SPECIAL ISSUE – REPRODUCTIVE HEALTH IS A HUMAN RIGHT

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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 sup-

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N SEARCH OF JUSTICE: Samburu and Maasai women sought audience with British High Commissioner Edward Clay in Nairobi.

GHANA

Tackling Africa's last taboo: talking about sex

By Eunice Menka

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

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Women count the cost of rape

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port for their children.

London-based lawyer Martin Day has sued the British Army on behalf of the women. Last year, Day's law firm won a £4.5 million compensation for 228 people killed or injured by unexploded bombs and explosives left behind by British troops. Coming so soon after that successful suit, many sceptics have dismissed the rape claims as a bid to get rich quick.

The women and their lawyer undoubtedly face an uphill task. Rape is one of the few crimes in which the victim is often turned into the culprit. Coming so many years after the fact, the Maasai and Samburu women can only hope to rely on anecdotal, rather than medical, evidence to prove their case. They also hope their children will be treated as sufficient proof that the far-off events did actually take place.

In suing the British government and not individual soldiers, however, they 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 times of 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 Kenya 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 a course of anti-retrovirals 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 drop in the ocean in a country where at least five women are raped every day.

Africa's last taboo

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

The decade of waiting was worth it, says Phyllis Kudolo of the association. In the beginning, the influence of religion on people's attitudes was so hostile that women would come to their offices after Sunday sermons to demand the removal of family planning devices. "There were prior requests for the contents of our education materials and some religious leaders were uncomfortable with the programme," says Kudolo.

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.

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 contraceptives."

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 Chinua 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 married 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 put at risk by further pregnancy.

Iit is no longer unusual for reproductive health practitioners to discuss the benefits of contraception and demonstrate family planning methods right inside churches. 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 elements 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 DePariiva, a Brazilian family specialist working in Abidjan, Cote d'Ivoire, as a counselling specialist 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 before increasing their families, husbands and wives should take into consideration whether God is glorified or dishonoured by bringing children into the world."

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POPULATION REFERENCE BUREAU PRB

HAPPILY EVER AFTER ...But only as long as the woman understands she is her husband's property, according to many African communities.

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 local, religious and government leaders and non-governmental organisations.

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, Iganga, Luwero, Pallisa and Tororo.

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'."

According to Karanja, many women became vulnerable to infection as a result of domestic violence in complex ways: "Most women saw domestic violence as innate to marriage and viewed 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."

"My husband 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'."

The coordinator of the Uganda Women's Network, Jackline Asiimwe-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 Asiimwe-Mwesigye, 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 Tibegywa, 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$36 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.

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EDITORIAL

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Pat on the back is nice, but safety comes first

There is an African proverb that says that the sun should not 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 transport systems to health centres and hospitals without even the most basic of facilities required for emergency services. Those who survive these rigours may get obstetric fistula – one of the most unsociable conditions, yet easily repaired in surgery.

Safe motherhood is recognised as a basic human right protected by a range of international human rights treaties and laws. Signatory governments are obliged to address the causes of poor maternal health through political, health and legal systems and are required to report on compliance with treaty goals.

In Africa, however, motherhood comes at the end of a long chain of handicaps. The poorest among the poor, women's 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 even as the military take possession of ever more sophisticated weapons of mass destruction. Indeed, the very quality of nursing care itself comes under scrutiny in our reports.

Sexual violence emerges as a major concern, if only because it raises serious human rights, legal, social and economic questions. It can also be a life and death matter with the high HIV infection rates. Yet few countries provide women with anti-retrovirals to try and head off the slow and painful death that HIV sentences its victims to.

All is not lost, however. In these pages, you will meet people, communities and governments that have their priorities right. From Ghana's experiences of inter-religious cooperation in matters of family planning to Zambia's investment in technology to ensure a more efficient service to pregnant women, you will find interesting perspectives on the challenge of securing the reproductive health of African women.

Much as we would like to see greater political will in provision of health care, the president of the Society of People Living with Aids in Africa, Femi Soyinka, hits the nail on the head when he says: "The continent is already at the lowest end of the global economy. African governments need to do more to complement what donor agencies provide yet they are spending more money on servicing debts than investing in health infrastructure."

Motherhood ought to be a time of joy and celebration, yet it is often the exact opposite for African women – not because they do not love their children but because of the hardships they must endure.

Kenya's minister for health, Charity Ngilu, is on record saying: "Women have never been acknowledged or rewarded for the role they play in society."

A pat on the back would be very nice, thank you. But the African woman would rather have her reproductive health needs met for the simple reason that it is her right, not because she has earned it.

POINT OF VIEW

Girls pay the price of negligence

By Yinka Shokunbi, Nigeria

Nigerian girls start having sex at the age of 15, according to reports on sexual activity among youth. A significant number will have experienced at least one reproductive health problem by the time they are 18.

Some experts have blamed this on a national social health infrastructure that does not accord sexual health, especially family life education, any importance in the school curriculum. "About five years after it received public acclaim, the approved family life education curriculum has yet to be implemented in schools across the country," says Nike Esiet, executive director of Action Health Incorporated.

It is estimated that there are 150 births per 1,000 Nigerian women aged between 15 and 49. As many as half of these could be teenagers. Among the sexually active young population aged 10 to 24, 72 percent of boys and 81 percent of girls say they have practised contraception. Nevertheless, condoms and the rhythm method are the most common and many do not practice contraception always and correctly. Result? Teenagers having children and abortions – and sometimes dying or becoming chronically ill in the process.

"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"

According to a survey of Cross River and Plateau states by the Planned Parenthood Federation of Nigeria, 65 percent of respondents consider teenage pregnancy a persistent problem. "Our recent survey among adolescents in the two states indicates that there is a problem on hand, not only in promoting responsible reproductive health but also in the fight against HIV/Aids," says O. Odusami, senior programme officer with the agency. "If the results from the two states are replicated in others, we are in trouble."

The rise in teenage pregnancies can be attributed to poverty and unemployment, the search for material wealth and ignorance of matters sexual. Esiet believes, however, that sexual violence against girls by people supposed to be their guardians contributes significantly to the problem. "Sexual abuse takes many forms – including sexual harassment, unwanted sexual contacts, coercion, rape, incest, prostitution and child trafficking," notes Esiet. "Often, the perpetrators are not strangers but relatives, neighbours and acquaintances. The younger a girl is when she first experiences sexual intercourse, the higher the chances that the sex is coercive."

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 infirmity in all matters relating to the reproductive system and to its functions".

It implies that people are 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.

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 Akwa-Ibom in the academic session 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 recognise 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

COSTLY DELAYS: Lack of education, infrastructure and well equipped hospitals contribute to maternal deaths in Africa.

"In some places, nepotism has taken over and they do not recruit people with right qualifications but those they 'know' "

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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 on curbing 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 relations 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.

SPECIAL ISSUE – REPRODUCTIVE HEALTH IS A HUMAN RIGHT

Having babies is a risky business when nurses strike

By Rebecca Kwei

IT HAS become an annual ritual for Ghanaian nurses to go on strike, either demanding extra duty allowance 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.

Because there is no 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 detained 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 implementing 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.

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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 countrywide. Its key objectives are to raise awareness about life threatening conditions and educate women, their partners and families on when and where to seek help in the event of complications. The strategy is not always implemented effectively, however.

Edna Osanbea 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 Tetteh also claims that nurses ignored her pleas for help, resulting in her losing one of her twins. "It was by divine intervention 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 arriving 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 proteins. In Zaria, in neighbouring 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 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 are seen to 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.

Tele-health works by installing information technology – such as digital cameras, camcorders, digital senders and other medical equipment – in all health centres. Lusaka women and their babies are the first beneficiaries of new technology in health, with the establishment of an electronic prenatal record system.

THE PATIENCE OF A MOTHER: Women queue outside a clinic waiting for medical help. Tele-health is going to ease this.

ZAMBIA

It is fitting that this new technological adventure should start at the source of life: many of the basic needs in the care of pregnant women and newborns have largely been unmet in Zambia. And this despite the fact that inadequate resources can literally be a matter of life and death in the maternity situation.

Zambia's maternal and infant mortality indicators are unacceptably high. United Nations statistics show a one in 14 lifetime risk of death in pregnancy for women. The just released demographic and health survey shows that these statistics have not improved over the past five years, making this a high priority concern.

Customised software designed by doctors from Lusaka district, the University of Zambia Teaching Hospital and the Central Board of Health will eventually replace the paper records currently in use. Computers in all Lusaka clinics that provide antenatal care will be linked with several wards at the teaching hospital through a high speed wireless network. Patient data will be entered just once and not a dozen times. Whether or not a woman goes to the same clinic, the nurse attending her will be able to see all the relevant information about her without having to ask for it and re-entering it again.

Healthcare for pregnant women in Lusaka is a complex system. Nearly 50,000 deliveries take place in Lusaka district clinics and the teaching hospital. Most mothers make multiple antenatal and postnatal visits, and many of them go to several sites for health care. Benefiting groups will receive better care because clinicians will have more information and more time to focus on giving care.

Maureen Chitalu, a mother of three, says she hopes the use of information technology to manage complicated cases. She explains: "I live in Mutendere, where I also go for my antenatal care. During my previous pregnancies, nurses kept on referring me to the University Teaching Hospital, where there are specialists, because I delivered by caesarean section. It was not easy. I had to spend a lot of money on transport and, in the process, wasted a lot of time. But this should now be a thing of the past."

At one time, clinic staff at the teaching hospital could not find her records as they were never kept in an organised manner. But the tele-health project now means clinicians will be able to monitor and track patients, see their entire history at a glance and analyse the outcomes. Health care officials will be able to generate better information about the population.

Tele-health will also ensure security and confidentiality of patient information because it will be more difficult to gain access to patient data. Nurses and doctors will have to enter a password to see individual records. Although officials of the Central Board of Health and the district health management board will be able to see statistical information but only authorised clinicians will have access to personal patient information.

For now, an automated referral system is being written for Lusaka and it will be the first programme that will be used in the computers.

Chinyama explains that each clinician will receive an individual e-mail address. Telephones will be connected to the computers, allowing phone calls throughout the network and training manuals will be available on the computers.

SPECIAL ISSUE – REPRODUCTIVE HEALTH IS A HUMAN RIGHT

ZAMBIA

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 put 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.

Fransisca 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.

While Zambia's medics are accused of being rude and uncooperative, Miriam Nambooze of the Disabled Women's Network in Uganda complains that the disabled are treated as though they have no right to sex and pregnancy.

The disabled often resort to traditional birth attendants to help them through the delivery process, and this despite the fact that they may need specialised care.

Besides, few hospitals have facilities that are custom made for the disabled. Beds are too high and there are no provisions for sign language for the deaf or Braille for the blind.

"There are a number of things we would like the authorities to address for us to receive quality services," says Miyenga, "but there are no channels to air our grievances."

OUT OF THE LOOP: Disabled women's needs are often not considered in reproductive health.

In Zambia, all issues to do with the disabled are handled by the ministry of community development and social welfare. "We have tried to ask for changes to make health centres more friendly but, because of discrimination, we are always referred to the community development ministry," Miyenga adds. "We get frustrated and opt not to go there because that's not where the solution is."

Christine Kaseba, head of the obstetric and gynaecology department at the University Teaching Hospital, expresses doubts about the health system's ability to provide quality reproductive health care for the disabled. For one, health centres do not have the facilities to meet their needs and there are few personnel skilled in handling people with special needs. Where there are health workers capable of doing this, they are often stationed in urban centres rather than the smaller health centres. There are few hospitals with the specialised equipment to handle complicated cases.

Kaseba, who is also the chairperson of the Medical Women's Association of Zambia, proposes research into how best to meet the reproductive health needs of the disabled. This will focus on how best they can be protected from sexually transmitted diseases, use of family planning methods, gender based violence and the special needs of the health care givers.

"There is nothing documented and it is up to the districts to tell us that they have issues to do with the disabled and reproductive health services," says Miriam Chipimo, a specialist on adolescent and reproductive health on the Central Board of Health.

Sixty percent of Zambians live in rural areas, where access to health care is limited. Only 42 percent of rural women and 62 percent of men have gone to school. It is expected that disabled women fare much worse off than the average Zambian women – reason enough to begin thinking of their needs.

The right to marry and have children

By Sibongile Ncube, Zimbabwe

NOT only must the disabled contend with the traditional barriers and challenges that women face, but they also are often denied the basic right of reproduction.

Although there is international consensus that special attention ought to be paid to the reproductive health of women with disability, discrimination is rampant and many laws and policies that violate their physical integrity, says the Centre for Reproductive Law and Policy. At best, they do not address their concerns at all.

In Zimbabwe, it is not exactly unknown for disabled women to be forcibly sterilised in the belief that it is in their best interests. Abortion and contraceptives are forced upon them. Some are denied reproductive choices and health services because of misinformation, physical barriers and unenlightened health care providers.

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 came face to face with the reality of harsh treatment, especially from the nursing staff.

I had heard my friends say that disabled women were not treated

ZIMBABWE

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 those 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, Zimbabwe 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 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 Kameo

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 for sex?" asks Porter Kafeero, 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."

TOUGH PROMOTION: Sales of the female condom are few and far between.

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 Sh500 (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 keeps it 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 13-year-old struggles to free herself from the grip of her parents and a few other relatives. They are too strong, however, and soon she is pinned to the ground. They watch as an elderly businessman subdues and rapes her.

The schoolgirl's assailants had gagged her when she tried to shout for help and her parents threaten to kill her if she dares return home. Confused and helpless, she watches her relations bid farewell to the smiling businessman. He has just sealed a deal making the child his wife. Some people would call it rape sanctioned by parents - a lifetime of it.

It turns out that the "marriage" had been arranged as payment for 4,000 kwacha (US$36) that her parents owed the man. The two parties had agreed that the old man should have sex with their daughter and even marry her if he so wished. The schoolgirl had escaped the old man's attentions before and fled back home, where she begged her parents to let her continue going to school. She was forcibly returned to the man's home, her parents making sure this time that she would stay.

The culture of exchanging daughters for outstanding debts is as old as time among the communities living in Iponga, Songwe and Ngana in northern Malawi, though it is practised to a lesser extent throughout the country. Known locally as *kupimbira,* the practice has seen girls aged between three and 16 being sold off to men as old as 60 in exchange for cattle or in repayment of debts.

Once the transaction has been done, the girl involved moves from her parents' home to that of her "buyer". If she is too young, her new "owner" might wait for her to mature before she assumes her "marital obligations".

he first people to raise concern about this custom were members of the Women's Guild during a meeting of the Livingstonia Synod's church and society programme. Jacobs Nkhambule, the deputy progamme director, said local residents had been reluctant to speak about *kumpibira*. Their unwillingness to open up was probably triggered by a government ban last year, leading to fears that they could be arrested if they admitted knowing anything of the practice.

Fourteen girls

Nkhambule cited the case of 17-year-old Rahab Msukwa, whose father arranged a marriage with Willy Kalambo, 69, after he failed to pay for a few head of cattle. In one instance, an Iponga man had collected up to 14 girls through *kupimbira*. AA report of the Church and Society Programme says such violations continue because the people here are ignorant of human rights. "If people, especially parents, became aware of human rights, they would be able to appreciate the rights of others, including those of girls. This would help reduce the prevalence of *kupimbira,*" says the report.

Not leaving anything to chance, the church has mounted a campaign to sensitise villagers on the need to end the practice. Posters used in the campaign bear messages such as: "Girls are crying. Forcing us into early or arranged marriages is a violation of our rights. We need a good future."

The Malawi Human Rights Commission says *kupimbira* has resurfaced in the past three years due to the famine that ravaged the region close to the border with Tanzania. Girls attempting to resist these forced marriages are threatened with death or a curse known locally as chighume. "Such serious violations of human rights increase the chances of contracting HIV/Aids and traumatise the girls," says a report of the commission.

Malawi's constitution outlaws forced marriages and discourages the marriage of children under 15. But there is little evidence of prosecutions arising from *kupimbira*. Baxton Mpando, a deputy secretary in the ministry of education, says his ministry has received no complaints about children being withdrawn from school over the custom. "In any case, even if we received such complaints, there is nothing we can do about it," says Mpando. "Our role is limited to providing and facilitating education and not going around punishing those who do not attend classes."

Elder Patson Kalinga from Karonga denies, however, that *kupimbira* is still in practice. He argues that it is increasingly difficult to convince women and girls to accept arranged marriages; many would rather go into prostitution to flee that kind of bondage than stay at home. He says nothing of the fate of those barely into their puberty. They might as well be classified as lost children who have fallen between the cracks of a social system that has no consideration for the reproductive health or education of girls on the verge of adulthood.

Kupimbira was initially meant to enhance friendship between families, which would arrange for their children to marry. It also applied where a young man eloped with someone's daughter. The man's parents would offer "payment" to the wronged family because communities here believed that it was taboo to return home once a girl had entered a man's house. Other families offered their daughters to witchdoctors in lieu of payment for treatment.

Whatever the case, the girl's feelings and human rights simply did not count.

SPECIAL ISSUE – REPRODUCTIVE HEALTH IS A HUMAN RIGHT

KENYA

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 sit 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 missions 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 Onduru 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 and is a major cause of infertility in women. Her husband had refused to come along, saying he had been treated months before. Case closed.

The National Reproductive Health Strategy 1997-2001 says that the risk of transmission from infected men to women is greater than that from infected women to men. Many women are powerless to protect themselves due to power relations within marriage.

"The danger is that the same men either re-infect their wives or fresh female partners," says Omu Anzala, a virologist who has spent a great deal of his time treating infected workers in the slums of Nairobi.

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.

HEALTH: Grace Muthumbi treating a woman at a clinic in Kibera one of the largest slums in Africa.

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 Onduru.

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 instructions, use of 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 Muthumbi, a health officer with International Medical Corps who works in Kibera.

Population Reports indicates that diseases such as cancroids, 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.

POINT OF VIEW

All it takes is a little understanding

By Grace Githaiga, Kenya

My friend called me recently, frantic and depressed. She needed to talk. I imagined she was tired since she had been hosting relatives who had travelled from upcountry to bury her husband's uncle. She sounded so serious that I immediately agreed to meet her and talk over a cup of coffee. "The die has been cast," she said in grim tones as we sat. "The clan has decided that I must leave since I am infertile and cannot give their son a child."

She then told me what had transpired after the funeral and how the "Kangaroo court" had made the decision. She had only remained sane because her husband was supportive but she did not know how long he could withstand family pressure.

My friend has been married for nine years. She and her husband initially agreed to wait for two years before starting a family. But when the time came to try for a pregnancy, nothing was forthcoming. On the advice of friends, she decided to seek medical help. She underwent various tests – all of which confirmed there was nothing wrong. Seeking a "second opinion", she traipsed from one doctor to another. They advised her to relax and let nature take its course.

That year ended, and the fourth and fifth. Nothing still. She started the hospital round again, with the same results: she was all right. This time, the doctor told her to convince her husband to go for tests. It took a while, but he finally gathered the courage. It 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 Exchange 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 couples 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 impaired fertility. They include ovulation, cervical mucus and fallopian tube problems, being 30-years-old or older, pelvic infections that may cause scarring in the abdomen and reproductive organs and too much alcohol, smoking and stress.

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 underweight 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.

SPECIAL ISSUE – REPRODUCTIVE HEALTH IS A HUMAN RIGHT

It takes a lot of courage to have a baby

By Esther Wamala

HAVING 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.

Byamugisha recalls: "I was surprised that Gideon proposed because I was on the verge of death since I had full blown Aids. My husband and I didn't have any plans to have a child due to our weak immunity but, with funds raised by our friends, we were able to receive anti-retroviral treatment at Mild Way Centre in Entebbe to reduce the level of the virus."

Virus levels fall

On her last test, the virus levels had dropped dramatically and her CD-4 cell count had risen, meaning she had responded positively to the treatment. "With this initial success, Gideon and I decided to try for a child. I went to Mulago, where

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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. Rukundo also received a dose immediately after birth."

Mulago's Mother to Child HIV/Aids Prevention Programme – some prefer to call such programmes parent to child because the mothers are often themselves infected by their husbands – started on a pilot basis in 2000. Other hospitals included Lacor in Arua in northern Uganda and Nsambya and Mengo in Kampala.

"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."

Nevirapine costs Ugandan shilling 10,000 per dose (about US$5). Studies carried out in Mulago in July 1999 showed that nevirapine reduces the rate of parent to child transmission by half.

Medical experts discourage breastfeeding, advising instead that the babies are fed on cow milk or formula.

According to Rukwenda, research carried out by the Centre for Aids Prevention indicates that the chances of an HIV-positive mother passing on the virus to her child is 25 percent during pregnancy, labour and delivery; the chances of transmission rise by 12 percent if the infant is breastfed.

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."

GHANA

They're young, beautiful and proudly virgin

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

By Rebecca Kwei, Ghana

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 for young Ghanaians: Abstain from premarital sex if you are to avoid HIV/Aids. Kwesi Fonu, executive director of the foundation, says the virgins clubs were formed to counter the promotion of condoms at the expense of abstinence as a way to avoid infection. Abstinence 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 total abstinence while only 24 per cent preferred condom use," he says. "The club was 2,000 members in schools and communities nationwide," he adds.

Membership is open to females and males and is divided into three categories – primary, secondary and tertiary. Primary virgins have never had sex; secondary virgins have had voluntary sex or been raped but are willing to abstain until they marry and tertiary virgins are widows and widowers who act as counsellors for the younger members.

The foundation is championing the Miss Virgins Beauty Pageant, which is open only to primary virgins between 18 and 25 and is to be held every year, but does not see any irony or discrimination in the situation. "We want youth to know that it is okay and very beneficial to stay chaste until they marry," Fonu emphasises. "The objective of the pageant is to select a goodwill ambassador who will be expected to preach the message of abstinence."

He adds, with a broad smile: "In our few years of existence, we have made significant progress, though it has been a big battle. The members are proud to be identified as virgins. Hitherto, they were shy to come out in the open and say so. Their parents and, indeed, the whole community have confided in us that the club has had a positive impact on their wards and they are convinced their membership will stop them from going wayward."

International conference

Dzreke is thinking big: there are plans to organise an International Virgins Club Conference next July, where participants will discuss the HIV/Aids pandemic and also the possibility of a worldwide Virgins Day.

The virgins club concept is not new. In Zimbabwe, Chief Naboth 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 counsel and assist those who are raped as a consequence of their exposure. Chief Makoni shrugs off concerns about the emphasis on girls being virgins and not boys. His festival is meant solely to curtail HIV/Aids infection rates in the country, he insists.

The True Love Waits initiative, sponsored by Life Way Christian Resources of the Southern Baptist Convention and started in the United States in 1993, encourages students to sign a commitment card promising to abstain until they marry. True Love Waits has offices in Uganda and Kenya.

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.

Abstinence is gaining credence, nevertheless, and at least one-third of the US government's $15 billion grant 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."

Nutifafa Afua Kpe, a 21-year-old Ghanaian polytechnic student who is a member of Dzreke Virgins Foundation, sees virgins clubs as the most effective way of stopping the spread of the pandemic.

Says she: "My virginity is my pride and treasure and I will maintain it and not allow anyone to deprive me of it. By joining this group, I have become more enlightened. Some colleagues think I am outmoded but many people, especially my parents, are proud of me. I have become a role model for others."

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.

Says Alangizi chairperson Iress Phiri: "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."

The grandmothers are also trained on the kind of nutritious food to give to babies, including porridge mixed with pounded groundnuts. But despite their critical role, modern maternal and child health practices have resulted in many grandmothers being shunted to the side. Health workers rarely refer to them or pay attention to their knowledge.

Alangizi argues that many households prefer to get grandmother to come and look after a new mother and her baby rather than the mother or aunt because of traditional perspectives on how they should relate. In the past, the grandmother would arrival in full regalia and ceremoniously wash their grandchildren with herbal medicines to protect them from evil and keep them in the best health. They would stay for months or years, depending on how soon their granddaughters adjusted to motherhood. But there are those who shun traditional medicine and argue that grandmothers are too old and often illiterate and cannot possibly learn new ways.

"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"

These arguments reflect prejudices against older women. The negative stereotypes have served to undermine the experience, potential and special place of grandmothers in the community. The exponential growth of HIV/Aids had further served to sideline them. Says Margaret Mporokoso: "It is no longer healthy to practice certain traditional remedies because of the danger of blood exchange when we make tattoos, for example. In the old days, if a child had the flu and its nostrils were blocked, we would remove the mucus by sucking it out with our mouths in order to help the child breathe easier, but this is no longer safe too."

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?

SPECIAL ISSUE – REPRODUCTIVE HEALTH IS A HUMAN RIGHT

MALAW1

Where are our men when we need them?

ALL MALE: Most African men want to have nothing to do with their partners' pregnancies.

By Pilirani Semu-Banda

MARTHA 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 the meantime, she had a baby boy about one-and-a-half hours after he left the hospital. Her husband did not get the good news until that evening, when he returned 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 broken-hearted. I decided there and then to get a divorce."

It was not the first time that her husband had behaved as if he had nothing to do with her pregnancy. He would act disgusted when she had morning sickness and use that as an excuse to disappear from the house. He would spend the night out because she was "not being very sociable". She adds: "He was unreliable and was never there for me when I needed him most."

Most African men play little role in the intervening 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. Engender Health 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.

Ghana's presidential adviser on population, reproductive health 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 Kalua, says the group has acknowledged that men have been the cause ofdisparities 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 Mtsogolo, also says his organisation visits workplaces and communities to form men's clubs on 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 government hospitals 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.

LAST WORDS

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 common approach is to control their mourning, presumably to avoid chaos in the wards.

During one such incident, *Africawoman* 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 wail 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 offhand 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 offhand 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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