COUNTING THE COST OF RAPE

Who will pay for the suffering of African women caught up in war and conflict?

By Betty Muriuki, Kenya

DRESSED in their traditional Maasai attire – brightly coloured wrappers and elaborate beaded jewellery – the 100 women marching down the streets of Nairobi in mid-August were bound to attract attention.

The gaiety of their dress belied the gravity of the issue to which they sought to draw attention. The women were demonstrating to demand redress for that most frightening, most dehumanising and most shattering of crimes – rape.

They were just a small number of 650 Maasai and Samburu women who claim they were raped by British soldiers on training missions in the semi-arid Laikipia district in the Rift Valley, where they have been holding military exercises for the past 50 years. The rapes have reportedly gone on since 1972.

Reports to the authorities never resulted in any arrests, and victims eventually gave up hope of ever getting justice. Until now.

Marching with the demonstrators were 40 children of mixed race ranging in age from toddlers to young adults in their early 20s – curly-haired, light-skinned evidence of the women’s ordeal. The demonstration ended at the British High Commission offices, where they sought audience with High Commissioner Edward Clay.

The women demanded justice. They sought action against the soldiers who violated them, compensation for their suffering and support for their communities.

Tackling Africa’s last taboo: talking about sex

By Eunice Mwencha

AFTER a 10-year courtship, a marriage between Ghana’s religious groups and providers of reproductive health services appears to be in the making.

The warming of relations between the two parties has seen religious bodies discuss sexuality in churches and mosques and there are strong indications that they may be amenable to promoting family planning. Although there have been some reproductive health programmes in some religious organisations, these have been limited and isolated. Indeed, discussing sexuality has generally been considered taboo in Africa.

This journey towards a middle ground began in 1992, when the department of religion in the Planned Parenthood Association of Ghana, with the support of UNICEF and the United Nations Population Fund, began a drive to address the issue of sexual and reproductive health within the context of faith communities.

In 1995, a coalition of religious groups was established under the umbrella of the Ghana Religious Council. This group, which includes the Presbyterian Church, the Church of Jesus Christ of Latter Day Saints and Al-Falah Islamic Centre, among others, is currently working with providers of reproductive health services to develop a faith-sensitive approach to reproductive health.

One of the key initiatives is the development of a guide for religious leaders on how to discuss sexuality in their places of worship. The guide, which is expected to be launched later this year, will provide a framework for religious leaders to address issues such as pre-marital sex, contraception and abortion in a way that is consistent with their faith.

Another important step was the establishment of a religious leaders’ conference on reproductive health and sexuality in 1999. This conference, which is now an annual event, brings together religious leaders from various faiths to discuss issues related to reproductive health and sexuality.

The success of these initiatives has been encouraging, and there is a growing recognition among religious leaders that discussing sexuality is not only important but also possible within the context of their faith.

With the growing awareness and understanding among religious leaders, there is hope that reproductive health and sexuality will no longer be considered taboo in Africa.

MARRIAGE SHOULD NOT BE A DEATH SENTENCE — PAGE 3

INSIDE

Having babies is risky when nurses strike – Page 6
Clinics matter, but so do women’s rights – Page 9
Women count the cost of rape

From Page 1 of the United Nations Population Fund, started extending reproductive health services to Christians and Muslims.

The new role of religious leaders in reproductive health has not gone unchallenged, however. Religious fundamentalists have sought to scuttle the new-found cooperation, arguing that family planning goes against the grain of their doctrines. Health experts and activists leading the campaign for reproductive freedom say religious fundamentalism seeks to control the sexual and reproductive lives of women. But Ghana’s religious leaders appear set to play ball with reproductive health practitioners and service providers in the country. “Religious leaders have been very supportive,” says Kudolo. “We have even started sensitising them on emergency contraceptive.”

This is a far cry from the situation in countries such as Kenya, where Catholic and Muslim clergy have publicly burnt condoms and led street protests at what they see as sufﬁcient proof that the far-off events did actually take place.

In Ghana, the British government and not individual soldiers, however, have opened up new possibilities for redress for women who have been sexually abused in situations of war and conﬂict. Should these women succeed in their suit, they will have set a precedent in getting governments to take responsibility for ensuring the security of women in conﬂict.

Thousands of women and girls in Sierra Leone are living with the scars of war after they were raped by armed forces from both sides of the conﬂict. The Human Rights Watch report We’ll Kill you if you cry: Sexual violence in the Sierra Leone conﬂict details crimes committed by soldiers of various rebel forces, government soldiers and militia and even international peacekeepers. Yet there has been no accountability for the thousands of cases of sexual violence or other human rights abuses committed during the 10-year war.

The UN has established a Special Court for Sierra Leone and a Truth and Reconciliation Commission to investigate human rights violations committed by all parties during the war. The same story is repeated in Liberia, where thousands of women and girls have been raped and killed by both rebel and government forces. A report by Amnesty International details cases of abuse by the Anti-Terrorist Unit, a special government military unit frequently accused of human rights violations, and combatants reported to belong to the opposition Liberians United for Reconciliation and Democracy.

According to Amnesty, “The scale of rape by security forces against women and girls – some as young as 12 – raises concerns that it is used as a weapon of terror in the civilian population. Women and girls have been raped – often by gangs of soldiers – after ﬂeeing the ﬁghting and being arrested at checkpoints. There is inadequate help for the rape victims, many of whom are unwilling to come forward for help. Concerned Christian Community is the only aid group that works with rape survivors in the country. Counselling is often a luxury for rape survivors in the African setting.

There may be little or no hope for restitution for the African women who are victims of rape by government or rebel militia. The standards of proof are too high in cases that happen in the home and the neighbourhood during times of peace, and it is hardly likely that the women, many of whom are gang-raped, can identify their attackers for purposes of prosecution.

The logic of the Day case can be extended to mean that governments should ultimately be held responsible for the actions of their troops and for ensuring the security of citizens. But it is very much a wait-and-see situation at present. Classifying rape as a human rights violation opens up the possibility of claiming compensation in more ways than one. The Kenyan government itself has already set a precedent by agreeing to compensation for people detained without trial by the Moi government.

Given the cost-sharing trend in hospitals, the economic dimensions of rape cannot be downplayed. Many rape survivors have often suffered horrific injuries that require long-term treatment and the cost of antiretrovirals for a full month. Women, often the poorest of the poor in African countries, may not be able to bear the burden of the cost of health care and many nurse their injuries in silence.

The South African government is probably the only one in sub-Saharan Africa to offer, since this month, ARVs to survivors of rape in sub-Saharan Africa. In Kenya, the Nairobi Women’s Hospital offers free treatment to rape patients, including ARVs, but it is a drip in the ocean in a country where at least five women are raped every day.

DIFFICULT CHOICES: Kenyan clergy will hear nothing of using condoms for protection against HIV/Aids.

But Ghana’s religious leaders appear set to play ball with reproductive health practitioners and service providers in the country. “Religious leaders have been very supportive,” says Kudolo. “We have even started sensitising them on emergency contraceptive.”

This is a far cry from the situation in countries such as Kenya, where Catholic and Muslim clergy have publicly burnt condoms and led street protests at what they consider to be a rise in liberal attitudes towards sexuality. Indeed, the conservative Catholics have vigorously fought against the introduction of sex education in schools and have lately taken the battle to literature that they consider to be pornographic. Their latest campaign is to have China Achebe’s Man of the People removed from the list of secondary school set text books, allegedly for promoting pornography.

Although Ghana’s religious leaders have accepted modern family planning methods among those people, they strongly dismiss the use of condoms as a means of protection against HIV/Aids. Besides, the Muslims have fallen short of accepting permanent family planning methods such as vasectomy.

According to Ahmed Dery of the Muslim Family and Counselling Unit, Islamic jurists object to family planning methods because it means “changing the creation of God”. They allow exemptions only when the life of a woman is at risk by further pregnancy.

It is no longer unusual for reproductive health practitioners to discuss the benefits of contraception and demonstrate family planning methods right inside church. The Planned Parenthood Association intends to extend its religious reproductive health programme to seminaries and imams.

Women’s rights advocates have accused religious fundamentalists and the clergy of pushing thousands of women towards illegal abortions and premature death.

Reproductive health remains a controversial subject in most of Africa. In January 2001, the Zambian government suspended a television advertisement campaign promoting the use of the condom as a protection against HIV/Aids, particularly among young people.

The decision followed intense pressure from religious leaders and conservative groups within the government. A spokesperson for the Catholic Bishops’ Conference said: “The adverts are offensive and in bad taste. They suggest to children and youth that sex is something nice to have, provided it is done with a condom.”

Ruth DePariva, a Brazilian family specialist working in Abidjan, Cote d’Ivoire, as a consultant for the Seventh Day Adventist Church in West Africa, says dealing with tradition and customs and the diverse teachings of other churches on family planning poses a great challenge. “We are teaching that birth increasing their families, husbands and wives should take into consideration whether God is glorified or dishonoured by bringing children into the world.”
Marriage should not be a death sentence

By Nabusayi L. Wamboka, Uganda

There is a popular saying in Uganda that you cannot refuse a man, meaning a woman can never say “no” to a man’s sexual advances. Local legislators have extended this argument to the legal realm: they say that when women say “I do” they consent to sex any time, any place and any how. Consequently, there is no such thing as marital rape.

Yet a report released in Kampala in August 2003 indicates that Uganda’s fight against HIV/AIDS is greatly undermined by its failure to protect women from domestic violence and discrimination. Revelations that marital rape has greatly contributed to HIV/AIDS in women have led to renewed calls for urgent legislation to protect married women.

The 77-page report, Just Die Quietly: Domestic Violence and Women’s Vulnerability to HIV in Uganda, documents widespread rape and brutal attacks on women by their husbands. It is the first study to establish a direct relationship between HIV/AIDS and domestic violence and is based on interviews with 56 women and 120 ethnic groups.

The survey, conducted by Kenyan researcher and fellow at the Women’s Rights Division of the Washington-based Human Rights Watch Lisa Karanja, took place from December 2002 to January 2003 in the districts of Kampala, Entebbe, Igauna, Lower, Pallisa and Toro. Karanja also interviewed individual men and women from over 10 ethnic groups.

Harriet Abwoli, who is HIV-positive and has been treated at Mulago Hospital, told Human Rights Watch how her husband used to force her into sex. “He would beat and slap me when I refused. I never used a condom with him. When I got pregnant, I went for a medical check-up. When I gave birth, the child passed away, they told me I was HIV-positive. I cried. The doctor told me: ‘wipe your tears, the world is sick’.”

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According to Karanja, many women became vulnerable to infection as a result of domestic violence in complex ways: “Most women saw domestic violence as an inescapable marriage and sex with their husbands as a marital obligation. Traditional attitudes that designate women as the physical property of their husbands deprived them of any authority over marital sexual relations.”

Cultural practices such as bride-price underscored men’s entitlement to dictate the terms for sex and to use force. Violence or the threat of it thus deprived women of their bodily integrity and compromised their ability to negotiate safe sex or even to determine the number and spacing of their own children.

Says the report: “In many cases, abandonment or eviction from home held even greater terror for those economically dependent women who, confronted by a hostile social environment, ignored their husbands’ adultery and acquiesced to their husbands’ demands for unprotected sex.”

Hadija Namaganda’s HIV-positive husband raped and beat her viciously, at one point biting off her ear. As he lay dying, too weak to beat her, he ordered his younger brother to continue doing so.

“He used to force me to have sex even after he became sick. He would accuse me of having other men. He said he would cut me and throw me out. I didn’t know about condoms,” Namaganda reported.

“Being married should not be a death sentence for Ugandan women. Women should not give up their rights to physical security and sexual autonomy just because they get married,” says LaShawn Jefferson, the executive director of the Women’s Rights Division of Human Rights Watch. “Any success Uganda has experienced in its fight against HIV/AIDS will be shortlived if it does not address this urgent problem.”

Interventions focusing on fidelity, abstinence and condom use tend to minimise the complex causes of violence and incorrectly assume that women have equal decision-making power and status in the family. “Now we have a report in place with women’s voices talking about their experiences,” says Karanja. “It is incorrect to assume that women have access to decision-making in a home. Women are raped in their marriages and can’t protect themselves or even access information about protection.”

The coordinator of the Uganda Women’s Network, Jackline Asimwe-Mwesige, says the report confirms the need to hasten reforms to discriminatory laws. Women find it difficult to adopt the safe sex strategy since very few of them can actually negotiate it in relationships.

“The pace of reform is so slow and does not take into account the number of women dying daily from domestic violence,” she adds.

Human Rights Watch has urged the Ugandan government to enact domestic violence laws and make women’s health, physical integrity and equal rights in marriage a central focus of Aids programming. Local women’s rights activists have had little luck asking the government to pass laws addressing domestic relations, rape and battery of women by their intimate partners.

According to Asimwe-Mwesige, the problem with marital rape is that even women view it as the ordinary wear and tear of marriage.

This view is supported by the evidence of Masturah Tillegiya, a 46-year-old living with HIV/AIDS: “He never forced me into sex. He would beat me for other things but not sex. There were times I had sex with him when I didn’t want to. I would just do it. What could I do? In our tradition, the men don’t physically force you – but then they don’t need to.”

HIV/AIDS donor assistance to Uganda continues to be considerable. Uganda is one of 14 African countries slated to receive five years of Aids programme support from the United States. In February, the Global Fund to Fight AIDS, Tuberculosis and Malaria signed a grant worth over US$60 million to support Uganda’s ongoing fight against HIV/AIDS.

Human Rights Watch has urged the donors to ensure that Aids prevention programmes specifically target domestic violence, including sexual violence in marriage, as core components of their strategies.
Pat on the back is nice, but safety comes first

There is an African proverb that says the sun should set twice on a labouring woman. Yet this is common in the health care systems on the continent. Thousands of women die needlessly in childbirth – victims of anything from poor prenatal care to inadequately equipped hospitals. Yet even the most basic of facilities required for emergency services. Those who survive these rigours may get obstetric fistulae – one of the most unsociable conditions, yet easily repaired in surgery.

In Africa, however, motherhood comes at the end of a long chain of hardships. The poorest among the women, whose reproductive health is often compromised by cultural and traditional practices that subject them to genital mutilation, early marriage and poor malnutrition. Violence against women, both physical and sexual, compound their inability to control their own sexuality; they remain powerless to negotiate safe sex even in these days of HIV/AIDS.

In this special edition, we approach reproductive health issues from a human rights perspective first and foremost. African women have the right to comprehensive reproductive health care, including family planning, education, adequate nutrition and basic health care services. Yet you will find evidence in these pages that maternal and child health are almost always treated with casual negligence.

The strong men in charge of our governments have their priorities sorted out: they would rather spend money on the military – to ensure their stranglehold on power, more often than not – rather than invest in getting the next generation off to the best possible start in life. And so maternity hospitals across the continent are so overcrowded that several sets of new-borns and their mothers must share beds and mattresses and even have to bring their own linen and medical supplies. Nevertheless, public and private schools and the health systems are designed to train and not of services in rural areas. The 1994 International Conference on Population and Development defined reproductive health as “complete physical, mental and social well-being and not merely the absence of diseases or infertility in all matters relating to the reproductive system and to its functions”.

It implies that we must be able to have a “satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.”

Broadly speaking, this could be interpreted to mean that everyone, including young people, are entitled to accurate and unbiased sex education, reproductive health services, facilities and personnel in a friendly environment and a government back-up policy safeguarding their reproductive health interests at all times.

Although there are regulations supporting safe abortion and management of complications arising from abortions, there are no laws regulating the provision of abortion in Nigeria. Neither is there any law backing the provision of such services. Although the government is agreeable to abortion in order to save a woman’s life or to preserve her physical and mental health, this policy does not cover rape and incest.

More than 600,000 unsafe abortions are carried out in Nigeria annually and it is responsible for more than half of all pregnancy-related deaths and illness.

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Although there are many youth-friendly centres and clinics set up by non-governmental organisations, there seems to be little political will to deal with youth sexuality decisively. And most of these facilities are in urban centres and environments that only those with formal education can go to.

Those with little or no education consider them too “high-brow” for their comfort. Girls who work in homes or as apprentices do not often get to attend such clinics for counselling or assistance. For such centres to be relevant and accessible, government intervention will be necessary.

To the credit of the establishment, the family life education syllabus is to be rolled out in Lagos, Plateau, Cross River and Alexu-Born in the academic year starting at the end of September. In Lagos, Action Health Incorporated and the Ford Foundation have trained 200 teachers on the syllabus. One only hopes that this project will be expanded soon and that the national assembly will come up with a categorical policy statement encouraging girls who get pregnant in school to return to class. As things stand, the girls are driven out of school while their partners – who could well be teachers or senior students – continue with their lives as if nothing happened.
“Each sub-county should have a health centre where there is a medical doctor, a theatre and a place where blood transfusion can be done”

Why should God love Africans more than anyone else?

By Edith Kimuli

Not a single day passes without the news, usually on radio, that someone has lost their life in the “women’s battle”. Sometimes the “news” is so frequent that it may hit you even though you have had the radio on for only an hour. And, of course, there are those who do not have the money to make the announcement. The messages of condolence follow. People will say: “God takes those He loves. We shall find her in the next world, which is better.” Newborns who lose their mothers during childbirth often die too, even when they are born healthy. So do some as old as two. Ugandan President Yoweri Museveni has been known to ask why God should love Africans more than Europeans and Americans. Is this to suggest that expectant women in Europe and America are more of sinners than those from the developing nations and, therefore, rarely die in childbirth?

Grim figures

According to the Uganda Demographic Survey 2001, 505 out of every 100,000 women die giving birth every year. In countries such as Sweden, however, it is the expectation that every woman who falls pregnant will remain healthy and deliver her baby safely. But there is a world of difference between living conditions in the Scandinavian country and Uganda.

The Ugandan woman in obstructed labour is likely to find herself in the care of a village birth attendant without the knowledge or skill to handle the emergency. She will eventually refer the woman to the nearest hospital, which is about 300 kilometres away. On arrival, she will find that there are no emergency facilities for a caesarian operation. Off she will go again, this time heading for the capital, Kampala. By the time she reaches the city’s Nsambya Hospital, she and her baby will have died. Little wonder that childbirth here is called the “women’s battle”.

There are those who argue that formal education would go a long way to help women recognize problems and get themselves off to hospital at the first sign of trouble. But education is no defence when there is no infrastructure to support quick transfer to hospital. Only 48 percent of Ugandan women deliver in hospitals and over 43 percent of women are illiterate.

Most of Uganda’s maternal deaths can be prevented, according to Olive Sentumbwe-Mugisha of the local World Health Organisation office. In the first place, she says, all births should be handled by trained medical personnel and not traditional birth attendants, who cannot handle complications. “The placenta may be partly retained, for example, and a midwife or doctor can use her or his hands to peel it off the uterus,” she says, “which a traditional birth attendant would not be able to do.”

The major causes of maternal mortality in Uganda are bleeding during pregnancy, delivery and after, unsafe abortions, infections, obstructed labour and high blood pressure. There are also indirect causes such as HIV/AIDS and malaria. Having too many children too close is also a high risk factor alongside poverty, ignorance and poor nutrition.

Should be priority

According to Henry Kakande, a senior consultant gynaecologist and obstetrician, says Uganda has excellent policies oncurbing maternal deaths. The problem is implementation. “The policies need to be translated into reality,” he says. If he had his way, maternal health would be a priority in the national budget and would be approached from a multi-sectoral perspective.

His wish list: “We need to have health facilities under skilled personnel, who should have regular supervision. There should be good working relationships between the midwife and traditional birth attendant or the next referral stage and vice versa. A midwife must be in a position to call a health centre or a hospital to inform them that she is referring a mother to them so that they can prepare for her.”

“There should also be ambulances so that a bleeding woman is not transported on a pick-up, otherwise she might reach the hospital too late. There should be good working relations between the private and public sectors since most midwives are private practitioners. The facilities should be well equipped with gloves, among other supplies. You may get a facility with the personnel, but small things like gloves are missing.”

Pay policies

Government recruitment and pay policies for medical personnel have also played a part in the maternal mortality crisis. Some districts have only three midwives and there is no incentive for young doctors to take up jobs in rural areas. Says Kakande: “When we came out of university, we were deployed and the ministry determined our package. In some places, nepotism has taken over and they do not recruit people with right qualifications but those they ‘know’. Each sub-county should have a health centre where there is a medical doctor, a theatre and a place where blood transfusion can be done.”

But Kakande believes that reducing maternal deaths is not just about medical personnel. There may be problems there, but solving them is the easy part. In the end, it will take the entire community – especially men – to make the social changes that will support expectant women before, during and after birth.
Having babies is a risky business when nurses strike

By Rebecca Kiwe

IT HAS become an annual ritual for Ghanaian nurses to go on strike, often demanding extra duty allowances or salary rises. Not this time. Nurses at the maternity unit of the Maamobi Polyclinic in Accra had a simple demand: they would not return to work until the unit was given an ambulance.

Besides the lack of transport, the clinic has to transfer complicated cases to hospital in a pick-up vehicle or by taxi. “The lives of our patients, including the unborn babies, are constantly at risk,” said the protesting nurses. “We will only resume work when the clinic is provided with an ambulance.”

The nurses got their way and the maternity unit is back in business, but the problem of poorly equipped health facilities has not gone away. Most clinics and hospitals in Ghana lack basic facilities and equipment ranging from beds to medical supplies required to manage obstetric complications. Unlike the Maamobi nurses, most officials are reluctant to speak openly about their problems for fear that they will give their hospitals a bad name.

Share mattresses

At Korle Bu Teaching Hospital in Accra, four to six mothers and their babies share mattresses on the floor in wards and in the corridors. Some of the mothers have been de-tained because they cannot pay their bills. The maternity block is so crowded that it is difficult to move around the building with ease. The toilets are pathetic and the stress on the facilities is beyond description. The “cash and carry” system practised in the country’s hospitals means women must buy all the drugs and other supplies required for safe delivery.

Ghana’s health facilities are ill prepared to manage maternity crises. Even though it is implement-

GHANA

ing the Safe Motherhood Programme — a global initiative aimed at making childbirth safe, thereby contributing to improving child health — maternal mortality remains high. 950 women died last year of complications arising from pregnancy and childbirth. The statistics could be higher given that these are just the reported cases.

Poverty, lack of information and prevailing traditional beliefs and practices have also contributed to maternal deaths. The Safe Motherhood Programme, started in 1987 in 12 districts, has spread country-wide. Its key objectives are to raise awareness about life threatening conditions and educate women, their partners and families on where and when to seek help in the event of complications. The strategy is not always implemented effectively, however.

Elma Osaneba Donkor, a trader in her late thirties, lost her baby last year at Korle Bu Teaching Hospital. She recalls: “I had to go through induced labour I was taken to the ward and I alerted the nurses when the baby was coming, but they ignored me. By the time they were ready to pay me any attention, it was too late. They took the baby somewhere and came back to tell me it was dead.”

Ignored her pleas

Martha Yetche also claims that nurses ignored her pleas for help, resulting in her losing one of her twins. “It was by divine interven-
tion that a doctor came to my aid,” she says. “I would have lost my other child.”

Even when quality health services are available, there are many social, cultural and economic factors that stop women taking advantage of them. Consequently, women do not attend antenatal clinics at all or report late for care — often as living on the doorstep of maternity clinics when already in advanced labour.

Because of the cultural milieu, some women must seek permission from their husbands before they can go to hospital; in some parts of the country, pregnant women are forbidden from eating eggs, snails and other foods rich in protein. In Tanga, in neighboring Nigeria, women must get their husbands’ permission even to seek life saving care. Should the husband be away from home, other family members would be reluctant to act on no matter how pressing the need.

In Benin, the government went as far as to impose fines in order to encourage women to deliver in hospitals. Still, many women continued to deliver at home supposedly because of the honour brought to their families if they should be able to endure difficult births without complaint.

Tele-health set to boost maternal care

By Brenda Zulu

DELIVERING care to pregnant women and newborns in Lusaka is on the verge of becoming easier and more efficient, thanks to the advent of Tele-health — which is simply the use of information technology to deliver health services and information from one location to another.

Collins Chinyama, an information technologist at the Central Board of Health, describes the concept of tele-medicine as a multimedia system — using voice, video and data — to deliver medical services remotely. “People may phone their doctors and prescriptions are done by telephone or fax,” he says.

But the new technology overcomes the limitations of the telephone and fax to ensure that patients are diagnosed from remote locations. Tele-medicine has its plus and negative sides: though it meets government needs for bringing health care as close to the family as possible, the need for medical workers will also diminish. But it has the potential to bridge the gaps created by Africa’s brain drain as health professionals seek greener pastures in developed nations.

There is need for tele-health in Africa because it has very few doctors and there are increasing health needs and staff constraints in most hospitals,” says Chinyama.

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Tele-health works by installing
The disabled have rights, too

By Barbara Kalunga

The sight of disabled women begging in the streets accompanied by several children under five is common in Zambia. These women are among the poorest in a country where poverty stands at about 75 percent. They are in double jeopardy because they are also among the most poorly educated. Why they should have so many children when free family planning services are available in all government hospitals is the key issue.

Francisca Miyenga, executive director of the Zambia National Association for Women with Disabilities, argues that nurses often treat disabled women so badly that they are discouraged from visiting health centres.

In Zambia, it is not exactly uncommon to have a child with a physical or mental impairment. Patricia Makweda, a 43-year-old worker in Bulawayo, Zimbabwe’s second city, has a harrowing report on her birth experience. Because she is physically disabled – Makweda lost an arm during the liberation struggle and almost half her body is paralysed – she was unable to stand or climb on to the hospital bed on her own. She gave birth on her wheelchair, with disastrous consequences for her baby:

“I went into labour in the early hours of April 13, 1987. This was my first child and I was so delighted at the thought of having him. It was this joy within me that kept me going despite the severe contractions and cramps. I really could not wait to have this baby. When I got to hospital, however, my happiness turned into bitterness as I felt mistreatment with the reality of harsh treatment, especially from the nursing staff. I had heard my friends say that disabled women were not treated like human beings, especially when they are pregnant. I saw it all that day. Despite the pain, I was shoved into a corner of the room, where I was made to sit on a wheelchair without any medical attention.

They kept insulting me, calling me all kinds of names. Some just stood there looking at me, as if it was strange that I was pregnant. I sat there for hours on end, writhing in pain. The baby started coming out while I was still seated. The nurses came when the baby was almost out. This is how my baby also became a handicapped person.

His legs never developed well. Whenever I look at him today, my eyes drown in tears. My son would have been a fit and stronger teenager had these nurses given him proper care.”

Anne Malinga, a local activist, says there is not enough awareness of disability issues, leading to negative attitudes in the community and in government. “We have taken it upon ourselves to form a lobby group, Zambian Women with Disability in Development, which is strong voice to air our grievances,” she told Africawoman.

Members of the group are particularly concerned that their needs are not taken into account when it comes to HIV/AIDS awareness programmes. Advertisements, for example, do not cater for the needs of the blind and the deaf. Signing is not recognised formally as a language. “As a result, they bear a lot of children because they know little about contraceptives,” says Malinga. “They won’t go to clinics for fear of negative attitudes. They are not able to make informed choices.”

Shunned by public clinics, these women are in a difficult position because they cannot afford private medical care. Zimbabwe has a Disability Act but activists say some parts should be repealed and others strengthened.

Malinga’s organisation wants a disability desk in the president’s office - just as is the case in South Africa, Malawi and Namibia. “This set-up works very well, going by the experience in the countries,” she says. “If this succeeds, it will go a long way in pushing the to the fore issues affecting disabled people.”

The International Labour Organisation acknowledges that in most developing countries, decisions for girls and women with disability are usually made for them. They are rarely consulted and almost never have an opportunity to make decisions for themselves. “As many as four households in developing countries has a family member with a physical or mental impairment and half of those are female... there is, therefore, a need to integrate disabled women into mainstream gender activities.”
UGANDA

Get a condom and save your life

By Elizabeth Karno

The women are almost unanimous in their views of the female condom. It is ugly, it is noisy and it is expensive. It has been three years since the female condom was introduced into the Ugandan market, chiefly as a preventive measure against HIV/AIDS and other sexually transmitted infections, but few local women realise that it offers the safest sex yet.

“It is not that we are not marketing or promoting the female condom,” says Janet Nassali, marketing manager at MSI-Uganda. “We are just looking for the best ways in which to ensure that communities, and not only women, accept the importance of the female condom.

In 2002, MSI-Uganda – which promotes Life Guard condoms and the Femidom – sold 17 million male condoms and demand exceeded supply at the project’s 14,000 retail outlets across the country, including grocery stalls and bars. In comparison, only 63,565 female condoms were sold.

Two obstacles

The female condom faces two major obstacles: the reaction of the women’s regular partners and attitude to the device and a widespread belief that only men have the right to use condoms since they would traditionally be the ones to initiate sex.

“How can a woman ask me?” asks Porter Kafero, a casual worker in Kampala. “If she is the one wearing the condom, it would, of course, mean that she asked me to bed!” Ugandan women are still subordinate to men in many aspects of their lives. Sexual inequality make them highly vulnerable to sexually transmitted diseases and unwanted pregnancies.

Justine Nanono, a young professional, has been using the female condom for the past two years and finds it a liberating experience.

“My partner does not hold the key to our sexual life any more; I make choices too,” she says. “We need to overcome the stereotypes, simplifications and strong opinions that threaten the acceptance of this method and efforts to encourage women to adopt it.

Though the aesthetics of the female condom are an issue, the major obstacle to its use is the cost. Male condoms cost as little as Uganda Sh100, the female condom goes for Sh300 (US$0.15). For poor women, especially those in rural areas, this money is enough to buy a day’s meal for the family.

According to Nassali, these rates are pretty low by international standards since Uganda is a beneficiary of a World Bank project to subsidise the cost of buying condoms. Clearly this is not enough to make the female condom widely available to women.

Relatively new on the market, the female condom is a thin, loose-fitting and flexible polyurethane plastic pouch that is designed to line the vaginal walls. It provides a protective sheath that prevents sperm from entering the vagina. There are two flexible rings at each end: the inner ring at the closed end allows the condom to be inserted into the vagina and the outer ring in place over the cervix. The second ring at the open end of the condom remains outside the vagina and covers and protects the external genitals.

No serious side effects or allergies have been reported and the female condom can be used with any type of lubricant, spermicidal cream or foam.

MALAWI

Rape sanctioned by parents

By Caroline Somanje

The 15-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 gagged her when she tried to shout.

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 as her relations bid farewell to the smiling businessman. He has just sealed a deal making the child his wife.

Some people would call it “marital obligations”. He is too strong, however, and soon she is pinned to the ground. They gagged her when she tried to shout.

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Clinics matter, but so do women’s rights

By Ruth Omukhango

THE scene is Nairobi’s Casino Clinic for Sexually Transmitted Diseases. Inside the dimly lit room, 10 women and one man sat pensively on a wooden bench. They look anxiously at each other, the silence in the room so thick you could cut it with a knife. Casino clinic, as it is popularly known, is tucked into a hidden corner of the city centre. The stigma attached to the clinic is strong and even those who come here on different medical risk being labelled as sufferers of sexually transmitted diseases. More women than men are affected by this stigma and men who decide to seek treatment here only make an appearance when matters are too serious to be ignored.

At the Kibera Community Self Help Programme, Nurse Pamela Onahru looks at her patient and shakes her head. “What is the matter?” she asks Mary Achieng, one of her regulars. “The same problem has come back,” replies Achieng. She first showed up at the clinic about four months ago with a chronic pain in the lower abdomen. She was diagnosed with gonorrhoea, a disease that causes pelvic inflammatory disease if not treated with antibiotics. She was advised to return within three months. But when she came back, she was told she was at risk of developing a serious complication.

“The danger is that the same men either re-infect their wives or fresh female partners,” says Onahru. “This is a problem of the die hard until we resolve it.”

Both partners present

Medical staff who work in such clinics say that men flout the government’s policy that requires that both partners be present during treatment. The symptoms of infection are often more subtle in women, leading to delays in seeking help and serious complications. Worse still, women who have been treated often risk being re-infected when they are coerced into having unprotected sex with their partners.

Sexually transmitted diseases are common at Onduru’s clinic. On an average, she receives six patients and only one is likely to be a man. Three of the five women examined are usually repeat patients. Men usually show up when the situation is desperate and, even then, it is only the poor who turn up here.

According to a health research unit report in Ghana’s ministry of health, anecdotal evidence suggests that women seek help in the public health care system while the men tend to consult private doctors or go directly to pharmacies. “It is not easy to get a man who lives within the Kibera community coming for treatment at this clinic,” says Onahru.

Neglected STDs

Despite tremendous progress brought about by investment in maternity care, family planning, child immunisation and better nutrition, according to research done in the United States, issues to do with sexually transmitted diseases have been neglected in the global fight against infectious diseases. In Kenya, management of sexually transmitted diseases centres on the four Cs: counselling, complying with doctor’s instructions, using condoms and contact treatment.

Whereas sexually transmitted diseases are known to facilitate HIV infection, the government has concentrated on the latter, with little said of sexually transmitted diseases. “We have many cases where those who come for treatment for STDs end up testing HIV positive,” says Grace Mutumbi, a health officer with International Medical Corps who works in Kibera.

Population Reports indicates that diseases such as chlamydia, gonorrhoea, syphilis and trichomoniasis may increase the risk of HIV transmission two to nine times in Kenya, as in other African countries, the need to curb the spread of sexually transmitted diseases has been amply recognised in a flurry of government documents in the past two decades. Little progress has been made in breaking through the social and cultural structures that surround the diseases, however.

All it takes is a little understanding

By Grace Gitahiwa, Kenya

My friend called me recently, frantic and depressed. She needed to talk. I imagined she was tired and understood the fear that had sent her to my home. She had been hosting relatives who had travelled from upcountry to bury her husband’s uncle. She sounded so low. “The clan has decided that I must leave since I am infertile and cannot give them a child.”

That year ended, and the fourth and fifth. Nothing still. She started the hospital round and her husband was with her every step. With the same results: she was at risk. This time, the doctor told her to convince her husband to go for tests. It took a while, but he finally gathered the courage. He turned out that he had a “low sperm count.” He was the cause of the “problem.” He would go no further; however.

In most African communities, it is usually the wife who is blamed when a couple has no children. Speculation is rife. During her younger days, it is whispered wide and far. She had too many abortions and messed herself up. It is, therefore, her fault and the man should not be made to suffer. He must take another wife who will give him the children to carry on the family name.

An estimated one in 10 couples around the world has difficulty conceiving, according to an article published in Sexual Health 2002 entitled “Culture, Infertility and Gender – Vignettes from South Asia and North Africa”. Although a growing body of social science and biomedical evidence suggests that nearly 40 to 50 percent of infertility is attributed to problems suffered by men, women are blamed. Consequently, they face guilt, anxiety, exposure to dangerous medical and ethno-medical interventions, stigma and the threat of divorce or abandonment.

It is a myth that infertility is a sexual problem. Most couples with impaired infertility do not have any problem having intercourse. It is also a myth that infertility is a psychological problem. It is actually a physical problem in 80 to 90 percent of the cases. Yet another myth is that adopting improves a couple’s chances of conceiving. Unfortunately, no improvement in fertility has been found in couples that have adopted.

Mary Thuku, a nurse and member of the Kenya Medical Women’s Association, says infertility means that a woman has had regular sex for a year or more without birth control and has not fallen pregnant. If the husband has a normal sperm count, this qualifies as female infertility. Female infertility also means being unable to carry a pregnancy long enough for the baby to survive after birth.

Infertility is not the same as being sterile, she points out. Sterility is when one cannot get pregnant and the cause cannot be fixed. It is important to distinguish between myths and causes of infertility, says Lydia Muli, a gynaecologist in Nairobi. There are many causes of infertility. These causes are complex, inter-related and have different effects on female and male fertility. Women are frequently blamed. Consequently, they face guilt, anxiety, exposure to dangerous medical and ethno-medical interventions, stigma and the threat of divorce or abandonment.

Couples should understand the risks and benefits of the different fertility treatments, discuss and make treatment decisions openly, Muli reckons. They should also consider adoption and this should not be construed as “unAfrican.” It is also important to take dietary measures. Maintaining an ideal body weight may be helpful since overweight or under-weight can both be associated with reduced fertility. Couples may feel scared, confused and angry because they have fertility problems.

One partner may blame the other, particularly the woman. These feelings are common. Couples should talk about them and understand the situation instead of blaming the woman.
**GHANA**

By Esther Wamala

**BRING out the champagne: virginity is back in fashion, if the appropriately named Dzreke Virgins Ambassador Foundation is to be believed. Dzreke means 'the battle is over' in the Ewe language spoken in the Volta region of Ghana.**

Since it was established in 2001, Dzreke has had one simple message to impart: abstain from premarital sex if you are to avoid HIV/Aids. Kweisi Fonu, executive director of the foundation, says the virgins clubs were formed to counter the promotion of condoms at the expense of abstinence among young people. Abstinence, he believes, is the best method of combating HIV/AIDS, he says, while the condom campaign makes young people promiscuous.

When he initially came up with the idea of a virgins club, Fonu recalls, people made fun of him and said it was not feasible. “But research we conducted had 54 percent of young people opting for temporary condom use,” he says. “But people made fun of him and said it was not feasible. ‘But research we conducted had 54 percent of young people opting for temporary condom use,” he says. “But the programme is currently being implemented in 42 hospitals in 28 districts countrywide,” says one of the key implementers, Edwin Rukwenda. “Clients receiving the services have increased from 22,316 in 2000 to 76,197 in 2002.”

Rukwenda adds: “We doctors recommend milk formula such as SMA since it is rich in iron, vitamins and calcium and is easy to digest for infants. In the absence of SMA, cow milk is recommended.”

**UGANDA**

By Byamugisha

**I met some counsellors who told me about the Mother to Child HIV/AIDS prevention programme,” she says.**

It was here that she learnt of nevirapine and how it was administered. She was also taught how to nurse a baby and feed it since HIV-positive mothers are advised not to breastfeed.

“When the labour pains began, my doctor told me to take the nevirapine three hours before undergoing a caesarean section. Rukwenda also received a dose immediately after birth.”

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**GHANA**

By Esther Wamala

**HATING lost her first husband to HIV/AIDS in 1992, Pamela Byamugisha had lost all hope of ever getting married again or even having a child. After all, she too was HIV-positive, she reasoned.**

Byamugisha, who went on to marry the first African priest to publicly declare that he was HIV-positive 13 years ago, has a big smile on her face today. Following a course of treatment with nevirapine at Kampala’s Mulago Hospital, she and her husband Gideon are now the proud parents of a bouncing girl, named Elizabeth Rukundo. Rukundo means “love” in Kinyankole.

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**VIRGIN AND PROUD OF IT: Abstinence is fast gaining popularity among African youth, especially girls.**

By Esther Wamala

**The virgins club concept is not new. In Zimbabwe, Chief Nahoth Makoni has revived a traditional festival aimed at celebrating female virginity. Already, 5,000 girls have received virginity certificates. Critics worry, however, that men will flock the festival in search of virgin brides believed locally to have the cure for HIV/AIDS. There are also worries that no security arrangements have been made to protect the girls from rape or to prevent them from being deflowered as those checkers inserted their fingers into their vaginas. The school owner had also not sought the consent of the parents. The Lagos House of Assembly set up a committee to investigate the matter, indicted the doctor who performed the tests and recommended that the Nigeria Medical Association take action against him.**

**Abstinence is gaining credence, nevertheless, and at least one-third of the US government’s $83 billion grand to combat Aids in Africa is expected to support abstinence-before-marriage programmes. Population Action International has expressed reservations about this, however, saying: “With 14,000 people becoming infected each day, this simply falls short of arming those most vulnerable with every possible resource to protect themselves from HIV.”**

**SPECIAL ISSUE – REPRODUCTIVE HEALTH IS A HUMAN RIGHT**

Membership is open to females who are proud to be identified as either primary virgins, who are widows and widowers who act as a way to avoid infection. Abstinence is fast gaining popularity among African youth, especially girls.

**Controversy**

The virginity campaign has been beset with controversy, however. In June this year, the owner of Beacon Secondary School, Lagos, Nigeria, decided to form a virgins club in her school. She ordered tests carried out, leading to a hue and cry from parents and guardians who protested that their children had been “deflowered” as those checking them inserted their fingers into their vaginas. The school owner had also not sought the consent of the parents. The Lagos House of Assembly set up a committee to investigate the matter, indicted the doctor who performed the tests and recommended that the Nigeria Medical Association take action against him.

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WISDOM AND EXPERIENCE: Grandmothers have traditionally had a major influence on maternal and child health in Africa.

**POINT OF VIEW**

*In praise of grandmothers*

By Diana Mulilo, Zambia

Grandmothers have traditionally had a major influence on maternal and child health in Africa. But the degree to which they succeed is determined not only by the women themselves but also to a great extent by the knowledge, attitudes, roles and resources of other members of the household.

In an attempt to capitalise on the respect accorded grandmothers, the Alangizi Association has come up with a programme to update the skills of grandmothers who must take care of their granddaughters and their newborns. Grandmothers relate freely with their granddaughters and their husbands, giving them plenty of leverage when it comes to negotiating issues to do with reproductive health.

“We teach grandmothers the importance of family planning to prevent pregnancy too soon after giving birth and how to prepare nutritious food for their granddaughters,” says Alangizi chairperson Iress Phiri.

The revival of the grandmother's role is based on an “assets” approach in which the focus is on strengthening the grandmother's knowledge as a community resource. The emphasis is on building grandmother networks — in recognition of the fact that they are already involved in giving advice on nutrition for new mothers and their babies — and on community leadership.

There is plenty of added value to having a grandmother close at hand upon childbirth. When the granddaughter has to return to work, she knows her baby is safe at home in the hands of grandma.

“I have always lived with my grandmother from the time I have a baby to when the child is 18 months old. I have full confidence in my grandmother's care giving skills and her vast experience. Who better than grandma to hold your hand until you are strong enough to do your own work?”

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*Take a fresh look at life in Africa*

AfricaWoman.net
**Where are our men when we need them?**

*By Piliiremi Sena-Banda*

**MALAWI**

Kamwendo’s labour pains started at dawn. Her husband rushed her to Malawi’s main referral hospital Queen Elizabeth Central, and left her in the hands of the nurse on duty. Since it was a Saturday, her husband did not have to go to work. To pass the time, he called up his friends and treated them to beer at their normal haunt. In fact, he was seen coming home rolling drunk. In fact, he only got to see the latest entrant into the family the following day.

“I was all alone when I gave birth,” says Kamwendo. “It was as if I was a single mother. I was so shocked. One and a half hours after I was rushed to Malawi’s main referral hospital, Queen Elizabeth Central, the doctor asked that the baby be brought in to spend the night. The mother was left with the baby in the incubator while the doctor was busy delivering another baby. The mother was so shocked that she did not even know her baby was breathing. She also had to go through nine more hours of labour. The baby was still not out. I had not that much, and I was so tired. The health staff did not even bother to give me a cold compress. They just kept me in that condition to give birth to another baby.”

Most African men play little role in the intervenion period between their partners’ pregnancy and childbirth. Reproductive health is seen purely as a women’s affair. Not even the risks involved are enough to get the men interested in a situation that they contributed to.

“The Population Reference Bureau’s Reproductive Health Outlook report indicates that men’s involvement has a positive impact on women’s and children’s health. In the Gender Programme Manager in Ghana Nicholas Sangogye says the failure to involve men has weakened the impact of reproductive health programmes on the continent. A study in the United States, he adds, has shown that men who are sensitised about reproductive health issues are more likely to support their partners.”

“Chaos is the essence of reproductive healthreligion and HIV/AIDS, Fred Sai, says in his book: Adam and Eve and the Serpent” that men need to be counselled about taking on more active roles in the family. Men, he says, are now in a position to have a significant impact on reducing women’s double burden of productive and reproductive work, especially since their traditional role as breadwinner is disappearing due to global changes.”

Says the professor: “Women do not need men’s sympathy as much as their empathy and cooperation. At a very basic level, we need to promote the understanding that, just as men and women are both active in the creation of children, so they should both be active in caring for those children.”

**Men’s network**

A group of concerned men from Malawi, Namibia, Botswana, South Africa and Kenya have lately formed a network. Men Against Gender-based Violence, which also advocates more active involvement of their fellow men in issues to do with reproductive health.

Malawi’s representative in the network, lawyer Chimwemwe Kadua, says the group has acknowledged that men have been the cause of disparities that have led to poor reproductive health standards in women.

The network of lawyers, journalists, human rights activists and the clergy will in November launch a crusade to champion the cause. Timothy Bonyonga, coordinator of community outreach for Malawi’s leading family planning non-governmental organisation, Banja la Mtsogo, also says his organisation visits workplaces and communities to inform men about the health standards in reproductive health.

Bonyonga believes that men’s attitudes are “slowly changing” and a good number are now accompanying their wives to antenatal clinics. He is concerned, though, that men’s network make no provision for men who want to be with their partners during delivery. Only three private hospitals allow men into the labour ward.” It is impossible for a man to be with his wife in a labour ward at a government hospital since they use communal wards, and this is frustrating for our men,” says Bonyonga.

Deputy Minister for Health Elizabeth Lamba shares this concern: “There are 15 women giving birth at the same time in one ward, and there’s no way the other women who are not connected to the man would feel comfortable with a stranger in their midst.”

Under the Safe Motherhood Project, the government will by the end of 2003 start reconstructing labour wards to allow men to accompany their partners to the delivery rooms. Bonyonga is cautiously optimistic: “Maybe in the next 10 years or so we will have managed to convince every man that he is part and parcel of his wife’s pregnancy.”

**Women have the right to mourn**

*By Sakina Zainul Datoo, Tanzania*

The attitude of health care providers in Africa leaves a lot to be desired. This is particularly true when it comes to consideration for people’s emotional well-being. Nurses, in particular, seem to think their role in providing care is limited to the physical well-being of their patients. They appear to have no time or the sensitivity to care for their patients’ feelings. Yet emotions are part and parcel of a human being’s complete needs. This is especially true when it comes to the well-being of a woman who has just given birth.

At Muhimbili Hospital in Dar es Salaam, it is common to see nurses speak harshly to new mums. Whether it is about helping the exhausted woman to change her dress or teaching her breastfeeding skills, the general attitude appears to be to make the new mother feel stupid and uncivilised.

But that is not the worst of it: how they treat mothers who lose their babies is simply unacceptable. The evening approach is to control their mourning, presumably to avoid chaos in the wards. During one such incident, Africanwomen observed an argument between a paediatrician and a nurse. On realising that a baby in the incubator was breathing his last, the doctor asked that the mother be brought in to spend the last minutes of her child’s life with him. The nurse said that this should not happen because the mother would wallow loudly and create chaos in the ward, disturbing everyone else.

The woman’s basic right to spend time with her dying child and also to mourn him were brushed aside without a thought for her feelings. This is appalling and unbelievable. None of the nurses thought of taking the mother to one side and counselling her. The nurses were too smart to think of such a simple, but very important step.

Women in public hospitals are often given such news in an off-hand manner as if the death of a child is just another “normal” event in a mother’s day. That their expression of grief should be controlled too is an abuse of human rights.

After nine tough months of carrying a child in her womb, a woman tends to be in delicate emotional state by the time the baby arrives. Telling such a woman abruptly and in an off-hand manner that this child is dead must be the height of callousness. Is it too much to expect that hospital administrators clamp down on practices that give their institutions such a bad name?

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**LAST WORDS**

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