especially on maternal health, they should not forget what they have pledged before: the right to health.

LOUD AND CLEAR: Women's voices must be raised and heard

Let women have their say

By Grace Githaiga, Kenya

Those who have had abortions should be heard before they are condemned

KENYA'S constitution review conference has just come to an end. Ordinary people made many gains, particularly in the Bill of rights. Perhaps one of the most emotive issues was abortion, which was discussed with a lot of passion.

Article 34 (1) of the Bill of Rights says that every person has the right to life. It also states that life begins at conception and that abortion will not be permitted unless, in the opinion of a registered medical practitioner, the life of the mother is in danger. At the end of the day, victory went to the anti-abortionists, who ensured that the word did not feature in a manner to suggest that it had a place in Kenya.

From the beginning, it was clear that the majority of delegates had already made up their minds and was not willing to accommodate any divergent views. And this despite the fact that Press reports indicated that abortion is widespread among Nairobi teens. According to a recent study in the city's schools, 45 percent of students said they knew of a peer who had an abortion. Only 14 percent knew that pregnancy could be legally ended to preserve a woman's or girl's health. Only one in five adolescents believed that condoms do not prevent pregnancy or HIV infection.

Despite the recommendations at the constitution review conference, pressure is mounting on the government to relent on abortion laws to check rising maternal deaths among young women.

Groups dealing with women's health have not given up on a campaign to convince MPs, doctors and powerful non-governmental organisations on the need to keep the debate alive; fearing that Kenya's abortion rate of 700 per day will skyrocket if nothing is done.

Eunice Brookman-Amissah of Ipas argues that women should take charge of their own health. She adds that restrictive laws in Kenya and other African countries are partly to blame for the deaths of many young women who turn to quacks. Poor women suffer since they lack the money to go to qualified doctors, she says.

Now for some hard questions: Article 34 (2) of the draft constitution says that life begins at conception. But this remains a highly controversial issue. Is a five-day embryo alive?

According to Hubert Mark, president of the German research organisation Marx Planck Society, different cultures believe embryos or fetuses become human beings at different times. His position is that the real biological decision about the beginning of human life coincides with the point at which the fertilised egg attaches itself to the lining of the uterus, not at fertilisation.

French law is clear that the dividing line is week 22 of pregnancy, the foetus not being recorded earlier as a person in the register of births. Aanother argument posits that life begins at the fusion of the egg and sperm cells and that both sperm and eggs are human life. It is difficult to reach consensus, even among physicians and clergy, on life and when it begins. Biologists tend to think of life by what it does rather than what it is.

The Catholic Church says allowing abortion is equal to sanctioning murder. Others argue that abortion leads to lasting psychological stress and trauma. Few people take into account the lifelong distress young women face when left literally holding the baby without any serious means of support.

Pro-abortionists feel that harping on moral and religious implications only serves to raise emotional temperatures without dealing with the real problem. Only concrete solutions will do for this group.

US President George Bush has signed into law an Act that will make it a separate federal crime to harm a foetus. The Unborn Victims of Violence Act has stirred controversy because abortion rights supporters say it may open the door to an erosion of reproductive rights by assigning a separate legal status to the unborn.

In all these debates, however, the voice of the woman who has gone through abortion has not been heard. Have reasons as to why women have abortions been considered? Should a woman who has been raped be condemned if she gets an abortion? How about those "accidents" that happen even when women have had enough children but still conceive despite a tubal-ligation – some even in their old age and with grown up children?

Women's right to make decision on their health and sexuality must be given due importance. Let them talk. Yes, the sanctity of life must be respected. But let those who have had abortions be heard before they are condemned wholesale.

South Africa, Tunisia and Cape Verde have legalised abortion. Perhaps other African countries could explore the reasons for this. Abortion needs to be debated with sober minds in an objective atmosphere. Whatever agreement is reached, women's voices must be raised and heard.

WOMEN'S VOICES

Saved by my mother

By Dorothy Mmari, Tanzania

Had it not been for my mother, I would have lost my son," says Mariam Juma. Her mother is a nurse at one of the referral hospitals in Tanzania, which is presumably better equipped to handle emergency deliveries.

But Juma's journey did not start here. Like many affluent people, she went to a private hospital in Dar es Salaam in the hope that childbirth would be trouble free. But she was in labour for a long time, the decision to send her for a caeserean section being held back for reasons that remain unclear.

After the operation, the baby's condition worsened. His colour changed. Luckily for mother and child, Juma's mother came visiting. Quickly assessing the situation, she took her new grandson to the referral hospital, where the baby soon stabilised.

Juma demanded a discharge from the private hospital and followed her baby to the public one, where they stayed for several days. Soon after being discharged, Juma had to return to hospital again after the c-section wound became infected. Juma and her baby have recovered from their nasty experience but she swears that had it not been for her mother, she would have lost her boy despite the expenses she had incurred in the private hospital.

Juma is one of the few lucky women in this country. She had an alternative solution that was quick enough to save her baby's life. Some 529 out of 100,000 Tanzanian women died every year of pregnancy-related complications. They are generally caused by poor facilities and the long distances that women have to travel from their homes to health centres and on to hospitals in urban areas should they get into trouble.

White Ribbon Allliance's Tanzanian chapter was launched in March this year in response to the desperate need for safe motherhood. The alliance, headquartered in Washington DC, aims to raise awareness, build alliances and call for action to improve the safety of mothers and cut maternal deaths.

Speaking during the launch ceremony in Dar es Salaam, First Lady Anna Mkapa said: "We must invest in the health of our people and, not least, in the health of mothers and newborn children. Success in this area is certainly an indicator of success in the larger war on poverty.

"Healthy pregnancies and safe childbirth help minimise the likely disruption of family incomes and food supplies by ensuring the mother is safe and able to get back quickly on her feet," said the First Lady.

EDITORIAL

Africawoman, P.O. Box 6064, Nairobi 00200, Kenya.
Tel: 254-2-2721429
Tel/Fax: 254-2-2721439 / Email: africawoman@swiftkenya.com

Editor: Lucy Oriang (loriang@nation.co.ke/lucyoriang@yahoo.com)
Associate Director: Lesley Riddoch, BBC The Tan, Holyrood Road, EH8 8JF, Scotland. (Lesley.Riddoch@bbc.co.uk)
Coordinator: Florence Machio (fmachio@yahoo.com)

Africawoman is produced by 80 women journalists from Uganda, Kenya, Zimbabwe, Ghana, Tanzania, Malawi, Zambia and Nigeria who meet in a virtual newsroom once a month. The information produced is then linked to community radios throughout Africa to reach grassroot women.

Women's rights are human rights

The article in Time magazine was startling in more ways than one: here was childbirth, an issue largely dismissed as a woman thing, not only making the cover of an internationally acclaimed publication but also getting the benefit of thorough analysis.

It also spoke so very eloquently of the chasm between the developed countries and those still developing on a matter so fundamental that it should be top of the agenda of any government. How can it be otherwise when maternal health is linked so inextricably with the beginning of life – and, sadly for so many African women, the end of it?

In a gripping account of the "tribulations" of European women fighting for control over how and when to have babies, the one item that leaps at the reader – at least the one from the so-called Third World – is the idea of a wish list for the woman preparing for birth.

Time cites the case of Esra Erkal-Paler, a London-based corporate affairs director of a global cosmetics company, who is all set to have her first child at 34 by design. She is one of 20 percent of United Kingdom's expectant mothers who have set out detailed birth plans on how they want their labour managed.

Erkal-Paler wants a "birthing pool" and nitrous oxide to ease her pain. In the event that this does not work, she wants an epidural that will numb most of her torso. If she needs stitches, she wants to be sewn up by a doctor and not a midwife.

It is a list so far removed from the traditional African childbirth as to sound like fiction. You will know why going through the articles that we present to you in this special edition on maternal health.

European women may be caught up in a battle of wills with their health systems over such choices, but they have them at least. Whereas it is true that many African women of means are able to enjoy the same benefits of technology as any woman in Europe, the majority of African women are still caught in a time warp where debilitating customs and traditions hold sway.

The key agenda for the health ministers meeting in Geneva today is the government's role in making maternal illness and deaths a thing of the past. From Kenya, we learn that contraceptives are considered a luxury item in the continuum of health care. The end result is that if the donors do not supply them, local women can just go and find their own – in a country where more than half the population lives below the poverty line.

And then we act surprised that abortion defies all the moralising and continues to rise. Even where it is legal, such as Zambia, abortion is often accompanied by such moral judgment that many women prefer back street operations started by quacks with the sole purpose of pushing the women on to public hospitals for completion of the process. It's a Catch 22 situation for health systems whose priorities appear all jumbled up.

The problem could be traditions that are meant to safeguard women's sexual purity – such as female genital mutilation and early marriage, which have been linked with obstetric fistula, one of the most obnoxious conditions that any woman has to suffer – or minimal investment in maternal health.

But maternal health in Africa is heavily influenced by the state of women's rights – which are virtually ignored in most parts of the continent, even where they are expressly stated in human rights documents signed and ratified by our governments.

The unacceptably high rates of maternal deaths and illness will remain unchanged until African governments begin to take stock of where the rain began to beat us. The key to solving the riddle lies in upholding women's rights as human rights.

The Geneva meeting can begin the process of change that will give African women the same level of choices as our sisters in the developed countries. Or our political leaders can simply choose to go the same old way. We refuse to allow them that luxury.

WOMEN'S VOICES

Two babies, worlds apart

By Kwamboka Oyaro, Kenya

I had just sat my final examinations for a diploma in journalism at the Auckland University of Technology, New Zealand, when I fell ill. I consulted my physician, Andrew Wong, later in the day. His diagnosis? I was pregnant.

Far from feeling elated, I was plagued by uncertainty and fear. Disturbing images of the expectant mothers I saw in my village when I was growing up crossed my mind. The stories I had heard about the insults nurses hurled at them at the onset of labour made me panic. Pregnancy was nothing to write home about and expectant women were said to be "hanging" from a precarious tree – meaning pregnancy is a matter of life and death. During the last trimester, they would ask her close relatives: "Has so-and-so descended from the tree?"

I didn't know whether to cry or be happy about my condition for the next nine months.

Things moved fast and three days later I received a letter from the Auckland Women's Hospital congratulating me on my pregnancy. Enclosed were details about what I was entitled to during pregnancy and childbirth. My husband and I were urged to go for antenatal exercises once a week at a neighbourhood community hall.

I would not pay a cent for medical care throughout my pregnancy and for my baby until she turned five! And after birth, a nurse would visit me at home for six weeks to ensure that I washed and breastfed the baby well.

It was enough to get me excited about the baby. I went for those exercises dutifully and shared experiences with the other expectant mothers and even envied those about to give birth. As soon as labour set in, I called a toll free number for a taxi that was at the door in less than five minutes. Within no time, I had checked into the labour ward.

I stayed in my room for three days before I was discharged after the child got all the medication and inoculation required. I was also thoroughly examined by a gynaecologist to ensure all was well.

At home, I didn't have to fumble about cleaning the baby because a midwife assigned to me visited daily to help me bathe the baby and the hospital called regularly to ensure all was well.

Nearly four years later, another doctor told me I was expecting. It was a private hospital in Nairobi, Kenya. Just like the two countries are thousands of miles apart, my second situation was as different from the first as chalk and cheese. There was no congratulatory note from the hospital and no smile from the doctor who gave me the news.

He referred me to the hospital's ante-natal clinic. I was given a list of "packages" offered by the hospital and I had to choose what suited me best. The cost of having a baby back home appeared overwhelming.

SET ADRIFT: Kwamboka Oyaro's experiences were as different as chalk and cheese.

For the "normal" delivery package, which included three days stay in the general ward, I had to pay Sh38,000 (US$500). If I chose to have an elective caesarean section, I was to pay nearly Sh100,000 (US$1,300) and meet any other expenses that arose. While the first inoculations at birth would be free, others would be paid for separately.

I picked the normal package and hoped for the best. I had to pay the money by the week 20 of the pregnancy. The money was non-refundable.

We went for the ante-natal exercises like zombies, lying on the mattress without bothering to check the face of the person next to you or knowing their names. It was a whole new experience compared to the first. I am still in touch with the mothers I met at the community hall.

After birth, my child was kept in the nursery and I would only hold her during feeding time. I wanted to bond with her but this was not allowed – not at the hospital. So the new mothers had to go upstairs to the nursery to sit on benches to feed the babies, as if it were a competition on who produced the most milk within a few hours of delivery. I longed for the Auckland Women's Hospital, where I could spend my time in the hospital studying my baby's face.

No one came home to check the progress of baby number two and I had to read the many books and notes I collected with my first baby to ensure I did everything right. My bundle of joy was definitely no big deal here, just one of the many born every minute.

No one to help Sarah

Mother of three loses her baby as nurses refuse to assist

By Lilian Juma, Kenya

MOTHER of three Sarah Chivumba recalls her last birth experience with a shudder: "Although I met some very kind nurses during my pre-natal visits, the ones I came across at delivery mostly ignored me. When it was time for the baby to come, I desperately called out for help. Only one nurse responded, rudely asking me: 'Are you giving birth to the second Jesus Christ?'"

She adds: "When I insisted that I could not do anything more to deliver my baby, one of the nurses came breathing fire, quipping that I was not the first woman on earth to give birth! Because of the prolonged labour, I ended up with a still-born baby."

It has been two years, but Sarah is still in trauma. She lost her fourth baby at the hands of uncaring nurses at Kenya's largest maternity hospital. With a capacity of 350-bed and an average of 70 deliveries daily, Pumwani is notorious for its lack of medical equipment and drugs, overcrowded conditions and midwives who run other businesses on the side.

Back to the story of Sarah. It was only when she left hospital that she learnt from one of her friends – who went through a similar experience at the institution – that the majority of the nurses expect the mothers to deliver by themselves, waiting only for summons to pick up the new-born.

Despite this reputation, poor women have no choice but to flock to public maternity centres in Kenya because they are the most affordable. A visit costs Sh350 (US$5) per day plus a deposit of Sh1,000 (US$17). This is modest compared with the private clinics that charge around US$30 daily.

Investigations by *Africawoman* reveal that the majority of women are largely unaware of their rights. "I feel that the birth experience is just a door to be passed through between being pregnant and having a child," says 30-year-old Rehema Chanzu. "I did not have a lot of expectations other than going home with a healthy child."

Most consider a day or two of enduring mistreatment at the hands of nurses is better than the risk of dying trying to have a baby at home.

Yet this need not be the case. In countries such as the United States of America, women having babies enjoy maximum attention from doctors. There have birth plans, with the patients' list of preferences during labour and birth in a hospital of their choice – all designed to help women go through the process as comfortably as possible.

NOT ENOUGH: Most government health workers in Africa are poorly paid and demoralised

Studies by the World Health Organisation indicate that bad attitudes among health workers contribute to the increasing maternal mortality rates. According to WHO, an estimated half a million women die every year from causes related to pregnancy and childbirth.

In Kenya, at least 700 women die annually from pregnancy-related complications. Over 3,500 women have died in public hospitals in the past five years due to complications during pregnancy and childbirth.

Experience in other countries has shown that strategies most likely to produce a significant decline in maternal morbidity and mortality include the assurance that women in labour can receive the skilled care they require.

A study conducted under the auspices of the Support for Analysis and Research Africa project and the Academy for Educational Development with the support of the United States Agency for International Development indicates that poor morale may lead to counter-productive behaviour among health workers.

The study notes that many government health workers are ill-motivated because they are poorly paid, poorly equipped, infrequently supervised and informed and have limited career opportunities within the civil service.

It also points out that the scope of professional practice by each cadre has been too rigid and inflexible, considering the African health settings in which they work. Attrition of civil servants has reached critical rates due to the combined effects of the accelerated retrenchment and voluntary retirement and departure, the search for greener pastures locally and abroad, and sickness and eventual death due to Aids.

However, economists point out that financial limitations reduces African governments' ability to attract, retain and maintain the morale of professional health workers as treasuries are unable to upgrade salaries and working conditions, especially for skilled staff.

This double pressure on the production and retention of health workers has created shortages in such key cadres as doctors, clinical officers, medical assistants, nurses, midwives and laboratory technicians.

Medical experts stress the need to reduce the rigid professional practice barriers to enable health workers to take on additional functions, increase and improve service delivery and reduce costs.

Almost there, but not yet good enough

By Sibongile Ncube, Zimbabwe

FOR all its political upheavals, Zimbabwe has invested significantly in its infrastructure-especially in social services such as education and health. It is policy that has been good for women, with a dramatic expansion of the family planning programme since the 1980s.

Consequently, knowledge of contraception is virtually universal and the level of use of modern methods is among the highest in sub-Saharan Africa. Still, the fertility rate remains high, and critics have argued that the programme has not reached the target market.

Statistics from the Zimbabwe National Family Planning Council indicate that the number of women using contraceptives rose from 34 percent in 1984 to 54 percent in 2000. But despite achieving one of the highest levels of modern contraceptive use in southern Africa, the family planning programme faces many challenges.

In a recent study, Duncan Thomas and John Maluccio combined household and community level survey data collected in the 1980s and early 1990s to measure the impact of service availability and quality of contraceptive use and fertility, paying special attention to the distributional effect of these investments.

They found that the family planning programmes had been well targeted and that certain forms of service delivery appeared to influence the use of contraception. In communities that received visits from mobile units, the probability of using modern methods was about four percent higher than in those that were left out. Availability of services through a community-based distributor increased the likelihood of use by about three percent. When the distributor was given a bicycle or had taken a course from the family planning council, the probability of use rose among less educated women.

The survey also revealed that among women who have completed primary school (seven years of education) that the powerful effect of education becomes apparent. Women who complete secondary education (12 years or more) are about twice as likely to use modern contraceptives as those who do not complete primary school.

The United Nations Population Fund estimates that the costs of family planning and other reproductive health services are rising and that donors and individual countries will find it increasingly difficult to meet them.

Complications of pregnancy and childbirth are a leading cause of death and disability among women aged between 15 and 44 in less developed countries. About half of nearly 120 million women who have babies each year experience some complications during pregnancy and between 15 and 20 million develop disabilities such as severe anaemia, incontinence, damage to the reproductive organs or nervous system, chronic pain and infertility. The tragedy is that these problems are almost entirely preventable.

Such disabilities affect the health and productivity of women in the prime of their lives; for those who survive, the injuries could have devastating social consequences later in life. Much of maternal deaths could be avoided if all women had skilled assistance during and after pregnancy.

Health practitioner Sarah Dub believes that making contraceptives available to all women could reduce unsafe abortion, a major contributor to maternal deaths.

Another study at the Mpilo, Lister and Spilhaus clinics gave rise to the argument that many reproductive health services operate well below capacity and that much of the equipment required for expanding reproductive health services may already be available.

Yet Phathekile Masuku, from an NGO working with people living with HIV/Aids, says information on contraceptives has not reached all women, especially in rural areas .

"Information on family planning methods is there to a limited extent, but it is not reaching everyone," she says. "That is why we find child spacing still lacking in rural areas, because women there do not have easy access to modern methods of family planning and this has a negative effect on their reproductive systems in the long term."

Beyond donor support

By Florence Machio, Kenya

DESPITE the World Health Organisation's 1998 statement declaring safe motherhood a human right, contraception is far from easily available in many parts of the world.

At least one-third of women in developing countries need contraceptive services. Yet some women do not know much about safeguarding themselves against unwanted pregnancy, are unable to get them or afford them or simply distrust the methods available. Other women are ambivalent about whether or not they want a child, still others live with a partner who does not approve of contraception.

The challenge of meeting the Millennium Development Goals is great – to reduce child mortality by two-thirds and maternal mortality by three-quarters. Experts agree that unless unprecedented levels of financial support, policy reform, and programme co-ordination takes place among donors, governments and civil society, it is unlikely that the targets will be met.

With the risk of dying during pregnancy and after childbirth high in Africa, it is imperative to nip the problem in the bud by simply providing contraception.

Fardhosa Ali Mohammed runs a clinic in Eastleigh to the east of Kenya's capital, Nairobi. Most women who come to her clinic prefer injectable contraception. Mohammed says: "That's the only way they can control how many children to have without their husbands interfering."

Her clients are generally poor. Most local residents are refugees from neighbouring Somalia and have no source of income. "They prefer buying drugs at local pharmacies and come to my clinic to be injected," she says. They have been complaining lately that they are unable to get the drugs and are wondering why.

What they do not know is that there has been a shortage of contraceptives in Kenya for the past nine months, according to Sam Orero, a Nairobi gynaecologist. The risks to women are great since lack of contraception is synonymous with unwanted pregnancies and unsafe abortions.

Women here depend on the Family Planning Association of Kenya and Marie Stopes International for their reproductive health needs, which in turn rely on donors for funding. The two organisations enjoy a wide geographic presence, national reputation, depth of clinical services and expertise to deliver quality reproductive health care.

But since the gag rule introduced by the Bush administration, these organisations have closed 5 clinics in rural areas. This has created a void in the unmet need, which is bound to rise.

Most developing countries, including Kenya, received advance warning in 2001 to start investing in contraceptives during the world conference on contraception commodities held in Istanbul, Turkey. In essence, they were told to stop relying on donor funding. Kenya was among the countries placed under the eight-year phasing off period. Three of those have flown past and women have already started feeling the pinch.

During last year's budget, there were a lot of expectations among reproductive health experts that the cost of contraception would be reduced and that they would be made easily available to all women. Sam Thenya, chief executive officer of the Nairobi Women's Hospital says: "Within the budgets we have in the health sector, we can manage to provide quality health care."

The health care budget in Kenya totals $6 per person per year. Assuming that a woman chooses to use Depo Provera as her family planning drug of choice, one-third of this amount would go towards preventing pregnancy.

The key question then is why the Kenya government has not seen it fit to invest in family planning?

Peter Odongo, who is the chair of the reproductive health committee of the Kenya Medical Association, gives several insights: "The government does not have a lot of resources to put into primary health care. At the moment, family planning is treated as a luxury. This presupposes that families have a choice of having children or not and the government does not want to infringe on this. Over the years, the government has concentrated more on treatment rather than prevention. When a woman needs contraception, she is not sick and, therefore, her situation is not an emergency."

HARD-PRESSED: Fardhosa Mohammed's clients are mostly poor.

Odongo adds that contraception prevalence is quite low at the moment and is not affordable to many Kenyans – cause enough for alarm. "What we are asking is that the government invest in family planning, even if it is on a small-scale. This will reduce the number of women who have to seek abortion. What we are asking is that the health care budget should include subsidised contraception so that all women can access their first shot at safer motherhood."

The WHO declares health a fundamental right. Women want to see this right entrenched in health care systems.

It does not take an expert to determine that more women's lives are lost without contraception and information.

According to Don Levy, a senior social marketing expert with the Washington DC-based Futures Group International, contraception security is possible. "If governments make an investment in primary health care with a strategic plan involving the private sector as well, then we are on the road to contraception security."

If governments remove the barriers that affect the private sector with a move to encourage them to invest in contraception, then contraception security would be real. He adds that such measures have worked in developing countries such as Turkey, the Philippines, Bangladesh, Nepal and – gradually – Uganda and Ghana."

Levy adds: "Ghana is an example of what a review of government policies can do to the health care system, especially contraception."

Odongo remembers that it took a year for the Kenya government to allow the social marketing of the female condom. 'The government needs all the help it can get and for its own benefit."

Orero adds: "Most governments have not committed to family planning commodities. We are depending on donor funding yet more donors want to see government commitment before they continue funding this part of the health care system.'

According to Ipas' vice president for Africa, Eunice Brookman-Amissah, governments can start taking small steps towards securing safemotherhood. "Free education for girls up to university, access to information and emphasis to basic needs has moved countries like Romania and Sri Lanka as success stories."

When governments introduce cost sharing – as in the case of Kenya, cash carry in Ghana and user fee in Nigeria – they need also take the steps Brookman suggests. Unless women are empowered in terms of education and access to information alongside contraception, Africa will surely lose the battle for safe motherhood.

All is not lost, though. Looking at how small measures at policy levels can change the health care system for the better, especially where family planning commodities are concerned, provides a light at the end of the tunnel. Most countries have wonderful policies that have never been translated into law and are, therefore, ineffective.

When looking beyond donors, we will need to look at the one-third of women in the developing world who need contraceptive services. Let us remember the women who attend Mohammed's clinic. Let us not deny them access to contraceptives that suit their needs.

According to United Nations Population Fund, simply meeting the need for contraceptive services could reduce maternal mortality by 20 percent and more. Let us not forget the 190 women that face an unwanted or unplanned pregnancy every minute.

In places where emergency obstetric care is not available, access to contraception may literally be a matter of life and death. The women at Mohammed's clinic need not go through this agony.

The anaemia connection

By Joyce Gyekye, Ghana

THERE are things that women have no control over when it comes to maternal health, pregnancy-induced hypertension and haemorrhage during labour and childbirth in particular. But, surprisingly, it is the preventable anaemia that is the second leading cause of death among pregnant women, according to Ghana's 2001 Review of Health and Disease Profiles and Pathology Report.

About 200 local women die every year due to anaemia, caused by lack of iron in the blood. Iron is found in meat, fish, chicken, snails, beans, millet and ground-nuts.

But tradition still holds fast in parts of the country and some women still believe that eating lots of fruits during the first trimester could lead to an abortion. Grace Vanderpuye, 86, also believes that eating snails and okra leads to babies dribbling saliva. Others believe that babies of women who eat eggs turn into snakes. Eating beans during pregnancy is also believed to lead to overweight babies, which might lead to the death of the mother during delivery. These are just the kinds of food expectant women need to eat to avoid anaemia.

Ironically, some women choose to eat what they should avoid. They may crave a clay substance locally known as "ayelo" among the Ga-speaking people of Ghana and 'shire" among the Akan. The clay causes anaemia due to worm infestation, but both educated and illiterate women chomp away happily, regardless of claims the clay could cause brain disorders in the foetus.

According to some estimates, Ghana's female labour force is expected to lose over $161 million in the period 2001 to 2005 due to anaemia. In developing countries in general, 40 percent of women are affected, rising to 50 percent of pregnant women.

But there is hope yet: the Ghana Health Service, in collaboration with the Anaemia Control Programme, adopted a five-year programme initially targeting women in the first six months between March and September 2003.

Healthy eating habits are the only solution. Women are advised to eat more leafy vegetables, which should not be overcooked. But while health experts are encouraging people to eat local foods that are rich in vitamins and other vital minerals needed for growth, television is busy promoting fried foods. "This makes the minerals needed for growth useless," says Rosanna Agble, head of the nutritional unit of the Ghana Health Service.

The national strategy aims at reducing anaemia rates by 25 percent by 2007. It champions attendance at ante-natal clinics throughout pregnancy, protection against malaria and regular iron supplements. But the key target must be the negative traditional beliefs that handicap pregnant women's nutrition. The strategy will work only if intensive education takes place.

When bad policies equal poor health

By Nkiru Okoro, Nigeria

FOR more than three decades, successive administrations here paid little heed to health, preferring to put their money in defence and security rather than health and education. Nigeria is now paying the price, with estimates that one in every five children born here will die before their first birthday.

Though the World Health Organisation recommends that at least 26 percent of annual budgets should be spent on health and education, Nigeria has routinely allocated a mere three to four percent in the past 30 years. This year's 8% is the highest in the past 35 years. "Of this, more than 90 percent is misappropriated through corruption," says Dr. Olatunde Olusomade of the Isolo Medical Clinic in Lagos.

The consequence is that hospitals are ill-equipped. They have become consulting clinics with no drugs, gloves and other supplies. Doctors are demoralised and have little or no incentive to work. Strikes are the order of the day; if it is not doctors, it is nurses going out into the streets to demand improved conditions of service. Many have left Nigeria in search of greener pastures and those left behind take refuge in private practice or hospitals where the charges are way out of the reach of the average Nigerian. With the public hospitals operating well below par, a thriving trade in traditional medicine has taken root.

Women have paid the price, with a high rate of maternal mortality blamed on "poor ante-natal care, poor access to health care delivery services, malnutrition, and anaemia", according to Richardson Ajayi, a fertility expert and gynaecologist who practices in the high brow Victoria Island in Lagos and in Port Harcourt.

Worse still, most hospitals do not have functional blood banks. Matters have been compounded by HIV/Aids. "Hardly is there a private hospital that has the capacity to manage complicated cases in pregnancy," says Olusomade.

From number 48 in the economic ladder of development in 1979, Nigeria dropped to 176 in 2004, according to the United Nations Development Programme. Despite its oil wealth, the country is now one of the poorest in the world, with over 70 percent of the population living below the poverty line.

Says A.C. Umezulike, a consultant gynaecologist at the National Hospital in Abuja,: "In most developed countries, medical bills are taken care of by health insurance. Nobody pays anything to receive medical treatment, yet they get the best regardless of social status. All you need do is bring yourself to hospital. In most cases, you can call an ambulance that will render that service effectively and efficiently."

He has just returned home after three months of training in Israel. In Nigeria, he says, staff in the supposedly best hospital does not even answer telephone calls. "Besides," he adds, "there have been attempts to streamline departments considered not lucrative or viable, such as ear, nose and throat."

But there are those who argue that government has no business running hospitals and ancillary services. Says C.O. Kelechi, an assistant bank manager: "I have not heard of a national hospital in the USA, yet it is the most developed country in the world and has a record of giving the best of everything to its citizens. Government develops these facilities and sells them to private institutions and individuals, who run them effectively."

Ajayi argues, however, that health should be a social responsibility of the government. It should improve access to care, child immunisation, blood transfusion, ante-natal services and improved facilities. Medical education should also be subsidised, so that doctors resist the temptation to charge astronomical medical fees in order to recoup family investment in the course.

Olusomade urges the Nigerian government to return to the drawing board and develop a health plan that will be implemented judiciously for the good of the citizens – from the womb to old age.

WOMEN'S VOICES

The right to enjoy good health

By Diana Mulilo, Zambia

Despite health reform partnerships with several international organisations, Zambia remains a long way from achieving anything close to adequate maternal care.

In collaboration with Care International, the World Health Organisation and Unicef, the government has been working on distribution of materials such as needles, syringes and disinfectant to all urban clinics as well as bed sheets.

Says Elizabeth Mundazi Phiri, the registered midwife in charge of maternal and child health services: "What we used to do is wash the gloves, sterilise them and dip them in baby powder to make them look new and smell good. We used to do the same with needles and syringes. We boiled and sterilised them. Then we'd use them more than twice on different patients."

Used needles and gloves came in especially handy when examining women during post-natal care. Perhaps this explains why many women did not return to the clinics as soon as they began to feel well – assuming, of course, that the absence of pain could be taken to mean they had fully recovered.

But nurses here can now follow up patients all the way to their homes and continue educating them on how to regain their full health. They are empowered to advise coups on issues such as HIV/Aids, growth monitoring, ante-natal and post-natal care and issues to do with violence against women and children.

The project has focused on the construction, renovation and equipping of health centres and rural maternity units, with the goal of wider access to emergency obstetric care and quality family planning services. Other elements include community-level information activities and improvement of contraceptive supply logistics.

As a trainer of trainers, nurse and counsellor, Phiri goes into the community to follow up cases of women who test HIV-positive during ante-natal check-ups. "I also educate women and men on how to use contraceptives. For youth, mainly girls, I advise them on how to avoid early marriage and HIV/Aids."

During one such visit, mother of three Memory Nkantu expresses her concerns: "Regardless of the illness, I am the one who works and brings food for the children. My husband does not even come home sometimes, yet I have no right to ask or protect myself when it comes to using a condom."

This is true to the counselling that women receive when they are about to get married. They are urged to look after their husbands and to be submissive – even when this infringes on their human rights.

Journalist Martin Mwamba argues the case for men to be involved in the childbirth process. "We men are usually left out, right from the ante-natal stage to the actual birth," he adds.

Certainly, women bear the burden of negligence when they lack information on safe motherhood and do not have the money to sort out their problems.

Though they have a right to adequate care, most women are denied even the right to make decisions on their own lives and in their own homes. The Bill of Rights is quite categorical that everyone has the right to be heard and to say "no" without feeling guilty. Everyone has the right to make mistakes and to say they do not understand or know and that they need more information.

Secret tests that condemn women

By Tinu Odugbemi, Nigeria

CALL it a cruel trick, but many private and government-owned hospitals in Nigeria routinely test pregnant women who attend ante-natal for HIV/Aids tests without informing them. Should they test positive, however, they can expect to be told the news without so much as an excuse-me. In many instances, those who test positive are also immediately isolated or treated with disdain. Women comprise about 60 percent of the six million Nigerians living with HIV/Aids.

Edith Ikejiofor registered at a government hospital for ante-natal care soon after she completed her one-year national youth service. She was asked to bring her husband along oas he was required to donate blood ahead of his wife's delivery. The couple and several others were tested for HIV/Aids.

She says: "There was no previous counselling, no advance warning or notice. At the end of the day, some of us were c told we were free to go. We learnt later that the others were told they tested positive for HIV."

Bidemi Akinlolu, a teacher, had been ill for a while. She suffered headaches for about four weeks. She went to the hospital managed by the corporation her technician husband worked for. As she reeled out her complaints, the doctor showed little interest, only giving her directions to the laboratory for a test. The laboratory request form was for a blood test tagged XYZ.

She recalls: "When I got to the laboratory, I was puzzled at how the attendants looked at me suspiciously. I summoned the courage to ask one of them what the test was for. She said it was for HIV. I was scared. I was afraid. Couldn't the doctor have told me and prepared me for it? I paid for the test and had it. It was negative. "

Ann Atoyebi, a matron in a government hospital in Ibadan, considers it reasonable that tests should be done for everyone who might need surgery and for pregnant women – if only to protect health workers. "Every reasonable person would want to take the test with proper counseling," she says, "pregnant women would also like to protectthe lives of the babies in their wombs."

It is possible that health workers have no idea how to counsel pregnant women before and after the test. They could also discriminate against HIV-positive people for fear of getting infected.

Florence Mhonie, contributing to a recent discussion on a global Aids stigma list service wrote: "Health workers are expected to know, feel and act in certain ways. But who has prepared them for this HIV/Aids? Many health workers have the same information the man on the street has.

The Nigerian experience is similar to that in Ghana. While the constitutions of both countries in principle guarantee and provide for fundamental human rights, including the rights to information, choice and privacy, the reality is that these rights are abused.

Justice Emile Francis Short of the Ghana Commission for Human Rights and Justice told *Africawoman* that the commission has repeatedly advocated that, "Nobody should be compelled to undergo the HIV test. Where it is obvious that it is needful for some to take the test, they should be counselled first."

Short says he is not officially aware that pregnant women in his country are compelled to undertake the test. "That is a no-no thing to do. It is a clear violation of the rights of those pregnant women."

His commission, he says, cannot act until the aggrieved people come forward to report to it. He invites people to report so there can be "test cases".

Ann Bossman, who is the deputy commissioner in charge of legal matters and investigation, adds: "There is the need to apply extreme caution in carrying out this unauthorised testing. Women have been killed and their children have been taken away from them. A woman whose child is forcibly taken from her is often traumatised and completely broken."

Paying lip service to women's health

OPINION

By Rosemarie Muganda-Onyando, Kenya

TWO meetings took place in different parts of the world last September – a low key one in Accra, Ghana, and an international one in Cancun, Mexico. The former brought together delegates from 20 countries in Africa to discuss the results of pilot interventions in a bid to reduce maternal deaths and illness to improve women's health.

The Accra meeting looked at reducing maternal deaths – a key issue at the 1994 International Conference on Population and Development (ICPD), and the Millennium Development Goals. The Cancun meeting focused on trade and the implementation of various international agreements such as that reached in Doha.

So what makes these two meetings important? Both highlighted the disadvantaged position that Africa finds itself in and the inability of African governments to respond to the needs of their people, both at the micro and macro level. The Ghana meeting highlighted the challenges facing Africa in providing basic health care services and in particular emergency obstetric care services to women. Both meetings served to highlight the gaps in understanding the problems and possible solutions to the myriad of problems facing African countries in different areas of development. Both meetings discussed and revisited agreements made at important international conventions. In both cases, progress has been unacceptably slow. Finally, as is characteristic of such meetings, big or small, there were the usual professional conference attendants who most likely had no reason being there. This is where the comparison ends, however.

While the Cancun meeting received extensive coverage, the Accra one received some coverage in the local media, which came to hear what the minister said in opening the meeting and heard the government official reiterate his government's commitment to women's health.

The organisers of the Cancun meeting probably hired a large public relations firm to market the meeting, hence the global interest and media coverage. The Accra one relied on the goodwill of the media. The attention doled out was far from representative of the importance of the meetings. Cancun represented issues of interest to powerful nations of the West and global corporations – two major groups that control the rest of world and dictate how the developing world, should live and die.

The Accra meeting, organised by the Regional Prevention of Maternal Mortality Network showed the resilience of Africans in coping with some of the severe challenges facing their communities. It highlighted the success stories of simple interventions being undertaken to save women's lives all over the continent. Stressing the motto "Thinking Big, Starting Small and Doing it Now", the meeting showed how communities were mobilising local resources and taking control of their lives. Given the magnitude of maternal mortality and morbidity in Africa, one would argue that this is a drop in the ocean. The fact is that the people who congregated in Ghana were doing something to reduce these unnecessary deaths.

Imagine, if you will, a Boeing 747 with 250 passengers crashing and killing all on board. There would be overwhelming international response, inquiries into the cause, lawsuits and measures to prevent future tragedies. What if this happened six times every day for 365 days, year in year out, with some years recording higher numbers of plane crashes?

This is simply unimaginable! But, believe it or not, an equivalent number of women die every year from pregnancy-related complications. Yet there is no outrage as one would expect from such a tragedy. The most regrettable thing about this is that most of these deaths can be prevented easily with minimal investments and political will – not the continuous affirmation of government commitment but actual allocation of resources to meet women's health needs.

In most African countries, reproductive health and family planning programmes are almost entirely donor dependent. Take the case of Kenya, where the family planning programme depends almost entirely on donors. How does one explain it when a government makes its budget and allocates little or no resources to such an important aspect of development? How does this government contribute to reducing the maternal mortality by 75 percent by 2015 as outlined in the Millennium Development Goals that have been embraced by countries, including Kenya? Even as we speak, a shortage of contraceptives is looming.

I do not know about you, but I am sick to death of hearing about what the government is committed to. I want to see some action. I would like to see the much-awaited anti-retroviral drugs programme on the ground, not in government documents.

I would like to see voluntary counselling and testing programmes running smoothly, with shortages of reagents and such basic supplies a thing of the past. I want to see relief for families severely burdened and children orphaned by Aids. I would like to see policies and legislation that protect women and other vulnerable groups. Last, but not least, I would like to see governments implementing economic programmes and spending time and resources creating jobs to improve the quality of life of its people.

Ordinary poor people struggling to raise orphans, care for sick family members amid crippling poverty are meeting their obligations as part of their contribution to dealing with this scourge.

Why can't African governments hold their end of the bargain? Governments may be doing something, but the situation demands more!

Agony that women need not suffer

By Florence Machio, Kenya

"To meet only one of these mothers is to be profoundly moved. Mourning the stillbirth of their only baby, incontinent of urine, of their offensiveness, often spurned by their husbands, homeless, unemployable except in the fields, they endure, they exist, without friends, without hope. They bear their sorrows in silent shame. Their miseries, untreated, are utterly lonely and lifelong." – Reginald and Catherine Hamlin, 1974

IN Africa culture brings out the fact that a real woman should be able to push a baby on her own. With about 60 percent of the births happening at home or under unskilled nurses, the general feeling is that it is not necessary for a woman to go to hospital to deliver.

Research carried out by Engender Health, in collaboration with the United Nations Population Fund, says culture and lack of commitment are the major reason why women continue to suffer from fistula.

If a woman has prolonged labour in some parts of Malawi, she is assumed to have had other sexual partners and must shout them out in order for the baby to be "released" through the birth canal. In some communities, the husband is also expected to name his other partners. One reason cited for women not delivering in hospitals is that it would appear that they are anticipating difficult deliveries – thus condemning themselves even before experiencing prolonged labour.

Cultural factors and delays in getting skilled assistance during labour often lead to women suffering fistula – a problem easily solved but largely ignored at policy level, and this despite the fact that it affects 50,000 to 100,000 women each year. Fistula may be a global problem but it appears to be particularly common in Africa.

It is a grim picture – the number of women with fistula is growing, there is a shortage of physicians with the skills to treat them, there are few and insufficiently equipped operating theatres and a growing dependence on visiting doctors to treat the large numbers of women awaiting surgery.

Things look different in Nigeria, though. The government has created a national task force on obstetric fistula and supported initiatives to train nurses and surgeons, gather data and rehabilitate and reintegrate fistula patients back into the community. Despite this political will, however, the situation gets ever more critical.

In parts of Nigeria, women are choosing to give birth in churches. Although the care they receive is unskilled, they believe that they will be protected from 'spiritual attacks" by evil forces or witchcraft unleashed by jealous or wicked neighbours. Female genital mutilation, a practice that is prevalent in Africa, may put women at risk for fistula if the blade reaches up in the bladder or rectum or if the ensuing scar tissue tears at childbirth.

Early marriage and pregnancy also put women at risk. In some communities, it is taboo for a girl to reach menarche in her mother's house and it becomes imperative that she is married off before the event. This increases the likelihood of a girl getting pregnant before she is physically mature and increasing her chances of getting a fistula.

All is not lost. In Zambia, two main hospitals perform fistula surgery – the University Teaching Hospital in Lusaka and Monze Mission Hospital, which is the only facility in the country that offers fistula repairs on a continuous basis and has the capacity to handle fairly complicated cases. Clients come from across the country to Monze; some are refugees from neighbouring Angola and Congo.

A single expatriate physician performs the vast majority of fistula surgeries in Monze. For several weeks each year, a visiting doctor joins him and works on the most difficult cases. Their success rate has been 90 percent in the past year, in part due to some innovative surgical techniques pioneered at Monze.

The Zambia case shows that it is possible to save women's lives with commitment at policy level and implementation in terms of the physical facilities and skilled labour.

Obstetric fistula is primarily a by-product of poor health care and transportation in much of the developing world. Beyond infrastructure lies the issue of women's powerlessness in these cultures. Part and parcel of these cultural attitudes is lack of recognition of childbirth as a medical issue. These are not easy issues to tackle, but we have to start somewhere.

Fistula was once common throughout the world but has been eradicated in Europe and North America through improved obstetric care and infrastructure. Obstetric fistula is virtually unknown in places where early marriages are discouraged, women are educated about their bodies and have access to family planning and skilled medical care is provided during childbirth.

It is agony that women need not go through.

Foreign & Commonwealth Office

BRITISH COUNCIL

Africawoman is funded by the Uk's Government's Foreign and Commonwealth Office (FCO) and by the British Council. The views expressed in Africawoman do not necessarily reflect the view or policies of FCO or of the British Council