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 pregnancy.

By Florence Machio, Kenya

TALK IS GOOD, BUT ACTION IS BETTER

FOCUS ON MATERNAL HEALTH

CONTINUED ON PAGE 2

WANTED: Motherhood is strengthened by the right to health.
It’s a dream too far for most women

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, hyper-tension 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, 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 govern-ments 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 preg-nancy she did not want.

The right to

HEALTH

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 with-draw 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, her condition wors-ened and she was wheeled into in-tensive 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 life (CEDAW Art. 16.1 Political covenant Art 17.1) “states obliged to inform, educa-tion and provide facilities that con-trIBUTE to the exercise of this right. Governments may not control or coerce reproductive choices. The choice of maternal and/or 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 humans rights to privacy. Such actions deter women from seeking health care.

Case two

Current studies estimate maternal mortality rates at 1,000 for every 100,000 live births. Maternal mor-tality 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 Nufula, 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 preg-nant. Her mother refused to sue the man because she felt that her son-in-law might divorce her elder daughter and leave her with chil-dren to take care of.

The girl’s rights: The right to freedom from torture or cruel, in-human and degrading ill treat-ment. 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 serv-ices, ensure women’s access to human and safe health services necessary to protect their lives, digni-ty, 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 now 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 threatened to kill her if she dared return home. Confused and helpless, she watch-es 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 pay-ment for 4,000 kwacha (360) 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 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 ( Ban-jul 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 pro vide protection to vulnerable women.”

We will never achieve the Mil lennium Development Goals as long as governments do not uphold these rights, which they have signed and ratified. As health min isters deliberate especially on ma-ternal health, they should not for get what have they pledged before: the right to health.

www.africawoman.net
Let women have their say

By Grace Gitahiha, Kenya

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, the 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 the Press reports indicated that abortion is widespread among Nairobi youths. According to a recent study in the city's schools, 45 percent of students said they knew of a peer who had an abortion.

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-Amisah 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.

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. Another 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 decisions on their health and sexuality must be respected. But let those who have had abortions be heard before they are condemned. Yet, the sanctity of life must be respected. But let those who have had abortions be heard before they are condemned. Women's voices must be raised and heard.

**Squick enough to save her baby’s life. Some 526 out of 100,000 Tanzanian women died every year of pregnancy-related complications. They are generally caused by poor facilities and the 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 Alliance’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 children. The alliance includes hospitals 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 disastrous effects of family planning and food supplies by ensuring the mother is safe and able to get back quickly on her feet,” said the First Lady.
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 gynecologist 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.

For the “normal” delivery package, which included three days stay in the general ward, I had to pay Sh10,000 (US$130) 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 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 was only in touch with the mothers I met at the community hall.

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.
Africa

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 protracted labour, I ended up with a still-born baby.”

It has been two years, but Sarah is still in turmoil. She lost her fourth baby at the hands of uncar ing 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 summans to pick up the new-born.

Despite 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$6) 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 Africa Woman 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 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 births, 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.

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 counterproductive 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. Attribution of civil servants has reached critical rates due to the combined effects of the accelerated retraining 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 Neube, 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 compared the use of modern methods in 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 Mpho, Lister and Spijkerhuis 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 Phathleke 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.”
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, it is in the preventable anaemia that is the second leading cause of death among pregnant women, according to Ghana's 2005 Reproductive Health and Disease Profiles and Profile 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, who believes that eating snails and okra leads to babies dribbling saliva. Others believe that babies of women who eat eggs will turn into small fingers. These 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 Tinu Odagbemi, Nigeria

FOR more than three decades, succes-
sive administrations have paid little heed to health, preferring to put their money in defence and se-
curity rather than health and edu-
cation. 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 Or-
ganisation recommends that at least 20 percent of annual budgets should be spent on health and edu-
cation, Nigeria has routinely allo-
cated a mere three to four percent of its budget to health and education. The consequence is that hospi-
tals are ill-equipped. They have be-
come 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 to 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 antenatal care, poor access to health care delivery services, malnutrition, and anaemia”, according to Richardson Ajayi, a fertility expert and gynaec-
cologist who practices in the high
brow Victoria Island in Lagos and in Port Harcourt.

Worse still, most hospitals do not have functional blood banks. Mat-
ters have been compounded by the HIV/AIDS. “Hardly is there a pri-
ivate hospital that has the capacity to manage complicated cases in pregnancy,” says Osuomade.

From number 48 in the economic ladder of development in 1979, Nigeria dropped to 176 in 2004, ac-
cording to the United Nations De-
velopment 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. Unemezie, a consult-
ant gynaecologist at the National Hospital in Abuja. “In most devel-
oped 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 him 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 are not adequately rewarded. “In case of best hospital does not even
answer telephone calls.”

“Besides,” he adds, “there have been attempts to streamline departments consid-
ered not lucrative or viable, such as ear, nose and throat.”

But then there are those who argue that government has no business running hospitals and ancillary ser-

The right to enjoy good health

By Diana Mulilo, Zambia

D
epite health reform partner-
ships with several international organisations, Zambia remains a long way from achieving any-
thing close to adequate maternal care. In collaboration with Care International, the World Health Organisation and Unicef, the government has been working on dis-
tribution of materials such as needles, sy-
ringes and disinfectant to all urban clinics as well as bed sheets.

Says Elizabeth Mundali Phiri, the regis-
tered nurse for the maternity and child health services: “We expect that we are to wash the gloves, sterilise them and dip them at home 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 pa-
tients.”

Used needles and gloves came in espe-
cially handy when examining women dur-
ing 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 pa-
tients all the way to their homes and con-
tinue educating them on how to regain their full health. They are empowered to advise on issues such as HIV/AIDS, growth monitoring, antenatal and post-

Secret tests that condemn women

By Tinu Odagbemi, Nigeria

CALL it a cruel trick, but many private and
government-owned hospitals in Nigeria rou-
tinely 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 com-
prise about 60 percent of the six million Nige-
rians living with HIV/AIDS.

A midwife was registered at a government hospital for ante-natal care soon after she completed her one-year national youth ser-
vice. She was asked to bring her husband along; she was required to donate blood ahead of his wife’s delivery. The couple and several others were told for HIV/AIDS.

She says: “There was no previous coun-
selling, no advance warning or notice. At the end of the day, some of us were told we were free to go. We learnt later that the oth-
ers were told they tested positive for HIV.”

Bidemi Akinola, a teacher, had been ill for a while. She suffered headaches for about four months. She went to the hospital man-
aged by the corporation her technician hus-
band worked for. As she revealed out her com-
plaints, the doctor showed little interest, on-
ly giving her directions to the laboratory for a test. The laboratory request form was for a blood
test tagged X25.

Her husband says: “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 pre-
pared me for it? I paid for the test and had it. It was negative.”

Ann Ayokhi, a matron in a government hospital in Badaru, 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 protect the 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 discrimi-

nate against HIV-positive people for fear of getting infected.

Journalist Martin Mwamba argues the need to develop a health plan that will be implemented judicious-
ly for the good of the citizens – from the womb to old age.

WOMEN’S VOICES
Paying lip service to women’s health

By Florence Machio, Kenya

“To meet only one of these mothers is to be profoundly moved. Mourning the stillbirth of their only baby, incompetence of urin, of their offensiveness, often spurned by their husbands, homeless, unemployed except in the fields, they endure, they exist, without friends, without hope. They hear their sorrows in silent shame. Their miseries, untreated, are utterly lonely and lifelong” – Regina 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 and 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 “re-leased” through the birth canal. In some communities, the husband is also expected to name his other partner. One reason cited for women not delivering in hospitals is that it seems that they are anticipating difficult deliveries – thus confirming themselves even before experiencing prolonged labour.

Cultural factors and delays in getting skilled assistance during labour often lead women to suffer from fistula – a problem easily solved but largely ignored at policy level, and is the outcome of the fact that it affects 50,000 to 100,000 women each year. Fistula may be a global problem but it is 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 are different in Nigeria, though.

The government has created a national task force on obstetric fistula and supported initiatives to train nurses and midwives, gather data and rehabilitate and reintegrate fistula patients back into the community. Despite this political will, however, the situation gets even 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. One result is that every 10 minutes, a woman is married off before she can experience labour. Women in such communities are also put at risk. In some, it is taboo for a girl to reach menarche in her father’s house and she becomes imperative that she is married off before the event. This increases the likelihood of a girl giving birth 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, which is the only facility in the country that offers fistula repairs on a continuous basis and has the capacity to handle emergencies, gynaecological and otherwise 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 government should ensure 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, 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 suffer through.

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, incompetence of urin, of their offensiveness, often spurned by their husbands, homeless, unemployed except in the fields, they endure, they exist, without friends, without hope. They hear their sorrows in silent shame. Their miseries, untreated, are utterly lonely and lifelong” – Regina 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 and 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 “re-leased” through the birth canal. In some communities, the husband is also expected to name his other partner. One reason cited for women not delivering in hospitals is that it seems that they are anticipating difficult deliveries – thus confirming themselves even before experiencing prolonged labour.

Cultural factors and delays in getting skilled assistance during labour often lead women to suffer from fistula – a problem easily solved but largely ignored at policy level, and is the outcome of the fact that it affects 50,000 to 100,000 women each year. Fistula may be a global problem but it is 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 are different in Nigeria, though.

The government has created a national task force on obstetric fistula and supported initiatives to train nurses and midwives, gather data and rehabilitate and reintegrate fistula patients back into the community. Despite this political will, however, the situation gets even 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. One result is that every 10 minutes, a woman is married off before she can experience labour. Women in such communities are also put at risk. In some, it is taboo for a girl to reach menarche in her father’s house and she becomes imperative that she is married off before the event. This increases the likelihood of a girl giving birth before she is physically mature and increasing her chances of getting a fistula.

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