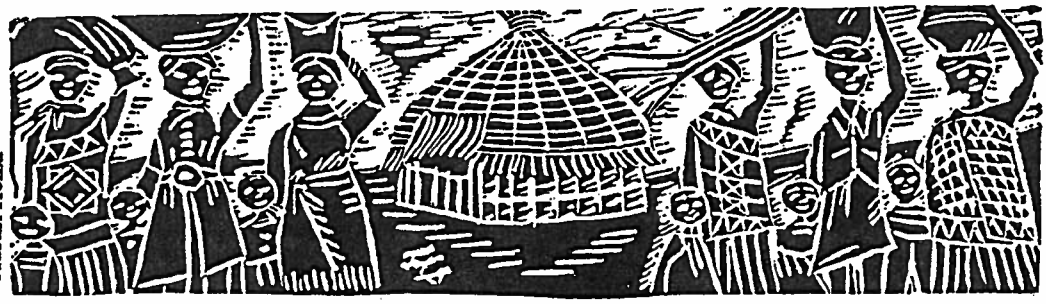


Women Hold Up Half the Sky

WIPHN News

A publication of the Women's International Public Health Network

Volume 10 · Winter 1991

"Specialists have been so dazzled by advances in chemistry and mechanics, health officers have been so absorbed in bacteriology and in plumbing, that it has largely been left to the non-medical members of the population to realize the importance of domestic details in the cure and in the prevention of disease."

—Dr. Cicely D. Williams

COMMUNITY MIDWIVES

To try to address the need for birth options for socially disadvantaged women that should be safe, satisfying, and affordable, a direct entry midwife and three nurse-midwives started a homebirth service called the Chicago Community Midwives. This is a primary maternity care practice with physician backup. In Chicago, most low income and immigrant women have little choice but to deliver their babies at the overburdened Cook County Hospital or other high volume inner city hospitals. Only 25% of the area's residents were born in the United States and 40% of the population are poor or below the poverty level. Since all four midwives are fluent in Spanish, Hispanic women have been particularly targeted. Homebirths and care by midwives are common in many of the countries of origin of the women in Albany Park.

Chicago Community Midwives offers individualized care which is culturally appropriate and community based, a reversal of the conventional health service model. The midwives are respectful of each family's culture. Emphasis is on family participation. Midwives consider themselves partners in the process. Because the births take place at home, women actively participate in decisions rather than feel compelled to conform to institutional routines.

The care women receive, includes prenatal visits which last 30 to 60 minutes to allow sufficient time for questions and discussions. There is one prenatal visit at the woman's home and each woman has one prenatal visit with the "back-up physician". Clients get to know all four

midwives during the prenatal period and at each birth two midwives are in attendance. The midwives stay in the home after the birth until both mother and baby are assessed to be doing well and until the baby is nursing well. At least one postpartum home visit is made and the mother and new baby return to the office at one, two and three weeks postpartum for breastfeeding assessment and infant weight check. The midwives are available by phone and beeper 24 hours per day. Postpartum exam is done at six weeks. Each midwife accepts only three to four births per month so as to be able to give careful, personalized care. Fees are based on a sliding scale and no one is refused care for inability to pay.

"Networking" or sharing the expertise of others has been important. The midwives receive business assistance from the Woman's Self Employment Project and grant writing assistance from the practice fiscal agent, Traveller's and Immigrant's Aid. Five private physicians serve as backup physicians, although women may also choose Cook County Hospital as their backup system. A county hospital perinatal clinician reviews infant resuscitation every six months with the midwives. Two other midwives, one from Cambodia and one from Cameroon, have offered translation services if needed. Community outreach serves as a source by informing women of their options. "Mixers" are held every three to four months for clients, professionals, aspiring midwives and others to get to meet each other.

In its first year of practice Chicago Community Midwives has drawn a varied clientele-native Chicagoans as well as some families from Mexico, Guatemala, Chile, England, Scotland, Puerto Rico, France, Algeria and Syria. Seventy percent of clients pay at a reduced fee and 30% pay the lowest rate. Outcomes have been very good: 5-10% cesarean-section rate, 10-13% transport rate, average weight 8 pounds, and 100% breastfeeding at 6 weeks and 80% at six months.

—Valerie Koster, USA

We wish to thank the Carnegie Corporation of New York for funding this issue. The Carnegie Corporation does not take responsibility for any statements or views expressed in this newsletter.

Midwives Provide Alternative Obstetric Care for High-Risk Women

Barriers to adequate maternity care contribute to the United States relatively high rates of infant morbidity and mortality. Among the less recognized obstacles to maternal and infant care is the limited availability and the distribution of physicians, as well as the unwillingness of some physicians to care for low-income or Medicaid-enrolled pregnant women. This barrier can be overcome by increasing the role of midwives. Midwives work exceptionally well with low-income clients who are often at high risk for poor

pregnancy outcomes. Midwives are less costly than physicians and, more likely than some physicians to work in a public clinic. They can serve as a more approachable and humane link between women of low socio-economic status and the maternal and infant care services these women so desperately need.

Several studies have illustrated that certified nurse midwives can be just as, if not more effective than obstetricians in managing the care of high-risk pregnant women. Due to social economic, and other factors, high-risk women are those who are more likely to deliver low birth-weight babies.

Midwives encourage and provide increased quality and quantity of prenatal care. Better care may reduce the impact of "high-risk" life-style factors (such as poor nutrition and substance abuse) and consequently, could reduce the incidence of low birth-weight, prematurity, and infant morbidity and mortality in this country.

Because good maternal care requires time-consuming activities such as pre-natal counseling, physicians may not be the best care-givers, especially for women of low socio-economic status who, in addition, cannot afford their fees.

Since the number of poor women at high risk of giving birth to unhealthy infants is increasing we must demand more appropriate care. Fortunately, some landmark improvements have occurred: for example, the National Women's Health Network serves some of the most medically indigent people in New York, as "the most humane obstetric service in the USA." We should promote the following principles to which midwives at this hospital are dedicated:-

1. The midwife should be the primary care provider.

2. All obstetric patients, even when of high risk, benefit from midwifery care, as long as there is an appropriate obstetrician for back up and consultation.

3. Medical staff should intervene in the birth process only when medically necessary.

4. All women, regardless of race, religion or socio-economic status, are entitled to family-centered care, obstetrical options and alternatives.

—Jennifer Stern

(Principles found in: Leader, M., & Stewart, M., Midwives Chronicle & Nursing Notes, April 1990)

Mujeres en Accion

SAFER MOTHERHOOD AT THE DR. JOSE FABELLA MEMORIAL HOSPITAL

Dignity, Comfort, And Safety

Dr. Jose Fabella Memorial Hospital is a 700 bed government hospital in the heart of Manila's depressed area. In 1990 it provided 193,000 women and children with free services and medicines. The Obstetrics Section handles 100 deliveries per day, 40% of which are abnormal.

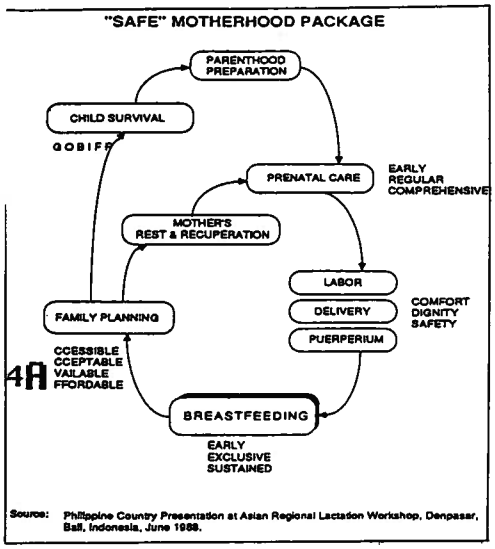
The "Fabella Safe Motherhood Package" consists of services and health education to ensure total health care for the mother and child from conception. It emphasizes early, comprehensive and regular prenatal care which includes health instruction/education on pregnancy care, breastfeeding, family planning and child care. During confinement, services are rendered by trained health care staff to ensure comfort, dignity and safety during labor, delivery and puerperium. Immediately after delivery the baby is put to the breast to achieve early maternal-infant bonding and the infant is

COMFORT, DIGNITY, AND SAFETY

Is the slogan of the Jose Favella Hospital in Guescon City Philippines.

Despite 100 deliveries per day and gross overcrowding–3 women to 2 beds–the hospital wards are immaculate. There are clean sheets and clean white gowns and no debris; clean bed pans although the toilet and washing facilities are very minimal. In 1977 maternal mortality was 500/1000 deliveries. In 1987 it was one death for 470 deliveries. The hospital serves a poverty population. In this population women didn't understand that bleeding in pregnancy is a problem requiring medical attention. 19% of the population served are teenagers primups and 22% are multips over 35 years of age.

Neonatal sepsis and postpartum sepsis have become nonexistent. All mothers breastfeed, and if there are problems, there is a lactation counsellor present to give them practical assistance.



kept in the ward with its mother as rooming in is practiced in all wards. Only abnormal babies stay in the Neonatal Intensive Care Unit. Ward volunteers, para-medical staff and students provide maternal support such as demonstration/lectures on infant care, stimulation of milk flow, milk expression, psychological encouragement, etc. Family planning information and education are provided to all and services are available before hospital discharge or at a later time.

Through the Rooming-In and Breastfeeding Program the hospital saves $290,000 per year in terms of costs of maintaining nurseries, staff, feeding bottles, intravenous fluids, formulas etc. It has received national and international recognition as a "Baby Friendly Hospital" with a Presidential Award to boot.

—Dr. Rebecca Ramos
Manila, Philippines

Maternal Health in a Time of Crisis: The Dominican Republic

The government of the Dominican Republic is proud to provide its citizens with free health care. During the 1960s and 1970s, the Dominican Republic made steady improvements in its health care delivery system, reducing the national infant mortality rate from 150 deaths per 1000 live births in 1950, to 73 deaths per 1000 live births in 1980. The economic crisis of the 1980s, however, stilled that progress and bankrupted the public health system.

Sugar exports, the mainstay of the Dominican economy, were drastically cut when the US reduced its sugar quota from 533,000 tons in 1984 to 176,710 in 1988 also the world-wide depression in sugar prices had serious consequences for the Dominican Republic, generating only $146 million from sugar exports in 1986 from an export that in 1981 had generated $560 million.

In the meantime the percent of export earning capital spent on servicing debt repayments continued to grow. In the four years between 1984-1988 the Dominican Republic allocated 70% of its export earnings to debt repayments on a debt that grew from $3.1 billion in 1984 to $3.7 billion by 1988. Wages remained artificially depressed while prices for basic commodities rose and food subsidies were removed, further increasing prices to consumers. Dominicans rioted in response to the austerity cuts demanded as part of the debt restructuring in 1988. Workers in the transportation unions struck to protest wages and price controls. Physicians joined the protest by striking against their low wages and poor working conditions.

"Free" health care in a system in disarray carries expensive hidden costs. The Dominican public health care suffered under the burden of the economic crisis. It has weakened by its lack of civil services, lack of equipment, poorly maintained facilities, and lack of necessary medicines. Access to health care is "free", but the patient is required to provide his/her own bed linens and medicine. Women planning to deliver their babies at public hospitals are told to bring with them whatever supplies may need, or to buy their supplies at a nearby drug store.

J. Gaumy, Magnum Photos, Inc.

These supplies include the xylocaine, pitocin and sterile gloves. Women and their newborn infants are wheeled into a recovery room and placed in a bed where they remain for the following 12 to 24 hours until they are discharged. Often they share the bed with another woman and her infant. Often neither woman can supply a sheet or pillow, so they lie feet-to-head on plastic mattresses. Often there is no electricity and no running water with which to wash and women lie in their own blood.

Levels of malnutrition rise, and maternal and infant deaths have increased. In some areas of the country infant mortality *continued*

rates have increased 20% over 1970 figures. The central government had decreased its capital expenditure on health to only 87% of its initial 1970 value. The public health system cannot meet the growing needs of its population with such a severely reduced allocation of resources, particularly when those resources are concentrated in personnel costs required to maintain a curative biomedical system.

Low cost, high impact interventions aimed at reducing neonatal and maternal mortality exist. In 1984, 120,000 women gave birth in the Dominican public health facilities; 50% of them had *no* pre-natal care. Of the remaining 50%, fully two thirds of them had their 1st Prenatal visit in the second or third trimester of the pregnancy. At the same time, post-partum care is almost non-existent, with fewer than 3% of total births receiving any care. Large numbers of Dominican women begin labor with moderate or severe anemia, a result of poor nutritional status and poverty, increasing the likelihood of hemorrhage and infection. High levels of maternal mortality could be avoided; 54% of maternal deaths are due to post-partum infections often associated with cesarean sections and the unhygienic conditions in which they are performed.

Among newborns, fully 31% of deaths are due to preventable causes. The most common known cause of newborn death is "unclassified anoxic infections", (19.3%) suggesting poor medical care during labor, delivery and post-partum. Adequate medical care during those high risk periods would prevent the second most recent cause of perinatal mortality, infections of the fetus and newborn (11.7%). The tragedy is that 31% of Dominican newborn mortality is preventable with adequate care.

The economic crisis in the Dominican Republic has made the public health system a mockery of its own aims namely: to provide free and adequate health care to its citizens. During this time of crisis the freedom from "fee-for-service" medical care has extracted a cruel toll, the insupportable costs of unnecessary and untimely deaths.

Linda Whiteford

MATERNAL MORBIDITY AND MORTALITY, NIGERIA

Maternal deaths and injuries in Nigeria constitute a tragedy that has been largely ignored by those who set national health priorities. No one knows how many women die each year as a result of pregnancy, because those who die are poor. They live in remote places and are accorded little importance and rarely recorded. When they are recorded the causes of mortality are not given or known. However, Hospital statistics indicate that many deaths are due to diseases or complications occurring during pregnancy like abortion, ectopic pregnancy, hypertension, ante partum and post partum hemorrhages, obstructed labor, and puerperal sepsis.

Apart from the medical causes there are also logistic causes i.e. failure in the health care system - shortage of staff at the nurse - midwife level with work left to community health aides and assistants who are not adequately trained and also there is a lack of supervision of health workers due to lack of transport to distant and remote places, and a lack of essential equipment. Utilization of the existing facilities by pregnant women is seriously defective.

Behind these are social, cultural and political factors which together determine the status of the women, their health and fertility e.g. having too many children, too early, too late and too close together. Poor women, especially in the rural areas are at all times either pregnant, breast-feeding, working in the farms or homes, and obeying local customs. For instance, women eat the left over food with their children after the men have satisfied themselves. The combination of the these behaviors produce a continuous cumulative nutritional drain on women. Their bodies do not have time to replenish stores of vital nutrients. As a result they are less able to combat infections associated with pregnancy, childbirth, incomplete abortions, perpetuum of everyday exposure to illness.

Over 60% of women still receive health care from traditional birth attendants where the services are affordable, accessible and acceptable. Looking at it critically these TBAs do not receive adequate rewards or the kits given during orientation are never replenished and the appropriate technology for the TBAs in most cases is missing. In addition to the above there are societal, behavioral and psychological factors that lead to reproductive tract infections such as inadequate sex education and health information, female circumcision, urbanization, and divorce. Other more serious ones are the stigma associated with seeking care, antibiotic resistance and poorly performed transcervical procedures - abortion, IUD insertion, manual removal of retained placenta by T.B.As, etc.

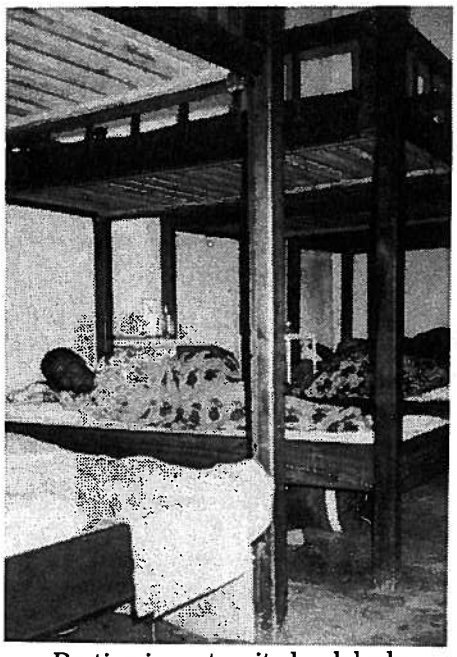
WHY THEN WILL THERE NOT BE MORTALITY IN MATERNITIES?

—C.M. Ofere, Nigeria

Maternity Services in Yaounde, Cameroon

Yaounde General Hospital is an ultra modern newly built hospital. Activities in the department of obstetrics and gynecology are limited for now to gynecology and antenatal care. The maternity will hopefully be functional soon; and because the services are expensive, we shall be seeing mainly the few rich people who can afford the charges.

The city of Yaounde has a population of about 650,000 people. There are about 12 centres providing antenatal care. The centres lack the basic materials needed to provide such care, for example sphygmanometers, reagents for simple urine and blood tests such as albumin, glucose or hemoglobin concentration. About 95% of all the women deliver in the biggest state-run maternity, called, Maternite Principale. This maternity conducts about 1,200 deliveries a month 30 to 40 deliveries a day. There is a serious problem of overcrowding and poor sanitation. The pictures taken at the Central Maternity of Yaounde early this year show some of the problems: The improvised waiting room for high risk pregnant women and gynecological patients is the corridor between two buildings covered to make a waiting room. Ventilation is poor. Bunk beds are used for the antenatal and post natal wards so as to increase the bed capacity. This room is about 10 x 4 m and takes about 6 bunk beds. The pregnant and post partum women use these beds!



Resting in maternity bunk beds.

Women lined up in "waiting room."

In the 1st stage labor room the beds are hard and cold beds. Because of this women prefer laboring at home, and rush to the hospital at the last minute just in time to push the baby out. Needless to say proper surveillance during the first stage in labor is inadequate, because of the late reporting to hospital.

Until recently there was a pit toilet just adjacent to the maternity ward. At some time this was the only functioning toilet and bathroom in the maternity. It was relieved of its duties when it sank. Thank God, no woman was caught in it.

After the fate of the toilet some "modern" toilets were repaired but for each 'gest' 25 frs (about 10 cents) had to be paid. You can imagine what would happen if you didn't have 10 cents, or if you had diabetes or urinary frequency.

—Lillian Wambua, Cameroon.

My Vision of the Future for Maternity Women in Nigeria

1. Adequate community mobilization and participation in the local health care system.

2. Women piloting the affairs of women because they can best speak for mothers and children, and view family planning as an asset.

3. Health facilities upgraded to improve manpower shortage, medical equipment and other logistic problems.

4. All practicing T.B.A's identified and trained to shorten the gap between scientific and traditional midwives.

5. Revitalization of general hospitals as referral points for P.H.C. workers: ministries of health as supervisory bodies: training institutions including universities, as technical training facilities.

6. Involvement of voluntary agencies and the leadership role of the Federal Government.

—C.M. Ofere, Nigeria

MIDWIFERY - U.S.A.

Midwifery in the United States finds itself at an important crossroad. Historically divided into two groups, Certified Nurse Midwives and Independent or "lay" midwives have not met to discuss ways to establish a new national standard for Midwifery practice and education.

The Carnegie Foundation for the Advancement of Education has sponsored two conferences thus far to facilitate dialogue between the groups. The first meeting sought to define the extent to which midwives can help address the shortage of health professionals available for quality maternity care. The second meeting focused on the scope of midwifery practice, the essential core competencies for entry level practice, and the curriculum for direct-entry midwifery education. The next step will be the formation of a joint task force in order to ultimately develop national standards, accreditation, and certification.

Currently only 2.6% of the nation's four million annual births are attended by midwives, yet midwifery care has been proven repeatedly to be safe, economical, and "woman centered". The formation of this new coalition could represent the turning point away from the misunderstanding and misinformation that has so far only served to divide this important profession and movement toward the establishment of midwifery care as the standard of care for childbearing women in the United States.

—August Burns, USA

Impact of Traditional Birth Attendants in Nepal

The United Mission to Nepal (UMN) has operated TBA training since 1973. Currently, UMN's Lalitpur Community Development and Health Project (CDHP) has 97 affiliated TBAs, who not only pursue their traditional profession as birth attendants, but are also active in the MCH/FP program components of the project. 1987 evaluation showed the child death rate (CDR) in CDHP project areas where TBAs practiced was 3.55/1000, whereas it was 4.55/1000 in project areas without trained and supervised TBAs. This was in contrast to a national CDR of 18. It was noted that, not only TBAs, but well-supervised health posts, referral services, a district hospital, and the availability of modern medicine were other factors contributing to the lower CDR in the CDHP project area.

The records of trained TBA revealed that there were only 2 maternal deaths over a three-year period of approximately 1600 births (MMR approx. 1/1000). The crude birth rate (CBR) at that time (1986) was estimated at 17/1000 in CDHP, compared to a national rate of 41/100. These earlier trends and estimates are corroborated by data obtained recently (1989-1990) through more precise record-keeping by village Health Workers. Maternal Mortality Rate (MMR) was reported at 83/100,000, which was one-tenth of the national figure. CBR was 10.5/1000, and CDR was 3.4/1000.

—Cynthia B. Hale, Kathmandu, Nepal

How Can Prenatal Care Reduce Maternal Mortality?

We were delighted by the views published in Volume 8 of WIPHN News in response to the questions we posed in Volume 7. They illustrated the range of opinion that we hoped would emerge - from Dr. Soetjiningsih's view that prenatal care is not the main priority for reducing maternal mortality in Indonesia, to Maureen Minden's suggestion that prenatal care will significantly reduce maternal deaths.

What we still seek is the evidence on which these various views are based. As we wrote in our earlier contribution, might it not be that, instead of providing routine prenatal care for symptomless pregnant women, limited resources could be deployed more effectively by trying to ensure that safe abortion is available to women who do not wish to continue with their pregnancy, and that appropriate care is made available to women during childbirth? Several opinions, unsupported by any documented evidence, emerged from the comments stimulated by our earlier piece.

i) routine prenatal care can help to ensure that women with symptoms such as bleeding, headaches or tiredness during pregnancy will be more likely to benefit from health care;

ii) routine prenatal care can help reduce the high proportion of women who are anaemic/malnourished;

continued

Woman giving birth in a barn with TBA attending.

iii) rountine prenatal care can help improve the relationship between health workers and women, and thus women's acceptance of advice and

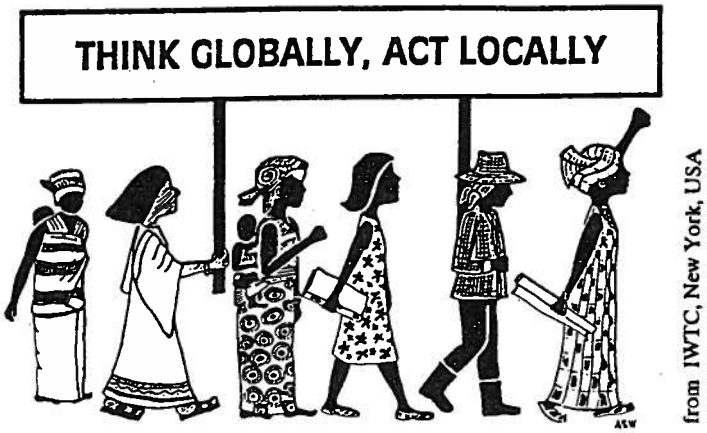
iv) routine prenatal care can help improve women's own views of the importance of their health and their status.

The implication of those who kindly put forward these views in response to our piece was that each of these postulated effects of routine prenatal care can have an impact on maternal mortality. We reiterate our call for the documented evidence to support these claims. This is not because we believe that no such evidence exists; but because we think that it is important that the evidence should be made explicit. We acknowledge that useful data in this field are difficult to gather; but such data are essential in planning appropriate and potentially life saving services for women. If indeed it can be demonstrated that routine prenatal care is a cost-effective way of reducing the risk of maternal death, this evidence can be used to support calls for extending prenatal care to symptomless women who do not currently receive it.

—By Mary Renfrew and Iain Chalmers

The Impact of Women's Income on Community Health in Ghana

Preliminary discussions with national and regional women's organizations and the village women revealed that priority issues for women were: access to credit and labor saving technology; water supply; health and literacy. Given that African women are involved in 80% of all agricultural production and have been traditionally neglected in the classic development models which target men as head of the household; and assume that the money will trickle down to their wives,and that if given incentives, women could be the single most cost-effective available resource to alleviate the African food crisis, CUSO designed a $3 million credit project for women in the three regions of northern Ghana.



from IWTC, New York, USA

For the women, credit was the key. Although the local banks recognized women as good credit risk few loans were actually disbursed. In an effort to assist them build a credit history in their local banks, this project offered women collateral free loans through the formal banking system to begin village based micro-enterprises. Training was also provided to help manage their money. While many women received loans for farming, others requested loans to begin handicraft production or food processing activities. One group received a loan to own and operate a corn grinding machine. Loans were disbursed for a defined period of time and at the prevailing rates of interest.

Despite difficulties faced by the women as a result of weather conditions and the macro economic constraints in Ghana, loan repayments have been excellent and the women have been able to make small profits from their enterprises. The success of their ventures and the increase in income has had a significant impact on not only the women's self esteem but also the general health status of their families. A mid term evaluation of the project revealed that when the women had access to increased income, they were more inclined to reinvest that income in their families than were the men. When asked how they spent their profits, the women responded that they purchased cloth for themselves, tinned fish and fresh meat to supplement their family's main meal, reinvested the money to expand their businesses; purchased extra food to bridge the family's needs during the pre-harvest lean season, and following the 1990 drought, had used the money earned from non-agricultural activities to sustain the family through this difficult period.

As a result of the structural adjustment program in Ghana, cut backs in social services have meant fewer resources going to health care, fee for service payments and increasing the cost of necessary drugs. When the men controlled the household income, the women were often forced to use traditional medicine as it is less expensive than provided through the local clinics. But they preferred the local health centre, mainly because of the pre and post natal clinics offered there, and were now able to do so with the income earned.

Finally, the women also invested profits in their daughters education. With female illiteracy as high as 90% in these areas, the move to educate girls would go a long way toward improving not only the quality of life for these young women, but would also have a significant impact in reducing fertility rates and improving the chances of survival for their children.

Although credit, and not health, was the focus of this innovative community development in northern Ghana, the effects on the health and well being of the women and their families has been significant.

By Virginia E. Ward

Abortion Around the World!

South African law allows women to have abortion only if

If she is under 16 years of age: If she was raped: If the mothers' mental health may suffer.

There are about 300,000 women in South Africa who risk their lives every year by having back street abortion.

—WGNRR Newsletter Jan - March 1991

Needs of Indigenous Q'eqchi Indian Women in Guatemala

Q'eqchi' girls receive no sex education because discussion of this topic is forbidden. Due to the influence of western culture and the breakdown of traditional ways, their knowledge comes from street talk or from their friends, and many of them are either misinformed or have wrong ideas.

At present no educational program nor materials exist for pregnant Q'egchi' women. A woman must go to the public health centre if she needs attention as no home visits are made. But Q'egchi' women do not use this service as all consultations are given in Spanish, which most women do not understand and secondly, a physical examination by the male doctor is forbidden within the indigenous culture, as the husband is the only person who has the right to see and touch the body of his spouse. There are also no follow-up programs for women after delivery. Public health centers sometimes provide foodstuffs to pregnant women, but the 'Ladina' women come first, and the Q'egchi' must wait at the back of the line.

Seventy percent of the 1987 births were unattended and 61% were midwife assisted. Dona Andrea is the most experienced and respected midwife in town. If she feels a birth will need western medicine or instruments she will recommend that the woman visit the private physician in town. She gives regular prenatal check-ups.

There is no coordination between the institutional health services and the midwives. The majority of women have more confidence in Dona Andrea and other midwives because they respect cultural beliefs and treat the women with dignity. The midwives could benefit from additional training in the use of some western techniques and diagnosis. What we want is a greater understanding of the indigenous women during pregnancy, and a program to complete the advanced skills of the midwives.

—Eugenia Juarez X01, Apartado 544, 01901 Guatemala

Companionship in Labor and Mother-Infant Relationship

Report on a randomized trial

Labor is approached by many women with considerable anxiety. Part of this anxiety is related to the unfamiliarity of the hospital environment and the accompanying feeling of loss of control (Lumley, 1989). Stress during labor is of particular concern because of the emotional vulnerability and potential for negative experience. This may have long-term adverse effects on the mother's emotional development as well as on her relationship with her child. In many hospitals in South Africa, women labor in particularly stressful conditions, without the support of chosen family or community members, and in circumstance which cut across cultural practices and taboos.

Labour Support

Susan Klein

Two previous randomized control trails have shown that simple social support during labor provided by a 'duola', produces quite dramatic decreases in the duration of labor, the need for oxytocin augmentation, the incidence of meconium staining of amniotic fluid and of a caesarean section (Sosa at al., 1980; Klaus at al., 1986). A possible mechanism for this effect is reduction in maternal catecholamine levels, related to anxiety (Lederman at al., 1978). In all, 189 women delivering at Coronation Hospital were included in a randomized control trail. Those in the study group (N=92) were attended by a lay worker with no nurse training but basic instruction from a psychologist in the provision of positive emotional support during labor. In all other respects the two groups were managed equally and according to hospital routine.

Marked differences in psychosocial reaction to birth as measured on day one were evident between the groups. Anxiety, pain in labor and, at the time of the interview, perceived coping with labor, were significantly more favorable in the supported group. At six weeks after delivery the supported mothers' anxiety scores remained significantly lower that the control mothers while self-esteem scores were higher.

The effect of labor support on mothers' satisfaction with parenthood and with their babies was

remarkable; mothers who had labor companionship had a far more positive attitude to their babies, were far more facilitative (as opposed to regulative) in their parenting style (Raphael-Left, 1985) and breastfed their babies more successfully. The babies experienced far fewer medical problems and feeding problems. Even their relationship with their husbands or partners improved significantly after the birth, and there was a remarkable reduction in depression.

These preliminary results lend strong support to the hypothesis that positive support, encouragement and praise during the vulnerable period of labor and birth may have a powerful effect on the mother's feelings of value and competence; establish a self-perpetuating cycle of confidence, competence and happiness in parenthood, and positive relationships with baby and partner.

By Beverly Chalmers, South Africa

For full article and sources write WIPHN, 7100 Oak Forest Lane, Bethesda, MD, 20817 USA.

PARTOGRAPHS for Reducing Maternal Mortality.

WHO has developed a document, The Partograph, A Managerial Tool for the Prevention of Prolonged Labor Sect II, A Users Manual (WHO/MCH/88.4) to teach the use of the partograph in the management of labor. In a peripheral center, the partograph is used to give early warning that labor is likely to be prolonged and that the patient should be transferred to the hospital.

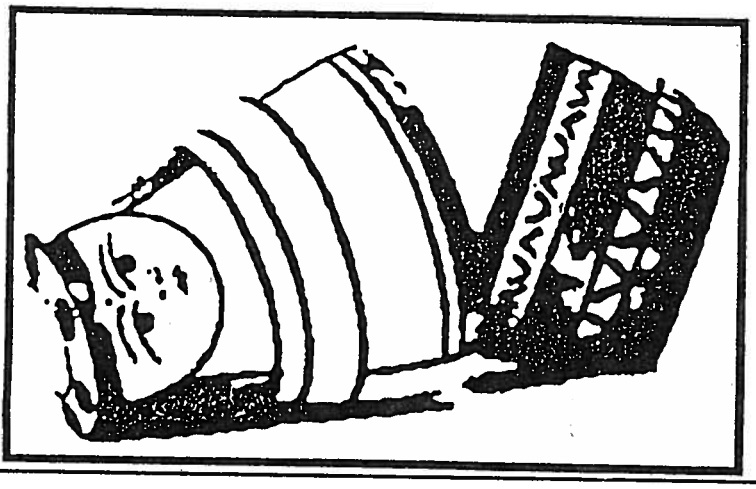
LET'S CHANGE THIS!

"THE BOYS NEVER MEANT ANY HARM AGAINST THE GIRLS. THEY JUST WANTED TO RAPE."

—DEPUTY PRINCIPAL OF ST. KIZITO BOARDING SCHOOL

On the night of July 14th, over 300 Kenyan schoolboys attacked their female classmates. 71 were raped, and 19 schoolgirls lost their lives as a race for safety became a stampede of death.

EDITORS NOTE: According to Fran Hosken, Editor of Women's International Netsworks (WIN), President Moi of Kenya stated publicly that this terrible affair would be investigated by his government and the results would be made public. To date no such investigation has been made public. In solidarity with the women of Kenya we urge you to contact the Ambassador of Kenya in your country to request this report be published. Also write to: The WOMEN'S BUREAU, Ministry of Culture and Social Services, P.O. Box 45958, Nairobi, Kenya.



National Network of Women's Fund

WANTED:

A MICROSCOPE for Cartoga, Costa Rica. While the regional government health centre performs laboratory tests for the local family planning and women's health consultations which are provided for free by a team of interns (part of a new pilot program in the community) the health professionals are limited. For a quick diagnosis, e.g. vaginal infections, a microscope is needed to identify the micro organisms involved and to start proper treatment. If you have one please send it: CEFEMA c/o Josefina Brizard, Apartado 5355-1000, San Jose, Costa Rica.

SHED SEEKS help for suffering mothers in their struggle. In the Koraput District, Orissa there is lack of clinical maternity attention. A population of around 100,000 living an area of 200 sq. kms. have to rush out somewhere for safe delivery and ANC. If you can offer ssistance or advice contact: Alice G. Mony, Executive Secretary, Society for Health, Education and Development, Polytechnic Road, Rayagada, Koraput District, Orissa, India - 765001 P.O. Box 18.

INFORMATION WANTED: We have some anecdotal information that the new drugs used for epidurals interfere with breastfeeding, particularly latching on. They also have been reported to affect the infants in other ways. Any information on this, especially case reports and drugs used, would be appreciated, as we are conducting a preliminary study in this regard. Write WIPHN.

Please send us information, articles, illustrations, materials for newsletter 11, which will be on Refugee Women. Your newsletter needs your input. If you would like to serve on the publications board, please let us know. Write WIPHN.

MATERNITY S

	PRENATAL		
FACTORS ASSESSED	*EDUCATION:*	*HEALTHCARE PROVIDERS:*	*AIDS TO A HEALTH PREGNANCY*
	Childbirth classes: Hygiene Nutrition Child care Women's Health & Hygiene Parenting First Aid Breastfeeding	Midwife Obstetrician General Practitioner Nurse Physician Assistant Birth Attendant Dentist	Health and diet counseling: Screening for: Anemia STDs Hypertension Diabetes Urinary Tract infections Dental Care Social System Support
EVALUATION RESULTS:			
EXCELLENT	All of the above in interactional classes, understandable, regularly held at convenient hours	Birth supervised by experienced trained health care providers If necessary, access to experts and special resources	Readily available to all patients irrespective of income
SATISFACTORY	Classes limited to childbirth, childcare, and breastfeeding short courses	Factory line exams by different trained healthcare professionals, but competent and considerate for mother's wishes	Available, but not offered to everyone
UNACCEPTABLE	Occasional lecture/no classes	Disregard the mother. Prenatal care mechanistic /or no prenatal care	Not available

Maternity Scorecard for use in evaluating maternity services anywhere in the world they are provided.
This scorecard can be used as a guideline for evaluating your institution's maternity services. Obviously it will have to be modified in each area and a re
you can rate them as excellent, satisfactory and or unacceptable. The UK Safe Birth Book, by defining activities in maternities, has been able to upgrade th
deliver with safety and comfort.

Prepared by: Drs. Sandy Mackintosh, Clair Senseman, Nikki Lee, Gayle Gibbons, and Namoi Baumslag and Ms. Cassandra Santos

)RECARD

AT DELIVERY			POST PARTUM
THING POLICIES FOR	*MATERNITY FACILITY:*	*TYPE OF DELIVERY:*	*EDUCATION AND SUPPORT:*
MAL AND ABNORMAL BIRTHS:			
ws for mothers to choose position	Hospital birthroom	Position of mother's choice	Breastfeeding support within
squatting	Delivery room	Natural e.g. squatting	facility and at home
gth of stay more than 24 hours	Maternity Center	Ice chips or juice in labor	Family Planning
rnal activity in labor unrestricted	Maternity Waiting Center	Cesarean rate less than 10%	Follow-up for mothers at 6 weeks
r indications for fetal monitoring	Home Referral Program	Privacy respected	Follow-up for infants:
technological interventions	Referral program	Physiologic management of third stage	growth;development; immunizations
stfeeding policy: rooming in, no free	Transportation	Use of technology and interventions	
ples, no glucose water, no supplemental	Sanitary environment	not routine	
s.		Pain Management	Contact at home:
lly produced education materials		Rocking chairs, tub or whirlpool bath	visit/ telephone call
l ligation delayed		Unmedicated delivery for majority of	
chemoprophlaxis for infant		women	Referral made if needed
ature infant to be given expressed		No routine epidural.	Mothers have numbers/way to call
stmilk		Analgesic not routinely used, but available	for help or information
		Mother's support person e.g. partner	
		allowed to be present at birth	
		Delivered under hygienic conditions	
bove put into practice; written	Hygienic- non interventions	All above plus Cesaeran section less	Services listed above available to
cols in manuals; healthcare providers	supported.	than 10%	all and follow-up
ed to implement these policies.	Can handle obstetric	No routine use of ultrasound, enemas,	
	emergencies	pubic shave, episiotomy.	
ies are followed but applied	Avaialble but limited	Non routine technology and interventions	Limited follow-up services
sistently and are not written down		Hygienic conditions	
if any policies No rooming in;	Not available	No supervision/ Facilities unable to	No follow-up/nor support.
restricted		handle emergencies and not responsive	
		to mothers	

ing mechanism developed. By color coding the interventions and activities or by using + or -s
en can force change through the use of such instruments. Women should be allowed to

MEETINGS

Global Health Consciousness: The University of Texas School of Nursing at Galveston and the World Health Organization Collaborating Centre for Nursing Development in Primary Health Care will hold their next Global Nursing Conference in April 24-25, 1992, Glaveston, Texas, USA. *Contact: Dr. Janet Gottschalk, WHO Collaborating Centre for Nursing Development, The University of Texas Medical Branch, School of Nursing, 1100 Mechanic Street, J-29, Galveston, Texas 77550-2782. Phone (409) 772-4812 Fax (409) 772-5118.*

Managing Health Programs in Developing countries June 22 - August 14, 1992 for further information *contact: Anne Mathew, Program Coordinator, Office of Continuing Education, Harvard School of Public Health, 677 Huntington Avenue, Boston, Massachusetts 02115, U.S.A. Phone: (617)432-1171; Fax (617) 432-1969; Telex 501003 (attention: Continuing Education).*

Susan Klein

From: Development forum, July-August 1991.

PUBLICATIONS BY WIPHN MEMBERS

AFRICAN BIRTH Childbirth in Cultural Transition by B. Chalmers, Publications C.C. P.O. Box 107, River Club, South Africa. This is an excellent book with fascinating insights.

AVAILABLE FROM THE WORLD BANK, OFFICE OF POPULATION. Health and Nutrition paper on the influence of maternal health on child survival by Ann Tinker, World Bank 1818 H Street NW, Washington, DC.

Women and Health in Africa, Ed. Meredith Turshen, Africa World Press 1991. Includes chapter by WIPHN Members Dr. Julie Cliff and Ncoceba Lubonga.

Hawaii State Commission on the Status of Women, **Newsletter**, 335 Merchant Street, Room 253, Honolulu, Hawaii 96813. Phone 548-4199 or 548-4576.

Maternal Mortality, A Call to Women for Action, Coordinated By: Women's Global Network on Reproductive Rights, P.O. Box 4098, Minahassastraat 1, 1009 AB Amsterdam, Netherlands.

Nacer En Casa, Jorge Diaz Walker, Associacion de Ayuda Materna

Manual De Cuidado Primario, Elly Engelkes, Servicio de Salud del Choco Programa Rural de Salud Convenio Colombo - Holandes.

Too Far to Walk: Maternal Mortality in Context by Thaddeus S and Maine D. Contains an analysis and 140 abstracts. Write Prevention of Maternal Mortality Program, Centre for Population and Family Health, 60 Haven Avenue, New York, N.Y.10032, USA.

Quality/Calidad/Qualite, The Bangladesh Women's Health Coalition, Write Ann Leonard, Editor, Quality/Calidad/Qualite. The Population Council, One Dag Hammarskjold Plaza, New York, N.Y. 10017, USA.

Safe Motherhood Programs: Options and Issues, Center for Population and Family Health, 60 Haven Avenue, B-3, New York. N.Y. 10032.

Women's Health Journal, Latin American and Caribbean Women's Health Network: ISIS International, Casilla 2067, Correo Central, Santiago, Chile.

Safe Motherhood Newsletter issued by the Division of Family Health, World Health Organization, 1211 Geneva 27, Switzerland. For a free subscription, please write to the above address.

Norplant : 'Piki 5 An' Planing Familyal Pepe Nan Peyi Dayiti. This study is available only in Creole.

Solomon Islands, National Nutrition Survey 1989, Rural Statistics Unit.

HEALTH AND FAMILY PLANNING MARKETPLACE is an 18-minute video documentary describing innovative community-based program that provides basic health and family planning services in the outdoor traditional markets of Ibadan, Nigeria.

Khabar, Women Uniting Against Exploitation, Finrrage-Ubinig Meeting 1990, Asian and Pacific Region.

Vena Journal, Women and Health, Women and Autonomy Centre (VENA) Leiden University, Wassenaarseweg 52, P.O. Box 9555, 2300 RB LEIDEN The Netherlands.

Women in Action, Strengthening Networking and South-South Dialogues, Isis International, 85-A East Maya Street, Philamlife Homes, Quenzon City, The Philippines.

International Journal of Gynecology & Obstetrics, International Federation of Gynecology & Obstetrics and Family Health International, Room 490, 333 East Superior Street, Chicago, Illinois 60611, USA.

Maternal and Child Epidemiology Unit, London School of Hygiene and Tropical Medicine, Keppe Street, London, WC1E 7HT, U.K.

Medical Textiles for Developing Countries, Intermediate Technology Development Group, Myson House, Railway Terrace, Rugby CV21 3HT, U.K.

Partnership for Safe Motherhood, to reduce maternal mortality and Morbidity, Maternal and Child Epidemiology Unit, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, U.K.

The Tribute, Women and Law, International Women's Tribune Centre, 777 United Nations Plaza, New York, N.Y. 10017, USA.

Research Initiatives

Modest funding and technical guidance is available for research which identifies ways of improving and extending existing services using available technology. Write Dr. Godfrey Walker, Maternal Health and Safe Motherhood Unit, WHO, 1211 Geneva 27, Switzerland.

NEW ORGANIZATIONS JOIN WIPHN

Save The Children, c/o Middle East Desk, 54 Wilton Road, Westport, Connecticut, 06880. Contact: Dr. May Haddad

Britain Nepal Medical Trust, P.O. Box 9, Biratnagar, Nepal. Contact The African Development Corporation, 6810 Highview Terrace #202, Hyattsville, MD 20782, USA.

Association for Childbirth & Parenthood, P.O. Box 2818, Randburg 2125, South Africa. This is a multi-disciplinary and multiracial association concerned with training ante and post natal educators. Its objections are: to provide short term training for childbirth educators a — to explore the longer term future of education of child birth educator. ACP is based in Johannesburg, S.A. and caters to the needs of local communities. For more information: contact WIPHN

The World Bank, Population & Human Resources Department, Population Health & Nutrition Division, 1818 H Street, N.W., Washington, D.C. 20433

Women's Healing and Empowerment, PO Box 10084, Arlington, VA 22210 Phone No.(703) 522-9231 - is an educational organization. It provides encouragement for the healing of physical, mental, emotional, or spiritual imbalances which cause ailments and diseases. The goal is to empower women to make the changes necessary for personal growth.

WIPHN'S SAVE A MOM CAMPAIGN

MIRIAM MAKEBA'S daughter Bongi while in Guinea went into premature labor and was taken to a rundown hospital where she was sectioned. The hospital was filthy, no linens, no food. The baby died at delivery and Bongi died of puerperal sepsis. Makeba's daughter went to the wrong hospital. Her story of medical negligence is unfortunately not unique. For each women who dies, twenty survive medical negligence and bad hospital conditions and unnecessary hysterectomies, but a few women have started taking action against obstetrical butchers. Much money has been spent on conferences, workshops, awareness sessions but still we get calls for linens, soap, antibiotics, blood pressure instruments, sanitary napkins and microscopes.

Susan Klein

Please donate generously to the **WIPHN SAVE A MOM CAMPAIGN** so we can reduce maternal mortality at the local level. Send donations to WIPHN.

Organize a function in your area and send us the proceeds so we can give small grants to places desperately in need of basic resources.

Naomi Baumslag MD, MPH
President
WIPHN

Progress In Romania

Nine months after the law on abortion was liberalized in Romania, maternal mortality due to abortion has been reduced by 72%.

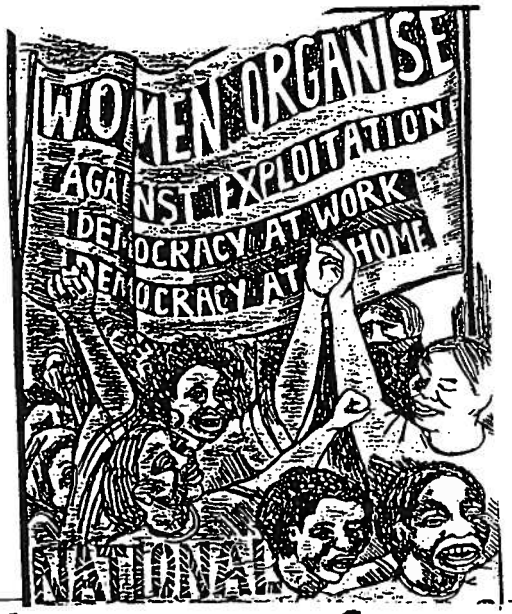
—Safe Motherhood Issue 5 March - June 1991.

'Life Saving Skills' Training Program in Ghana

The Ghana Registered Midwives Association working with the American College of Nurse Midwives through a continuing education project are updating midwifery skills. These include vacuum extraction, sutuning practice, use of the partograph, fluid management, anemia assessment, cardiopulmonary resuscitation and Heimlick Maneuver.

It has provided 120 Ghanian midwives with simple obstetric emergency techniques. They are producing a manual for midwives of 'Life saving skills': For more information write Margaret Marshall, American College of Nurses - Midwives Special Project Section, 1522 K Street N.W. Suite 1000, Washington, D.C. 20005. The project is funded by a Carnegie Corporation grant.

In South Africa Umlazi Women Are Waking Up



Speak

Women from the township of Umlazi outside Durban formed a group called Phaphama Club. *"Phaphama"* means "wake-up". The members (neighbors) meet monthly to discuss their problems and how to solve them. They also share their personal joys and grief with one another.

A club member said, "Coming together has given us a chance to learn different things. We have organized workshops. One was on child abuse. We called a social worker to tell us about this. Another workshop was on women and the law. A lawyer told us how the South African law sees women. Slowly we will learn other things which affect women. Workshops are held every third Sunday of each month.

The lawyer who talked about women and the law gave the Umlazi women a shock. They found out that the law does little to protect the interests of married women. The husband is given the right to make important decision for his wife. One woman said, "I cannot believe how unfair the law is towards women. What are we going to do about this?"

Another said, "There is much to do about a new South Africa. It is up to us to make sure that these unjust laws go so that South Africa will be new for women as well."

The women felt strongly that it is they who have the responsibility to ensure that a future South Africa has new, non-sexist laws.

"How are we going to make sure this happens?" one woman asked.

Another answered, "Let us come together, bring in more women. We must share ideas. If we do not, we will be left behind."

The Phaphama Club members have realized that women are always being left behind, locked in their houses by housework and child care. Knowledge of their rights gives them the confidence to challenge unfair laws.

—ISIS International, 1/91

THE PLACE OF BIRTH, FOR A NORMAL BIRTH

1. HOME is the most comfortable, least disturbing and pathologizing environment. A woman can feel freer in her own place, to move, moan, without needing to check herself with regard to disturbing others. She is in her element surrounded by family and friends.

2. BIRTHING CENTRE is next best choice. It offers convenience and safety for both woman and health assistant. It may promote easier birth for a majority of women by combining the comfort and smallness, privacy of a home environment with the proximity of emergency technology in some 3rd world countries it may actually be free from the restrictions of home especially in societies which strongly subdue women.

3. NURSING STATIONS in remote areas could be set up to handle normal births though an outreach program. Home-based practices would be more feasible and practical for the overworked nurse. She could provide emergency back-up and convenience, also promotion of health and education.

4. SMALL HOSPITAL with personalized care, less mass-production assembly line atmosphere e.g. pithiviers in France! - an *excellent* experiment.

5. BIG HOSPITAL last choice, very dehumanizing in general, dewomanizing in particular where it comes to giving birth, which in essence is as remote from an institutionalized procedure as you can get (with the exception of sex, which it

National Network of Women's Fund

is anyway) giving birth is primal, basic, instinctive, awe, inspiring, luminous. It requires immense strength and forbearance from the birthing woman, patience and love from her attendants and *lots of contact,* physical and psychic, between them. Machines don't substitute at all and unfortunately hospital-based obstetrics is enamored of tools and statistics, and practitioners never once truly *look* at a woman in labor, smile or cry.

However! the more midwives move into the vacuum being created in natal care, the more women centered birthing will become.

By Maria Cadaxa, Midwife
USA

ISIS No 20 Women's Health Journal

Campaign for Women's Health

The Campaign for Women's Health has been convened to ensure that women's voices are heard and concerns reflected in the debate surrounding health care reform. The Campaign today is over 35 organizations strong. The list of facts is endless.

- 4.5 million American women between the ages of 40-64 are currently uninsured.
- Health insurance in the U.S. is tied almost exclusively to full-time employment. Yet, only 49 percent of all women working full-time in 1988 reported direct employer coverage. Since women's work patterns tend to be more episodic than those of men (women typically spend 11.5 years out of the paid work-force because of family care-giving responsibilities), women are doubly disadvantaged.
- Research has shown a direct correlation between poverty and ill health. Two out of three adults living in poverty in the U.S. are women. Eighty percent of all the poor are women and children.
- The fact that women live longer (on the average, women live 7 years longer than men) also means that more women than men are affected by chronic disease requiring long term care. In 1977, 73 percent of all nursing home patients 65 and older were women.
- Women have been either underrepresented or omitted altogether from many important research studies. For example, a 1982 study measuring the correlation between cholesterol levels, lack of exercise, smoking and heart disease included no women. As recently as 1988, a study demonstrating that small doses of aspirin effectively prevented heart disease included 22,071 men and zero women. (See recent issues of the **Network News** for information about Network activities in support of women's health research.)

The need to incorporate a women's health agenda into the current effort for health care reform is clear.

Based on a set of principles regarding health care treatment, access and research, the Campaign is working to improve our health care system's responsiveness to women's health needs. Health care reform efforts must address women's needs for preventive diagnostic and treatment services and must remove current barriers women face when trying to access to services must not depend on ability to pay, marital status, employment status or health status. Further, the national research agenda must include significantly increased attention to health issues of concern to women.

The Campaign is committed to promoting policies and initiatives that are inclusive of all women, respectful of and sensitive to a diversity of backgrounds and needs.

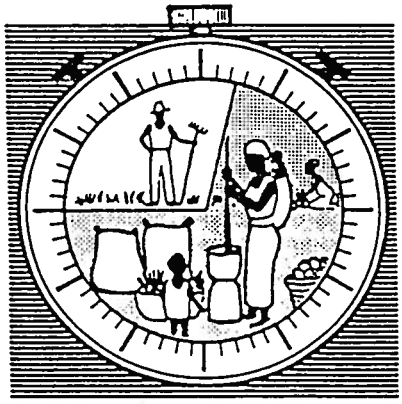
The Campaign's approach is multifaceted, including analyses of present and proposed health policy, advocacy at state and federal levels of government, and a nationwide public education effort, with a strong grassroots component.

Organizations interested in participating in the campaign and individuals seeking further information should contact:

Sally Garrett, Health Policy Associate, Older Women's League, 730 15th St. N.W., Washingon, D.C. 20002, Phone (202) 783-6686.

Maternity Needed

In Katende village, the population is 100,000. The health zone serves about 3,000 people in the zone. Most residents are farmers. It is a male dominated society; many men have two or three wives. The women's work burden is inordinately heavy. They till the fields, carry water and firewood, peel and pound manioc (to make a paste called fufu, their main staple) and take care of children. Men may work the fields or hunt for game, but many prefer not to this on a regular basis. They spend their days sitting in front of the house drinking palm wine or tshetshanpe, a local whisky made from manioc and corn. In an attempt to sensitize the family I dared some men to pound manioc one afternoon! but they were quite embarrassed.



Source: Worldwatch Institute

My work involved health education and coordination of the 12 catchment areas in my health zone which I share with a another Peace Corps volunteer. Each catchment area needs a health centre, a health committee, and a maternity. The health committee is made up of three representatives from each village. The health committee members who take time for monthly meetings and village educational meetings receive nothing for their work except the respect from their communities. Some members assist the nurse in prenatal consultations and vaccinations. At present, vaccinations are done by a team of nuns/nurses who travel by Landrover once every three months to each village. (This obviously does not reach every child). They often do not do education.

My work includes coordinating health committee meetings (an experimental idea) in the existing nine health centres. Equally important is the construction of the health centres in the three other catchment areas and subsequent sensitizing of the community to form health committees. I assist health committee members in learning new health lessons at each monthly meeting and learn how to best teach this message in the villages. They work to promote the idea of disease prevention which is still foreign to most people in rural Africa (as well as the rest of the developing world, for that matter).

Another facet of my work focuses on the challenge of decentralizing the distribution of vaccinations so that the nurses and health committee members in each catchment area will take the responsibility for the education of their own women and children. It has been a political struggle with the Catholic church in my zone, which wishes to continue with their centralized method of vaccination. But recently, because of lack of funds and staff, they have conceded to our (the central office of the zone's) idea of spacing refrigerators throughout the zone and also some vehicles (motorcycles and/or bicycles).

We need funds for office supplies, such as paper to run off health lessons and for paying for gas for the nurse supervisor's motorcycle.

In my health zone, there are at least three maternities which need to be built. I have made a list of needs for one maternity (5-20 deliveries/month) along with the cost in U.S. dollars where I know it.

20 basic receiving blankets (cotton)
3 buckets – $20
3 medium size basins – $12
2 bulb syringes (poire)
1 pair bandage scissors
4 sponge forceps
4 large hemostats
a newborn scale – $20
1 bathroom scale (for prenatal clinic) –$10
10 hand towels (huck type)
5 3cc syringes
20 hypodermic needles (22Gr. x 11/2 in.
20 needles (25 Gr x 1/2 in)
1 ventouse(midwife must be trained in it's use which training costs $100).
1 vacuum extractor (about $300)
1 clock with a second hand –$10
100 pr. latex gloves
Initial stock of medications –$50
4 meters of heavy plastic sheeting
10 beds –locally made at $300.
10 mats (to cover beds –easier to clean)
10 blankets (optional)

Beth Outterson
Zaire

Note: Since this was written, Beth was evacuted from Zaire. The work will hopefully continue when the civil unrest is ended.

I Want A Wife!

...."I want a wife to make sure my children eat properly and are kept clean"

... My wife must arrange to lose time at work and not lose the job.

...My wife will arrange and pay for the care of the children while my wife is working.

... I want a wife who will take care of my physical needs; a wife who is a good cook. ... I want a wife who is sensitive to my sexual needs, a wife who makes love passionately and regularly when I feel like it, a wife who makes sure that I am satisfied.

If, by chance, I find another person more suitable as a wife than the wife I already have. I want the liberty to replace my present wife with another one. Naturally, I will expect a fresh, new life; my wife will take the children and be solely responsible for them so that I am left free.

When I am through with school and have a job. I want my wife to quit working and remain at home so that my wife can more fully and completely take care of a wife's duties.

My God, who wouldn't want a wife?

— from Chapter 9 by Judy Syfers in the Green Render Ashton - Jones - Olsen, Alleyn & Bacon, 1991

WE SALUTE YOU! SRI LANKA'S WOMEN'S PUBLIC HEALTH NETWORK (SLWPHN)

"Woman Support For Women's Health"

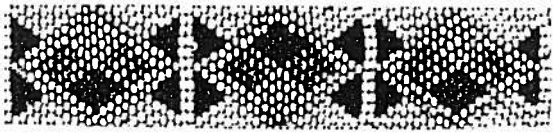
The Sri Lanka Chapter of WIPHN is very active and has just conducted a program on 'Women and AIDS' and a workshop on MCH and FP for representatives of Women's NGO's. In March the Network commenced a pap smear screening facility. So far 110 patients have been screened. The clinic is conducted on a voluntary basis by the Medical Officer from the municipality and coordinated by Dr. Siva Chinnathamby, (One of the most senior and experienced obstetricians and gynecologists in Sri Lanka). She is also Vice-President of the SLWPHN.

—Dr. Thiloma Munasinghe
Hon. Secretary SLWPHN

SEASONS GREETINGS FOR WIPHN MEMBERS
MAY 1992 BE A BETTER YEAR FOR WOMEN
UNITED WE BARGAIN, DIVIDED WE FALL.

Making a Difference

In Nigeria, 70,000 women die each year, 1 every 10 minutes. For every woman who dies, 20 more are diseased. One of the most serious problems women suffer is vesico vaginal fistulae (VVF). A repair station has been developed for these women. In the center, women make detergents and body creams for themselves and for income generation. The products are sold to the public to raise funds for the center and help women become self--sufficient.

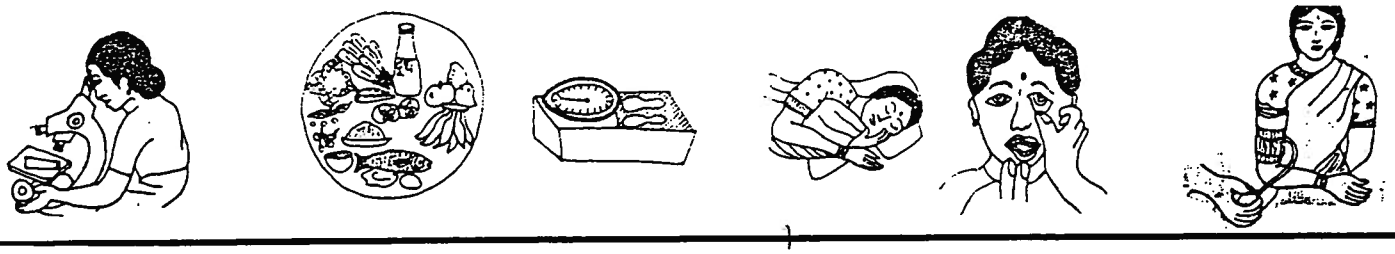


MAKING HOSPITALS 'BABY FRIENDLY' AND MOTHER FRIENDLY

The World Health Organization and UNICEF have launched a new initiative aimed at promoting breast-feeding globally through the creation of 'baby friendly' hospitals. The plan was adopted at a meeting of pediatricians, obstetricians, community health workers and members of non-governmental organizations in Ankara, Turkey, on 28 June 1991. It aims at promoting adoption of the '10 Steps to Successful Breastfeeding' by hospitals and maternity services.

Institutions that adopt and apply these 'ten steps' will be designated as "Baby Friendly" and will receive a plaque or other award of public recognition.

UNICEF has managed to get the formula companies to stop giving free samples to maternities and hospitals in the developing countries so the Baby Friendly Hospital Initiative can be launched. This holds until the end of 1992. Would this would happen in the United States.



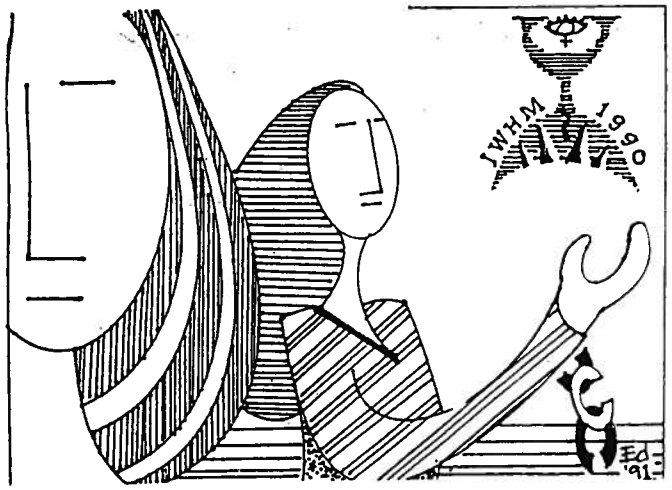
HIGH-RISK MOTHERS - BANGLADESH

TBA's provide an invaluable, cost-effective and culturally acceptable maternity service in developing countries where the majority of deliveries are performed at home and where health services are poorly distributed. TBA's are trained to provide antenatal care, perform safe deliveries, ensure that mothers breastfeed and motivate mothers to have their babies and themselves immunized and to adopt a family planning method. An important part of the TBA's function is to recognize a mother who is considered to be at risk, applying the standard criteria of high parity, age, height, obstetrical history, bleeding, edema and so on. We are teaching her to refer these high-risk mothers to a hospital service which in many places does not exist, is too far away from the family home or is feared because of its (often justified) association with death. Furthermore, a referral may represent loss of earnings from the delivery for the TBA.

For every step in the right direction, we meet a problem and the question of how to cater to women who have been identified as requiring trained medical supervision and hospital care must be addressed as a matter of urgency and innovative solutions found and tried.

The idea of establishing maternity waiting homes or halfway homes is not new but it seems that they are few in number, perhaps owing to our historical indifference to maternal care. In Bangladesh, we are starting to find solutions and monitoring the impact of these so that if successful, they can be replicated elsewhere in the country or abroad.

The "natural delivery room" at Ad-din Welfare Centre in Jessore, opened in 1990, is attempting to tackle not only the problem of providing a user-friendly referral centre for high-risk mothers, but also cater to the practical training needs of the TBA's in an environment which completely resembles the one in which she works.



MARHIA 3

Ad-din is a small 20 bed hospital with surgical facilities situated in Jessore a small town in western Bangladesh. Ad-din's community-based programs in nearby rural areas meanwhile, provide integrated PHC/development services which include TBA's. Within the hospital compound, is a corner where a village home complete with mud floor and thatched room has been constructed. This is the delivery room, and adjacent to this is a latrine, tubewell and accommodation facilities for relatives and women in labor.

The delivery room allows women to feel comfortable in its non-clinical environment which entirely resembles their own homes. The TBA who has referred the woman is encouraged to stay with her during the delivery which is conducted by trained medical personnel. If the situation demands, the woman may be taken into the main hospital where a caesarian section or other medical intervention can be performed.

It is too early to say how successful this small and unusual maternity unit is though the numbers of users is increasing, including those who are not at-risk but simply like the idea of having a baby there. It does seem to meet many of the needs, providing the professional back-up care at very close proximity. A detailed delivery monitoring record is kept and following delivery, the TBA can provide home-based postpartum care and ensure that the mother attends one of the clinics for her 6 week check-up. We shall be pleased to provide information on this project and details of its progress to anyone interested.

Fiona Duby, Dhaka, Bangladesh

LET'S CHANGE THIS

UNICEF

This picture shows how well the male infant fared on breastmilk. The belief that there is not enough milk for twins is a common myth with disastrous effects in many developing countries for the infant bottlefed. The infant that is frequently sacrificed is a girl.

Shall I call you Factories
For you produce children,
Whom you neither own nor control
Yes, you are factories for you have no control over your uteruses
You are better factories when you produce sons
But rejected factories when you produce girls
But what is your pay
What payment does a factory receive for production?
Please help me to answer

The Hon. Miria R. Matembe
Uganda

Research Reveals

Results from the first year of a New Zealand cot death study in 120 cases of SIDS and 50 controls found maternal smoking, lack of breastfeeding on hospital discharge, and keeping the infant in the prone position during sleep to be significant risk factors.

Breastfeeding Review vol. II, No. 3, July 1991.

"Breastfeeding Out of the Closet" by Helen Leonard

May 1991 was a very important time for breastfeeding mothers in Australia. On May 7th, right smack in the middle of National Mothering Week, a young mother from Newcastle laid a complaint with the Human Rights and Equal Opportunity Commission because she had been denied the right to breastfeed her baby in a cinema foyer. "Women have organized for their right to breastfeed in public." The author says, "I've kept my eyes open, but I've yet to see anyone strip to the waist in some public place so they can shock the sex off everyone."

Breastfeeding Review vol. II, No. 3, July 1991.

The high Cesarean rate in the United States has not decreased infant mortality. Women privately insured have higher C section rates. So profit is a major determinant. If we are not careful, C sections will become the norm just as bottlefeeding has replaced breastfeeding in the United States.

From Rhetoric to Reality

There is an urgent need for donors and PVOs and NGOs to recognize that technology cannot replace hygiene and that a little initiative and attention to local conditions can save lives. More expenditure to improve delivery conditions will make more difference than conferences. Women in most parts of the world deliver in fear and filth. Often they deliver unwanted infants. They are raped in and out of marriage and are expected to be good mothers. Unless there is choice for women, the wretched situation will continue. Poor women are getting less choice and resources. In the United Kingdom, a man was recently given five years prison sentence for raping his wife. He is still the exception. There has to a MAJOR SHIFT IN POLICY AND RESOURCES DISTRIBUTION according to prioritorized need, not fashions.

The Women's International Public Health Network

The Women's International Public Health Network was formed as a grass roots movement at the World Federation of Public Health Association Meeting in Mexico City (March 1987), to provide all women in the field of public health with an opportunity to work together to improve women's health worldwide.

Who Is It For?

Any woman working in public health.

What Are The Objectives?

To serve as a resource network and umbrella organization for women's groups throughout the world in health or health related areas. Through this educational support and communication network, women in public health will be able to maximize their resources and work together more effectively to promote better health for all women.

What Do We Do?

- Provide support to colleagues in the field of public health. Groups in each country share information, experiences, ideas and resources. Colleagues visiting from other countries will find a network of friends.
- Promote women in international public health and identify women's issues such as: safe motherhood and health rights.
- Network with other women's organizations.
- Publish a newsletter that addresses international women's health issues, programs and opportunities.
- Participate in policy development related to women's health and publish position papers on specific issues.
- Serve as an exchange forum.
- Maintain a speakers bureau and sponsor programs, panels, and meetings at conferences.
- Provide technical assistance.
- Offer information on existing training, resources and materials for identified needs.
- Act as a resource for funding information and opportunities for members.
- Research neglected women's health areas.
- Provide employment information through a job bank.

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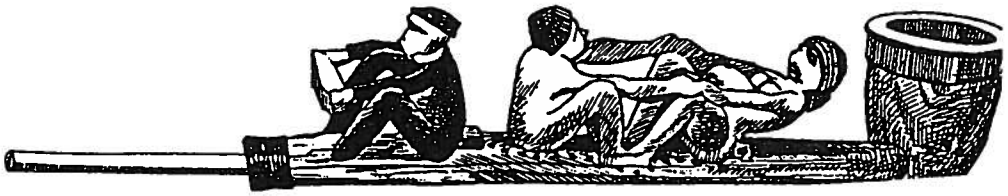

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