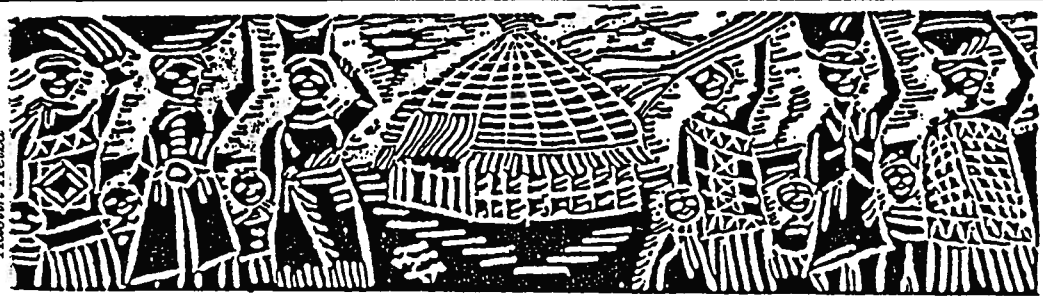


WIPHN News

A publication of the Women's International Public Health Network

Women Hold Up Half the Sky

Volume 11 · Spring 1992

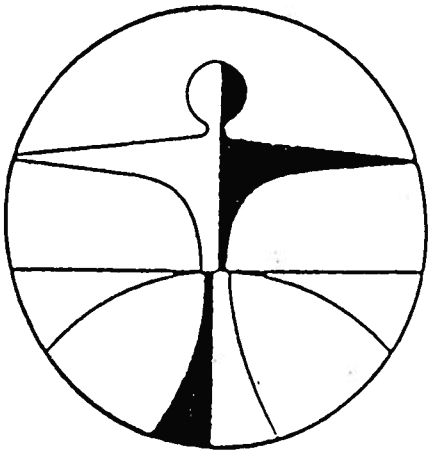
Nations of women still lift
Up their voices with nations of other women
And turn pans into printing presses
And weave cloth into protest banners

Mary Gashoh

Barriers to Training And Employment in A Khmer Refugee Camp

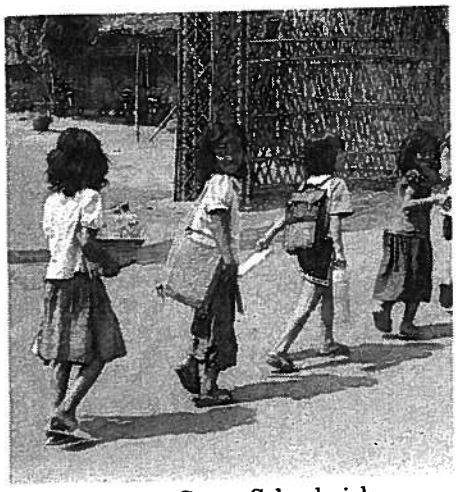
The Thai-Cambodian border is currently home to approximately 300,000 Khmer (Cambodian) "displaced" people in several camps inside Thailand; thousands more have been resettled in third countries. Those that remain have been refused refugee status and are subject to repatriation scheduled for mid-1992. Khao I Dang Holding Center (KID), with a population of 15,000, is the only camp administered by the United Nations High Commissioner for Refugees (UNHCR). The remainder are supported by the UN Border Relief Organization (UNBRO) but administered by one of three factions of the Coalition Government of Democratic Kampuchea (the political-military groups who have been fighting the current government of Cambodia; all parties have recently signed a UN-sponsored peace agreement.

Health services in KID are provided by as many as 10 Thai, international and non-governmental organizations (NGOs) who employ over 400 camp-trained Khmer health workers. The majority of health training is provided by the Khmer Health Training Center, an NGO-sponsored program. In a 1991 study I found approximately 25% of graduates and health care workers over the past 5 years were women. Women graduates were fairly evenly distributed throughout the courses (anatomy, community health, nursing and medicine); the attendants of the gynecology and midwifery courses were nearly all women. Women tended to be younger (21.5 years) than men (23.1 years) although age data was limited. On the other hand, women health workers were more often concentrated in the lower level positions, comprising 23-42% of basic and community health workers; 100% of midwives (traditional and western) were women. Conversely, a smaller proportion of nurses (0-11%) and medics (24% in 1991) were women. Few women have been physiotherapy assistants, health instructors or supervisors. Some of the most consistent and important findings in this study were related to the cultural and practical barriers Khmer women face in health training and employment. Focus group discussions with women health workers (including traditional midwives, hospital and clinic workers, public health and para-social workers) as well as (mostly male) health instructors, revealed a variety of prevailing customs. In general, Khmer culture places women in the home with household and child care duties resulting in a lack of access to education and jobs. Gender segregation at work and taboos against women and men working together, particularly at night for fear women might get involved in love relationships, limits the type of work acceptable for women.



While few focus groups acknowledged customs that would be supportive to women seeking health training or employment, most agreed that there were personal or family conditions (not necessarily viewed as "customs") which do support women such as: having sufficient money, family approval, support, and literacy. Two dominant forces that may shape women's lives upon return to Cambodia were also revealed. First, women's individual attributes or abilities were thought to affect their future job potential; some felt that if women studied hard they would be able to obtain or change jobs. Age also was significant. "Women are getting old and will stay at home and not work." Secondly, many were apprehensive about the potential discrimination they may face by the current government (they may be seen as a "minority").

The concerns voiced in this study



Khmer Camp School girls

highlight the need for increased access to education and training as well as employment for Khmer refugee women. In fact, health worker data from UNBRO camps confirmed our findings regarding the numerical and role discrepancies. As UNHCR in Cambodia has pointed out, building job skills now will be crucial to reintegration. Even if returnees are not employed in government institutions, they will be able to use their skills in the community.

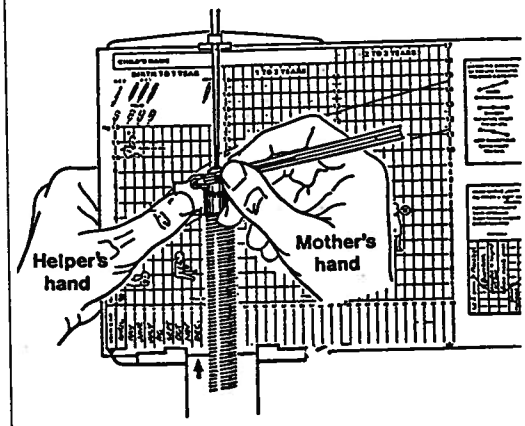
The path to accessing education and jobs will continue to be a difficult one for Khmer women, given the cultural and practical barriers. Supporting the initiatives and participation of women in health planning and research will be crucial in their attempts to make change.

Sherry Lipsky
Seattle, Washington, USA

Professor Dick Jelliffe died suddenly and unexpectedly of a coronary heart attack in March 1992. He is great loss to our cause and to the world. He was a wonderful doctor and humanitarian and a supporter of WIPHN.

NEWSLETTER NUMBER 12 WILL BE A COMMEMORATIVE ISSUE DEDICATED TO THE LATE DR. D. JELLIFFE. THE FOCUS OF THIS ISSUE WILL BE ON BREASTFEEDING. PLEASE SEND ILLUSTRATIONS, THOUGHTS AND ARTICLES (1 page, double spaced), as soon as possible and not later than JULY 25, 1992.

Teaching midwifery students
—Photo: Sherry Lipsky



TALC scale in use.

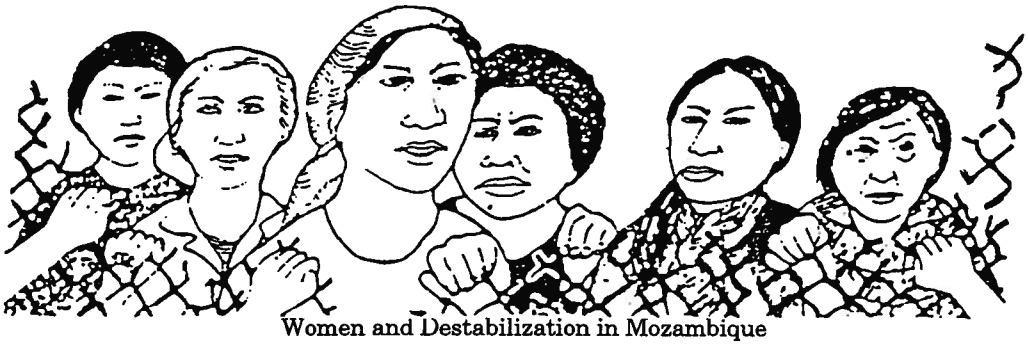
Appropriate Technology

News from David Morley

TALC BABY. Cardboard models of baby and pelvis specially designed for training of TBAs and midwives and for providing a better understanding of the need for flexion of the head available from TALC .

TALC SCALES. Involve mothers through direct recording scales so mothers can plot child growth by themselves in the community. The scale costs less than half the price of existing scales but can only be used with A4 charts on which the kilogram lines are 1 cm apart. They even can be used by illiterate mothers and through it mothers understand the growth curve.

For further details or copy of TALC Baby model, write David Morley, TALC, P.O. Box 49, St. Albans, AL.1 4 AX, United Kingdom.



Women and Destabilization in Mozambique

Women and Destabilization in Mozambique

RENAMO, a rebel bandit group in Mozambique, has waged a brutal war, hitting civilian and economic targets. Women have suffered both directly and indirectly in this war. Direct aggression against women has included rape and torture. Several researchers have interviewed Mozambican women victims of war. Their testimony is chillingly consistent. The worst atrocities have been committed against women who have been kidnapped and forced to live in RENAMO bases.

Indirectly women have suffered displacement from their homes and disruption of the social fabric of their lives. Within Mozambique, an estimated 2 million of the total population of 15 million have been displaced and a further million have sought refuge in neighboring countries. Many have lost their husbands and children. Studies reporting on widows among the displaced probably give an underestimate of the true number; women tend to remarry quickly as unsupported women have difficulty surviving alone.

With RENAMO attacks, rural women's lives have become increasingly insecure. Since last century, women were left to tend the family farms in the rural areas, as men migrated to the South African mines and the cities and plantations in search of work. Now, in addition to the long hours spent in producing the family food supply, they have to spend time searching for safety. They often sleep in the bush, as RENAMO usually attack after dark. A trip to collect water becomes a perilous journey, as bandits may be lying in wait.

In the cities, life is also harder for women because of the war. Many have had to look after relatives who have fled from war affected areas. Urban women have always moved back and forth to the rural area; city wages have never been sufficient to support a family, and sale of produce from the rural family farm has provided a necessary supplement. Now, as this supplement is no longer available, women have to seek other sources of income in the city. Pressures for land have increased in the greenbelt around the cities, causing small-scale producers to sell their land.

The war has caused closure of over 2500 primary schools (45% of the total), depriving almost half a million primary age children of schooling. Gains in adult literacy were an important post-independence advance for women. The number of adults entering literacy classes fell from 200,000 in 1982 to 60,000 in 1987.

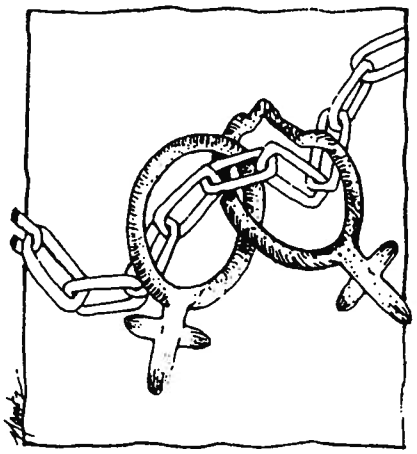
RENAMO has forced the closure of 1075 peripheral health units by the end of 1989. Maternity units have come under direct attack; for example, in Inhambane province attendance at maternity units for delivery dropped after a massacre in the town of Homoine, when RENAMO bandits murdered pregnant women awaiting delivery in the hospital. The war caused the state to divert funds from health to defense; the percentage of the state budget spent on health fell from 10.7% in 1981 to 4.6% in 1986.

Little information is available on the impact of destabilization on women's health. Two topics merit special attention for research and action: the impact of the war on venereal disease incidence rates and on women's psychological state. Programs exist to rehabilitate children who have been psychologically traumatized, but women who have been raped and otherwise traumatized may also need special support. Also, women in rural areas who have lost access to health services owing to the war are at high risk of maternal death and merit high priority in the safe motherhood initiative.

Julie Cliff
Mozambique

Refugee Women—Neglected and Abused

Over 85% of the 15 million refugees worldwide are women and children. Programs seek to deal with physical needs only and are inadequate. Men are given more food than women and women may even have to trade sex for rations. Women are abused physically and mentally by their camp guards. They have no input in the decision making. Where education is made available, it is only primarily for males.



Trouble and Strife, No. 21

Women's special needs such as menstruation, family planning and maternity care, let alone health needs, are ignored. In Malawi, for example, women deliver in the dark. Gas lamps are urgently needed for traditional birth attendants' use in the camps. Schooling for girls is limited. There are few services for widows, married women, or orphans.

WOMEN AND CHILDREN'S HEALTH IN THE LIBERIAN CIVIL WAR

Provision of adequate and quality care to women and children has been a concern in Liberia, even before the war. Liberia has one of the highest infant and maternal morbidity and mortality rates in the world. Efforts to improve the provision of care to mothers and children have started but the lack of adequate resources is a major problem.

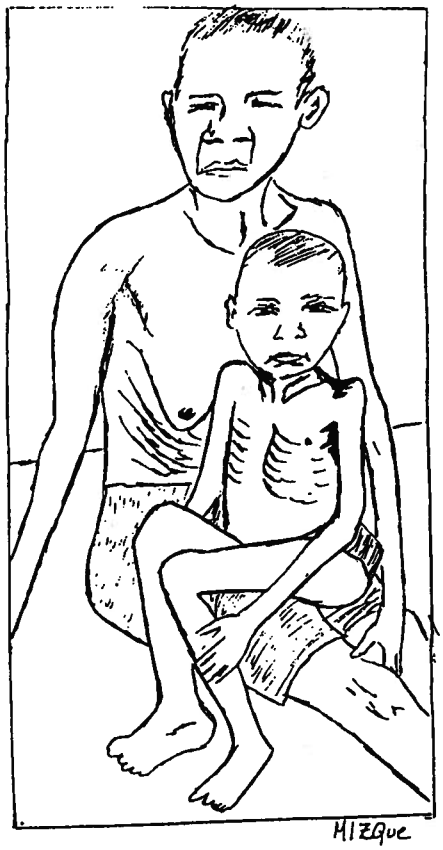
The civil war has caused a lot of suffering for women and children in Liberia. During the war, hospitals and clinics were closed and health personnel sought refuge outside Liberia; this caused MCH/FP services to be very scarce.

Pregnant women already lacking prenatal care had to walk miles in search of safety. There were many abortion and deaths of mothers and newborns. Deliveries when possible, have taken place in the most inhumane and unsanitary conditions. Many mothers could not have C-sections done, lacerations sutured or bleeding stopped, resulting in mother and/or infants dying during deliveries. Teenage pregnancy, from what we have observed, is on the increase. There are many girls 15 years old and younger who are pregnant or with newborns. Many children lack food, clothing and shelter, many are orphaned, malnourished and handicapped. More importantly, they have seen, heard and undergone so much that their minds have been damaged.

As a consequence of the war, even the little that had been accomplished in women's and children's health in Liberia has been destroyed. There is a need to start all over. Now is the time to emphasize the importance of prenatal care, under-five care, breast feeding, family planning, sanitary deliveries and treatment of common illnesses.

Since resources are very limited, institutions/organizations who would like to work in Liberia must remember that people (the most important resource) have gone through very terrible experiences and have feelings of grief, apathy, confusion and hate. Dealing with these experiences needs to be a part of any MCH/FP program if the health of mothers and children is to be improved. Tomorrow will be too late for our children; we need to work today for growth and development both physically and mentally for our future children.

Marion Subah
Monrovia, Liberia



The Plight of Refugees and the Displaced in Liberia

When refugees arrive, they are housed in a fenced-in transit center where 30 to 40 people live in a tent, register for rations and receive assistance in rural resettlement. After one week they are required to leave the center for rural settlements and they must leave behind bedding and other items they have used in the center. Some people find their own accommodations in Danane, a city with 12,000 Liberian refugees. Others have ended up staying in the transit center longer than one week. Finding urban housing is difficult because of lack of availability and rising rents. Unaccompanied youths (ages 13-20) who live in the center often cause trouble. They are not cared for because of a lack of staff.

From Shana Swiss
Women's Commission for Refugee Women and Children

Income-Generating Projects for Refugees

Members of the Liberian Refugee Women's Committee (LRWC) have taken the initiative on behalf of 1,000 refugee women to serve as a liaison between them and the service organizations as there is a lack of income-generating activities and skill development programs. They would like to coordinate women's activities with education and health education but do not have the necessary resources. Another problem is that female nurses, teachers and typists -- have not been absorbed into the work force and refugee business women have no capital to start small-trading. There is a need to expand projects such as: soap-making, cooking, knitting, sewing, tie-dying, handicrafts, bread-baking and wood-conserving stove construction, as well as health and agricultural training.

REFUGEES' NUTRITION CRISIS

Their faces are familiar, but we seldom meet them. Refugees, trailing in endless lines, loaded with bundles of remaining possessions, exhausted, carrying bewildered children. We see them in photos and television pictures - as they become refugees, we lose sight of them as attention shifts, and they start their long stays in overcrowded camps.

At least 35 million people in the world have either fled their country as refugees, or been displaced internally due mainly to civil war. Of today's 15-20 million cross-border refugees, about 13 million are in Africa, southwest Asia and the Middle East, and their situation cannot be considered temporary. These numbers have at least doubled during the 1980s. The numbers themselves are not certain - that too is part of the problem.

Refugees suffer from the same type of diseases as other vulnerable groups in developing countries, only more so. Malnutrition, infectious disease and mental imbalances are some of the more common consequences of being uprooted. At first they need water, food shelter and medical help.

The immediate cause of their nutritional crisis is that not enough food gets to many refugees. Refugees may be largely dependent on the food provided by governments and donors, and unable to use the diversity of foods or the food rations may lack certain essential nutrients so that after some time bodily reserves are exhausted and deficiency diseases break out. Many continue to starve, and get deficiency disease as they languish in camps neglected by world attention. Outbreaks of scurvy, beri-beri, pellagra, reminiscent of half a century ago and hardly seen since, have now actually reappeared as epidemics amongst refugee camp populations. These disease are easily prevented by a more diverse diet; and in some cases by fortification of rations.

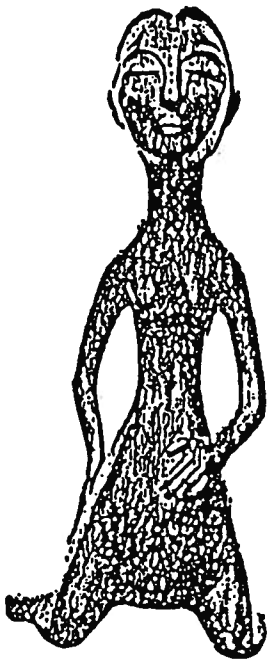
There is a lack of accountability among organizations responsible for feeding refugees. When things go wrong, everyone blames everyone else. No one accepts responsibility and mistakes are perpetuated. Host countries claim insufficient resources, UN agencies inadequate mandates and NGOs a lack of coordination. Failures to effectively deliver food to refugee populations can be traced to inadequate information on which to base decisions or inadequate policies guiding such decisions, compounded by ill-defined operational roles and responsibilities. Food received may be inadequate because rations ordered were not enough or not sufficiently varied, or delivery was hampered by logistical problems. or equitable distribution within camps could not be achieved. Usually it is a combination of all these reasons. Refugees like anyone else require food adequate in quantity and quality, clean water, good latrines and shelter. Expensive medical technologies like intravenous drips dispensed by Westerners may be attractive to the media, but are only required by a small minority. Far more people benefit from less-glamorous methods such as oral rehydration and immunization. Refugees should be viewed as being resourceful rather than dependent, and their ability to engage in self-sustaining economic activities should be maximized.

Governments should re-affirm the right to food as a basic human right, and establish new mechanisms for upholding such rights among refugees and displaced persons. Within the UN system the coordinating role of UNHCR should be strengthened and cooperation in international relief with competent NGOs facilitated. Refugees should not be treated as a political tool, nor should they be labelled and stereotyped or manipulated through the use of food.

Source: Abstracted from SCN News No.7, 1991. Esther Kazilimami

HELP WANTED

The Institute for Development and Training (IDT) is revising its self-instructional Training Course in Women's Health and would like WIPHN members to review the present version. Reviewers will receive credit. *If interested, contact Jeanne Betsock Stillman, Institute for Development Training, 475 Riverside Drive, 18th Floor, New York, N.Y. 10115; Phone:212-870-3074.*



Reaching Out to Refugees

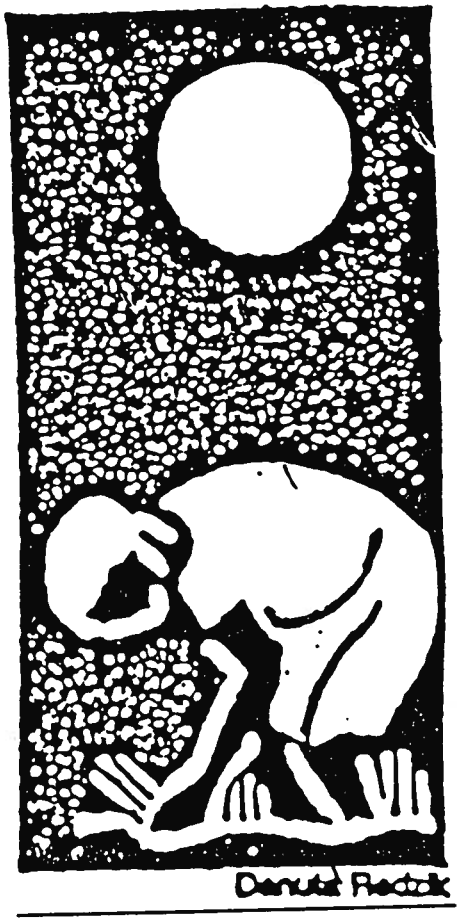
Hai had the misfortune to go into labor early, while she was still with her family. This was against the rules. Because of the lack of medical facilities, no Vietnamese refugee is permitted to give birth inside the detention camps. Hai is one of the more than 60,000 "boat people" who fled the Communist regime in her homeland and landed in Hong Kong. Depending upon the route, those who escape by sea can risk a 50% chance of being killed in typhoons and a 70% chance of being pillaged by pirates. These refugees hope to be permanently resettled, but first they must seek temporary asylum in detention centers in neighboring countries.

In Hai's case contractions had begun while she was lying on the wooden pallet where her family lives inside a large camp. She claims that orderlies swept into the barracks to remove her from the premises. The baby's head was already emerging. Hai's legs were held together to prevent the infant from being born on the spot."They did not release my legs until I got to the delivery room," she explained later. "When I delivered my child it was no longer alive. It had suffocated."

In Hong Kong, within the shadow of high rise buildings and well tended city streets, the Vietnamese refugees live behind barbed wire in concrete warehouses, packed in, like sardines. Some women told of being raped by masked gangs that terrorize the camps at night. One woman says she was sexually assaulted while she held her child in her arms. Others are separated from husbands and children who have been assigned to different camps. When one woman was about to be relocated, she could not locate her 3 year old child. Though the mother pleaded with the guards she was not allowed to find her little girl and take her along.

The plight of the world's displaced people is growing worse. There are so many refugees because there are so many more internal conflicts. Third World children are paying with their lives.*

Women's Commission Newsletter No.2, June 1991



LAOS: As the Refugees Return

For the past 15 years, nearly 10 percent of the population of Laos—including a third of the Hmong people—have fled their country. The vast majority have spent more than a decade in camps in Thailand, where approximately 70,000 remain. However, Thailand is pressing to close the camps within the next three to four years at which time Laotian refugees will be forced to choose between resettlement abroad or repatriation to Laos. Meanwhile, as support wanes and Laos begins to renew ties with the West, there is a growing interest among the refugees in returning to their homeland. Some however, are being forced back against their will.

Refugees face much more than mere economic deprivation. They flee a past of persecution and suffering and they face a future of homelessness. They are clusters of humanity left to endure the aftermath of terror: lost family members, lost possessions, lost hopes.

If we abandon our responsibility to uphold freedom by providing hope to those who are not free, to those terrorized by political persecution, then we have failed history and failed ourselves.

Women's Commission for Refugee Women and Children Newsletter No.2, 1991

Haitian Refugees

The majority of people who fled Haiti were men, and they left a lot of women behind. It was hoped that the men would send for them later. A "passage to the free world" costs about $100. A family had to raise or borrow this money and hope they could pay back when settled in the land of their refuge. There have been no studies on the state of the women and children left behind. Traditionally Haitian women marketed food produce and their men cultivated the land. The exodus of the men has created more work for the women as they now have to do both jobs. The health centers have closed because most of the physicians and nurses who are foreign have left. The vaccination program has broken down and there is decreased patronage of, and access to, health services.

Esther Kazilimani
USA

FFW

Women, Medicine, and Health

In the isolated east Sudanese village of Mreibea, Madina, the traditional birth attendant faces a problem. The community has boycotted her services after her decision not to circumcise females any more. She made that choice after noticing the association of persistent urine leakage with circumcision. Although she is sure she has done the right thing, Madina is powerless to confront her critics alone.

Liyamna, a woman from the poor village of Wilad Hamouda in northwest Tunisia, is confused. Her sister, Khadija is still suffering from severe menstrual pains and infertility, though they have spent hard-earned money to travel to the distant town of Makthar for treatment. The monthly injection of tetracycline, an antibiotic prescribed in a hurry by the town physician, has done no good.

The medical hierarchy in Middle Eastern countries today reflects the sexual hierarchy of Arabic societies: women, historically providers of health care, have been marginalized, and men have taken over. Women's skills in healing and health provision are devalued, and traditional midwives are often cast aside. The monopoly of expensive medicine continues as few question the reasons for medical management of childbirth, in increasing numbers of cesarean sections and hysterectomies, and overuse of medicines.

Other factors endanger women's health and survival. The scarce data on maternal death points toward a drastic situation. Almost every village encountered describes as a common scene the burial of a women who died in labor. Do these women die from malnutrition and anemia, from insufficient obstetric care, from lack of contraceptives, or from factors related to social and sexual hierarchy? Research on maternal death is minimal in societies where women occupy a low status. Laws fail to provide sufficient protection. Child marriage, chastity rules, repudiation, polygamy, segregation of women, demands for high fertility, unequal share in nutrition, circumcision (in Egypt and Sudan), household overwork, unpaid agricultural labor, preference for male children, unequal inheritance, minimal participation in leadership-all of these are factors often taken for granted and accepted as normal.

The adoption of primary health care as a strategy over the past decade challenges the curative medical model and implies a variety of approaches, including promotive, preventive, curative and rehabilitative action. Primary health care also implies the need for health workers who live with the community, know their problems, and work with them toward better health status.

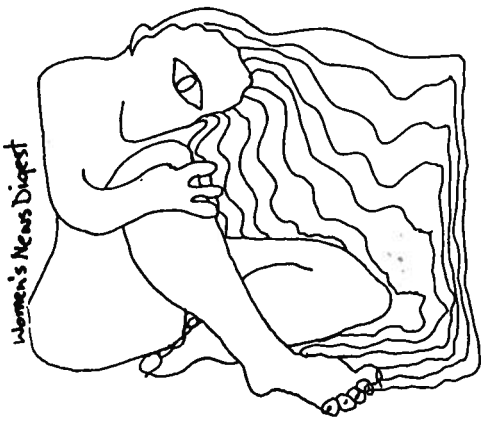
Innovative educational methods are an important part of the primary health care approach. Non-formal adult education methods used to train health workers assume that adults have learned much from life which is applicable, and that they apply lessons best when they discover things for themselves. Problem-posing approaches help people observe, listen, think, analyze, differentiate, discover and plan for appropriate action.

Rural women health workers are usually in charge of about 50 homes in their own communities. They help mothers learn to use oral rehydration therapy, discover immunization defaulters, deal with breast-feeding problems, promote family spacing, act as a liaison to traditional birth attendants, refer those at risk, and perform many others tasks. In some areas they have established women's groups and health committees, initiated home gardens and income-generating projects for women, and planned adult education sessions. They provide models of how communities can take charge of their health needs.

As with many primary health care projects, questions of funding, sustainability and integration into ministry of health structures remain. But for the present such projects have enabled women like Madina and Liyamna to regain their self-esteem and to find support in meeting the health needs of the women in their communities.*

May Haddad

** For full article write WIPHN*



The Kurdish Crisis

More than two million people in Iraq, the vast majority of them Kurdish, fled their homes and villages for what they hoped would mean safety...but unlike the ability of the international community to galvanize around the deployment of war, there was no such unity or commitment to deploy forces of humanitarian aid. Lack of shelter, food and adequate clothing resulted in thousands of Kurdish people dying, mostly children and the elderly.

• Facts and Figures

Sudan is facing another devastating famine and yet it is hard to get the government to accept it. Apparently in Arabic the word famine indicates that there are "people dying in the streets." When asked if there is a famine, the answer is "no."

LETS CHANGE THIS

From: Women's World, Summer 1991.

- The small reduction in risk of women dying as a result of pregnancy and childbirth has failed to shrink the annual death toll. From "Safe Motherhood", Issue 8, March-July 1992. Support our SAVE A MOM CAMPAIGN with your donation and lets make the difference.

- **The Dangers of Being a Girl Child in an Indifferent Society**: Females in the Philippines are twice as likely as males to be anemic and in children (7 to 14 years) the prevalence of goiter was eight times more for females(6.4%) compared to (0.5%) in males. MARHIA, Institute for Social Studies and Action (ISSA), Vol. IV, No. 1, 1991.

BREASTFEEDING NEWS

- Mother's milk is threatened by Free Trade Pact (Infact Fall 1991)
- The mortality rate of infants who are bottlefed is 14 times greater than for breastfed infants.
- Formula-fed infants are at risk for iron deficiency, but breastfed infants are not.
- Breastfeeding duration of Ethiopian women falls in Southern California from 12 months to 4.2 months. Reasons given for stopping breastfeeding were milk insufficiency and work outside the home. Meftuh, A.B., Journal of Tropical Pediatrics, Vol. 36, 203-204,1990.

  Editor's comment: The free formula from WIC programs is a contributory factor.
- As a recent study revealed, Vitamin D fortified milk may have too little or too much Vitamin D and both are harmful. Better monitoring of the fortification process is needed.

Jacobus CH et al, New England Journal of Medicine, No. 18, Vol. 326, p. 1173, 1992.

Teenage Pregnancy— Call for Action

Approximately 15 million women between the ages of 15 and 19, give birth every year. 80% of these births are in Latin American, Caribbean, African, Asian and Pacific (LACAAP) countries. The United States has a higher teenage pregnancy rate than most other countries and is the only country outside the LACAAP where teenage pregnancies have been increasing in recent years.

Women's social and economic position is made even worse if they have a child in their teens, especially if they are unmarried. The teenager ends up marrying later due to social changes, so her number of pregnancies outside marriage increases. For example, surveys have shown that about half of all children born to teenagers in Latin America and the Caribbean are born to single parents.

Major barriers prevent teenagers from having access to reproductive health services, including contraceptive services. Moreover health services are deteriorating in LACAAP countries due to the worsening economic situation.

Pregnancy poses special health risks for teenage women, especially those under fifteen. The younger women are, the higher their risk of death or severe physical damage due to pregnancy, childbirth or clandestine abortion. Surveys in large cities in Latin America have shown that the abortion rate is increasing fastest among teenage women.

The health risks are even greater for poor teenagers since their physical condition is generally worse and they are less likely to have information about antenatal care or means to pay for clandestine abortion.

Editor's Note: May 28th is the International Day for Women's Health Action. This year it will focus on teenage pregnancies. If you organize any activities on this theme, write to Women's Global Network for Reproductive Rights, NZ Voorburgwal 32, 1012 RZ, Amsterdam, The Netherlands.

Family Planning and Race in South Africa

Reproductive health is a key issue in contemporary South Africa, as population growth is one of the major problems of the future. Demographic trends during the last 40 years show a decrease in the white population, an increasing black population, and a relatively stable Colored and Asian population.

A field study carried out to ascertain contraceptive use associated with ethnicity indicated that long-acting contraceptive agents are more commonly given to poor (black) sections of the community. Use of other methods is negligible. The dominant method used among white women is short acting oral contraception.

Clinics in the "white" areas have more staff, fewer patients and consequently more time for each patient. At a clinic in Khayelitsha (a black area) a family planning sister could have 200 patients per session giving an average of 2 minutes per patient. Among black and colored women the most common way of first encountering family planning was when, on the day of their discharge from a postnatal ward, they were given an injection of Depo-Provera, often without information or consent.

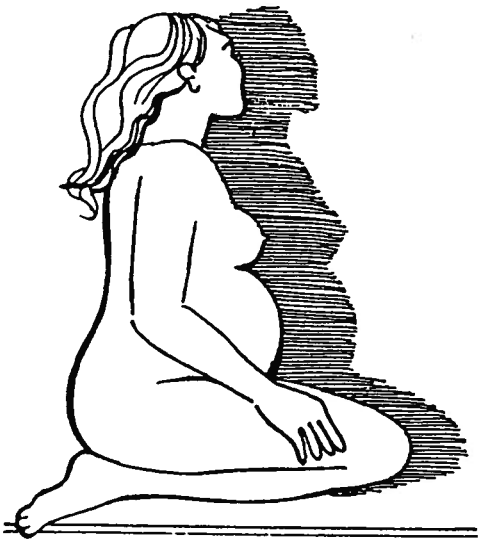
Another area where evidence of pressure to use Depo-Provera was found, was in occupational settings. Mobile teams visit factories regularly and cater to the contraceptive needs of the employees. At some factories the employer actually checks to see that female employees regularly receive contraception. As such a check cannot be done with an oral method; it is not difficult to understand why injectable are their method of choice. Proof of regular contraceptive injections can be a criteria for employment in some cases.

Women interviewed expressed the view that South Africa needs less rapid population growth, showing an awareness of problems associated with a rapidly increasing population. This awareness might, under different circumstances, have an impact on the demographic trends in the country and has had such an effect among the white and Asian population groups, only partly among the colored group, and not at all among the black group. Contraception continuation rates are low among black and colored women.

Poor social circumstances of the majority of blacks is the single most important factor contributing to the continued high fertility rate in this group, and an absolute lack of power the causative agent. By "lack of power" we mean not only political power in general, but the status of women in society in particular. With little or no hope of attaining an education, career possibilities outside the home, and little influence on decisions concerning family or community matters, the only remaining status is that of motherhood.*

Elizabeth Kollstedt
Staffan Bergstrom
Sweden

* For copy of full paper write WIPHN and send postage.

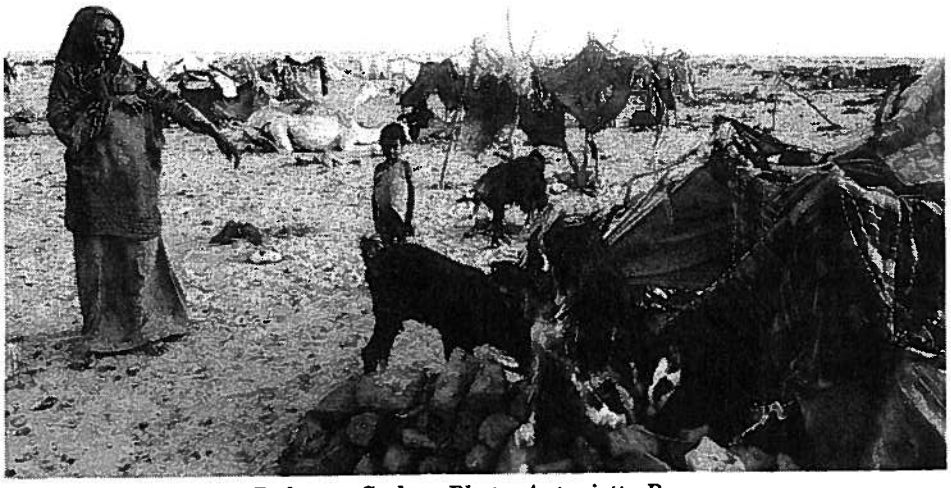


Harare, Zimbabwe:
HIV/AIDS Crisis Centre

Jane Shepherd

The Mashambanzou T-shirt was produced to raise money for the HIV/AIDS Crisis Centre of the same name in Harare, Zimbabwe. (Mashambanzou means "time of day when elephants wash themselves" or "dawn of the day"). The drop-in contre was instigated a year ago to meet the needs of people with AIDS living far from their families. The centre already produces its own vegetables and can provide free clothing. It will be run by two paid workers and offer advice, a support group, workshops, dance and theatre projects, while long-term plans aer to provide week-end care or temporary accommodation for people with AIDS.

Source: AIDS Watch, 1991, 2nd Quarter. For information, write to: IPPF, Regent's College, Inner Circle, Regent's Park, London NW1 4NS, United Kingdom.



Refugees Sudan *Photo: Antonietta Peru*

Statistics and Facts Need To Be Checked

The Sudan TBA Training Project was based on information received from the Ministry of Health that 80% of deliveries were conducted by untrained TBAs. However, the Sudan Demographic and Health Survey conducted in 1990 showed that this data was incorrect.

In fact, in the five years before the survey, 60% of births were assisted by trained health workers/midwives at the time of delivery, 9% by doctors and 26% by TBAs. Urban mothers are more likely to receive professional assistance than rural mothers. However, the trained health worker remains the dominant assistant for both urban and rural mothers. The proportion of births assisted by doctors is notably higher in urban areas (18%) and Khartoum region (26%) , and those assisted by TBAs are higher in rural areas (34%) and Darfur region (48%).

Another reason for involving the TBA more actively was to be able to help influence women with regard to female circumcision and was based on the assumption that as the TBA was doing most of the deliveries she would also be doing most of the circumcisions. But village midwives have superior technology to the TBAs, such as local anesthetic. In the Sudan they are the main practitioners of female circumcision which they learn from other midwives as an extra-curricular activity. 75% of women in the Sudan support female circumcision as a practice. The only opposition is from a small educated elite.

Breastfeeding is another area of concern. VMWs practice feeding boiled water to the newborn infant for as many as 3 days, or until the milk comes. This practice is also taught and maintained in the obstetric hospitals. The need for exclusive breastfeeding along with the importance of colostrum ingestion for the new born child needs to be taught, so that the VMWs can share this information with mothers.

Correct reproductive knowledge is known by less than 30% of married women. Reproductive control is used by an estimated 17% in urban and 4% in rural areas. There are a lot of discussions being held by obstetricians and MCH staff about the possibility and suitability of VMWs becoming more involved, but no research has been done to find out the attitude or desire of VMWs themselves to be involved in this area.

Last but not least, there is a very low level of literacy among VMWs. Unfortunately, the method set up in 1924 by the Wolf sisters of teaching by sight, smell and touch continues today. The lack of teaching literacy is most probably a reflection of the continuing control that the present hierarchical system exerts to maintain power.

Village midwives are on the way to replacing Traditional Birth Attendants as a source of influence in areas of childbirth. Furthermore, not much is known of the opinions and needs of the women themselves who rely on VMWs.

Migration from rural to urban areas increased from 8.8 in 1955/56 to 20.5 in 1983. Migrant rural women (which increased from 8.8% in 1955 to 21% in 1983) are particularly disadvantaged in the new urban settings. They suffer from a loss of supportive kinship relationships, less education and very few marketable skills. Their knowledge of reproduction and reproductive control is practically nil. The competition for income generation selling tea and homemade goods, has increased rapidly with the consequences of reduced income for those participating. In the meantime, prices for basic commodities continue to rise making life more difficult nutritionally and having a detrimental effect on the health of women and children.

The Women's Office of NARP (Natural Resources Protection Group), composed entirely of concerned Sudanese who are interested in environmental development and women's issues, especially in the way they are related and interconnect. They are now in the process of conducting a needs assessment of women and VHWs in the Sudan to ensure that the project proposals will deal with issues that women feel most important.

For a copy of the needs assessment instrument, write WIPHN.

*Eaman Mahmoud**
Sudan

** Dr. Eaman Mahmoud is the Director of Women's Office of NARP and a member of WIPHN.*

The Debate Continues: Does Antenatal Care Reduce Maternal Mortality?

Dear WIPHN:

We were very surprised at Dr. Chalmers' and Ms. Renfrew's response in the recent WIPHN News (Vol. 10, Winter 1991) to our responses to their call for opinions on how prenatal care can reduce maternal mortality (Vol 7, Spring 1990). They state... "What we still seek is the evidence... Several opinions, unsupported by any documented evidence, emerged from the comments... We reiterate our call for documented evidence to support these claims." The original request was for opinions asking which elements of prenatal care we "think" can effectively reduce the risk of maternal death. The request for evidence seemed to be secondary since it was bracketed, and, as is well known, evidence is sorely lacking. This is especially true in Nepal and amongst Afghans, from which perspective we both replied. References were supplied to WIPHN for Nepal, which is all that seems to be available at the present time aside from anecdotal information.

The fact that views differ between Indonesia and Nepal (or any other country for that matter) may reflect differences in the existing conditions, as opposed to being a statement about prenatal care per se. As for the response from Indonesia, while stating prenatal care not to be a priority, the list of priorities goes on to include teaching TBAs to "recognize high risk pregnancies and deliveries using a simple check list and providing them with basic training in safe delivery procedures, *and prenatal care*" (our emphasis).

Those of us responding from our work in the field commented on the problems associated with Dr. Chalmers' and Ms. Renfrew's opinions that maximum benefit may be achievable by safe abortion and appropriate care available during childbirth. However, our qualifications of these as useful measures went unacknowledged because they reiterated their own opinions. Shouldn't we rather try to aim at strategies that are feasible, based on the infrastructures and legal/religious restrictions currently existing on a country-by-country basis? For example, at the present time, safe abortion is not a possibility of either Nepal, Afghanistan, Iran, or Pakistan.

New Global Network: The International People's Health Council has just been formed. If interested please contact David Werner at the Hesperian Foundation, P.O. Box 1962, Palo Alto, CA 94302, USA.

Are the authors suggesting that any attempts at establishing prenatal care (which has not been shown to reduce maternal mortality) are irresponsible?

Our responses seem not to have been read in good faith. Nevertheless, we thank Dr. Chalmers and Ms. Renfrew for initiating this important discussion, and we look forward to proposals for research concerning the part prenatal care might play in the prevention of maternal mortality in developing countries.

Maureen Minden
Judy Carlson
Nepal

FOOD AID AND WOMEN'S HEALTH: New Approach in the Dominican Republic

Traditionally, the priority for PL480 Title II project food aid has been maternal child health (MCH) projects. The subject of women and appropriate food use, both in terms of nutritional and general developmental impact has, however, been largely ignored both in official guidelines and practical implementation. The Dominican Republic historically has been no exception to this rule despite disproportionately high maternal mortality rates.

The focus has been on child malnutrition, yet the three most common causal factors of child nutrition; low birth weight, maternal illiteracy and the absence of exclusive breastfeeding are directly related to women's/maternal health. The worsening health status of Dominican women through the decade of the 80's challenges this traditional model and calls for innovative use of food resource to ensure impact on maternal health status. This paper presents a new model for food aid currently being implemented in the Dominican Republic and a review of the contextual framework in terms of the wider food aid debate and women's health politics.

Hilary Cottam

An Alternate Strategy For Improving Maternal And Neonatal Survival In Rural Bangladesh

The remoteness, poverty and cultural conservatism of the rural Bangladesh region where Save the Children (SCF) operates require that maternal and neonatal mortality be addressed through an approach different from that outlined in the last issue of WIPHN, for example, the establishment of maternity waiting homes. Neither of the government hospitals serving SCF's impact area have ever operated a primary care outreach program similar to that offered by Addin; the process of being admitted to the one government hospital with surgical facilities is, for logistic and administrative reasons, long and circuitous; and the population has been unable and/or reluctant to accept referral to hospital.

We have instead adopted a three-pronged strategy that emphasizes:
1) improvements in village-based preventive care for pregnant women and newborns;

2) improvements in village-based case management of complications during pregnancy, delivery and the post-partum and neonatal periods; and,

3) reduction of financial and cultural barriers to timely hospital referral of complicated cases which cannot be managed in the field.

All three components of this strategy have been designed to maximize their sustainability by the community after SCF withdraws from the area and their replicability by the Bangladesh government in equally poor areas of the country. Information about problems experienced during the case pregnancies, care received during labor and delivery, breastfeeding practices among case mothers, and women's nutritional status also guided us in planning new strategies. The high rates of low birthweight and prematurity are not surprising in a population where 40% of all women of reproductive age are moderately to severely malnourished (Krasovec, in "Maternal Nutrition and Pregnancy Outcomes", PAHO, 1990). Improving women's nutritional status both before and during pregnancy will obviously improve maternal health and reduce adverse birth outcomes.

In this culturally conservative area, it would not be productive to direct health messages only toward pregnant women" 82% of case mothers reported that husbands and mothers-in-law were the first persons consulted for advice in cases of neonatal illness.

One of the most valuable findings of this study concerned current breastfeeding practices; it was surprising to discover that only 37% of mothers of liveborn cases had breastfed their infants exclusively during the first month of life. Sugar-water was most frequently used as a supplement to breast milk, followed by cow or goat milk. Only 51% of mothers initiated breastfeeding immediately after birth or sometime on the first day of life. Mothers who administered supplemental liquids to their children frequently did so by allowing the infant to suck on a cloth which had been soaked in the liquid; such a mode of feeding could certainly predispose this infant population to a high incidence of oral candidiasis. Clearly the promotion of exclusive breastfeeding up to age of five months should be a cornerstone of any strategy to improve neonatal survival in this area.

Village-based nurse midwives are crucial to all parts of the three-pronged strategy outlined earlier. The nurse-midwife will support TBAs and will provide more advanced case management. Prenatal care and post partum care of mother and newborn has been and will remain the responsibility of female medical assistants. However, nurse-midwives will improve the ability of female medical assistants to treat infection (especially urinary tract infections and vaginitis), hypertension, and pre-eclampsia, and to detect abnormal lies. Findings from this study emphasize that a home visit shortly after delivery to reinforce the importance of exclusive breastfeeding and to treat breastfeeding problems would in itself be life-saving. The high incidence of mortality associated with thrush and ARI make it essential that this level of worker be able to effectively treat and monitor at least these two infections.

Over the next two years we will be evaluating the effectiveness of this strategy in terms of its ability to reduce rates of stillbirth and neonatal death, change the spectrum of cause of neonatal death, and improve the practice of behaviors conducive to improved maternal and infant health.*

Afzal Hussain, Najma Khatum and Katherine Kaye
Save the Children, Bangladesh and USA

** For copy of full article write WIPHN.*

Video

EXCESSIVE GLOBAL POPULATION GROWTH

"Population and People of Faith" shows how uplifting women through health care, family planning, education and jobs improves quality of life and helps to reduce population growth. The video challenges viewers to examine the role of their church, denomination or community group and suggests actions to take. Purchase for $29.95; rental $18. A 20-page discussion guide is included. Call 919-967-0563 or write Institute for Development Training, P.O. Box 2522, Chapel Hill, N.C. 27515-2522, USA.

PUBLICATIONS by WIPHN MEMBERS

Ahrtag Annual review '91. Working for Health Worldwide. AHRTAG,

1 London Bridge St., London sei 9SG, UK.

"A Controlled Trial of a Program for the Active Management of Labor." New England Journal of Medicine; 326:7, 450-454, 1991.

Refugee Women. April 1991. Women's Studies/Development/ Refugee Studies. Women and world development, Zed Books, 57 Caledonian Road, London, NI 9BU, UK.

How Schools Shortchange Girls: the American Association of University Women(AAUW) Report. AAUW Educational Foundation, Dept. S, 1111 Sixteenth St., N.W., Washington, DC 20036-4873, USA.

"Working with Street Girls." Centro Brasileiro da Crianca E Do Adolescente-Casa De Passagem Rua Treze De Maio, 55. Santo Amaro, Recife-Pernambuco-Brazil, CEP: 50.040

IPAS. Advances in Abortion Care. IPAS, 303 E. Main St., P.O.Box 100, Carrboro, N.C. 27510, USA.

Childbirth Graphics Ltd., P.O. Box 20540, Rochester, New York 14602-0540, USA.

The Exchange; Women in Development. WID Newsletter, Peace Corps/OTAPS, 1990 K Street, N.W., Washington, DC, 20526, USA.

Refugees. United Nations High Commission for Refugees(UNHCR), P.O. Box 2500, 1211 Geneva 2 Depot, Switzerland.

Our Forgotten Family. Liberians: The Plight of Refugees and the Displaced. Women's Commission for Refugee Women and Children, c/o International Rescue Committee, Inc. 386 Park Avenue South, New York, N.Y. 10016, USA.

Newsletter. Infant Feeding Action Coalition, 10 Trinity Square, Toronto, Canada M5G 1B1.

Women Who Make a Difference:Reaching out to Refugees. Stephanie Abarbanel. Family Circle, June 26, 1990.

Where There Is No Doctor by David Werner. New edition May 1992. The Hesperian Foundation, P.O. Box 1692, Palo Alto, California 94302, USA.

Haiti Insight: A Bulletin on Refugee and Human Rights Affairs. National Coalition for Haitian Refugees, 16 East 42nd Street, 3rd floor, New York, N.Y. 10017, USA.

Safe Motherhood. A Newsletter of Worldwide Activity. Division of Family Health, WHO, 1211 Geneva 27, Switzerland. Available for free.

Viagem ao Mundo da Contracepcao, a guide on contraceptive methods. The book describes all method of contraception available in Brazil and explains the proper way to use them and the advantages and side effects of each. It contains many illustrations. S.O.S. Corpo, Grupo de Saude da Mulher, Recife, Brazil.

A Safe Motherhood Action Kit is available from Family Care International. It is available in French and Spanish and was developed to promote low cost effective solutions to the problems of maternal mortality and morbidity. These publications are free to individuals and organizations in the developing world. Write Family Care International, 588 Broadway, Suite 510, New York, NY 10012, USA.

Towards a Woman's Health Research Agenda: Findings of the 1991 Women's Health Research Roundtables. Write: Society for the Advancement of Women's Health Research, 1601 Connecticut Avenue, N.W., Suite 801, Washington, D.C. 20009, USA.

The Birth Gazette. Edited and published by Ina May Gaskin, it represents the public health attitude in the midwifery community. 42 The Farm, Summertown, TN 38483 USA.

Info Kit on Women's Health. The Institute for Social Studies and Action (ISSA) has just published an information kit entitled "Women's Health Facts and Issues. Write: ISSA, Q CPO, Box no. 84, Philippines.

Rethinking Development - Challenges and Priorities in a Changed World. Society for International Development, 1401 New York Avenue, N.W., Suite 1100, Washington, D.C. 20005.

Gender Equity Guide: Produced by the American Association of University, 1111 Sixteenth St., N.W., Washington, D.C. 20036.

Testimony for the Task Force on Opportunities for Research on Women's Health, Presented by WIPHN, Bethesda, NIH, Maryland, June 12, 1991.

CORRECTION

Newsletter 10, page 6, the report by *Cynthia Hale* entitled "Impact of Traditional Birth Attendants in Nepal", should read "Crude Death Rate" and not "Child Death Rate".

International Public Health Internship Program in Maternal and Child Health is offered by Columbia University, School of Public Health, Centre for Population and Family Health, 60 Haven Ave., B-3, New York, NY 10032, USA. Contact person: Patricia Gass.

A Woman's Guide to Yeast Infections by Naomi Baumslag, M.D. and Dia L. Michels. Pocket Books, 1992. Will be available from WIPHN, $4.70 plus postage.

ORGANIZATIONS THAT HAVE RECENTLY JOINED WIPHN

ADVENTURES in HEALTH, EDUCATION and AGRICULTURAL DEVELOPMENT, Inc., AHEAD, P.O. Box 2049, Rockville, MD 20852, USA.

WOMEN'S HEALTH PROJECT provides information about and involvement of women in the process of developing health policy in South Africa. Center for Health Policy, Dept. of Community Health, Wits Medical School, 7 York Rd., Parktown, 2193 South Africa.

CHILDHOPE. Focus on Needs of Street Girls, Brazil. c/o U.S. Committee for UNICEF, 333 East 38th St., 6th Floor, New York, N.Y. 10016, USA.

WOMEN IN DEVELOPMENT. The Society for International Development (SID/WID) is a professional organization interested in and committed to advancing women's roles in social, economic, and political debate and is involved with refugee and migration work groups. SID-Washington Chapter, 1401 New York Ave., NW, Suite 1100, Washington, DC 20005-2121.

HEALTH FOR ALL BUREAU provides scientific and technical consultation in primary health care and prevention of blindness as well as training and research. Dr. A. H. Mushtaq, Jamilah Al-Audus St., Baghdad, Iraq.

FOUNDATION FOR THE SUPPORT OF WOMEN'S WORK. Siphioglu Cad 3/2 Yesilyurt, Istanbul, Turkey.

FREEDOM FROM HUNGER supports the development of women solidarity groups (support network of 30 or more women). Women bring their own income - earning proposal to the group for approval and support. Then the group as a whole applies for the grant from Freedom from Hunger. The group distributes loan funds to its individual members and is responsible for repayment. Write Freedom from Hunger, 1644 Da Vinci Court, Davis, CA 95617, USA.

TICIME is an association of Midwives and Traditional Birth Attendants (TBAs) in Mexico. It has been supporting and promoting midwifery through educational projects and a newsletter called "Conversando entre parteras". The December issue of this newsletter was dedicated to nutrition of pregnant women and breastfeeding. For copies write; TICIME, Cerrada Flor de Agua No.11, Colonia Florida, 01030 Mexico D.F. 5241423-5241412, Mexico.

WOMEN'S COMMISSION FOR REFUGEE WOMEN AND CHILDREN. Established in 1989 under the auspices of the International Rescue Committee seeks to promote change at the field level by empowering refugee women. The commission believes that refugee women are a valuable resource, whose input is crucial in the formulation and implementation of programs affecting them and their children. For more information write: Mary Ann Schwalbe, 386 Park Avenue South, New York, NY 10016, USA.

Course

Managing Health Programs in Developing Countries; Harvard School of Public Health. June 22-August 14, 1992. Contact Anne Mathew, Ph.D., Office of Continuing Education, Harvard School of Public Health, 677 Huntington Ave., Boston, MA 02115.

MEETINGS

INTERNATIONAL MEDICAL SERVICES FOR HEALTH is sponsoring a 3rd Millennium Conference June 9-12, 1992, at the Omni Shoreham Hotel, Washington. Involving Children in Community Partnerships to Control Parasitic Disease and End Hidden Hunger. Contact INMED, 45449 Severn Way, Suite 161, Sterling, VA 22170, USA.

THE FIFTH INTERNATIONAL FEMINIST BOOK FAIR from June 24-28, 1992. For more information contact the International Feminist Book Fair office: Entrepotdok, 66 1018 AD Amsterdam, The Netherlands.

GLOBAL SUMMIT OF WOMEN. July 9-12, Dublin 1992. Write Global Forum of Women; 1000 16th St., N.W., Suite 810, Washington, D.C. 20036, USA.

WOMEN, VOICES, VISIONS AND VEXATIONS, conference to be held on September 24-26, 1992 at Western Kentucky University. Contact Catherine C. Ward, English Department, Western Kentucky University, Bowling Green, Kentucky 42101, USA.

The 7th INTERNATIONAL MEETING ON WOMEN'S HEALTH, October 17-23, 1993, will focus on independent and interdisciplinary approaches to the problems and solutions in the field. For more details contact the Coordinator, 7th IWHM, C.P. 1191, Kampala, Uganda.

UNITING FOR HEALTHY COMMUNITIES, 120th Annual Meeting of APHA, November 8-12, 1992, Washington, D.C., USA.

THE NINTH INTERNATIONAL CONGRESS ON CIRCUMPOLAR HEALTH, Reykjavik, Iceland, June 2-25, 1993. For more information contact: Carl M. Hild, President, American Society for Circumpolar Health, P.O. Box 24282, Anchorage, Alaska 99524, USA.

WORLD CONGRESS ON TUBERCULOSIS, November 16-19, 1992, Fogarty International Centre, NIH, Bethesda, Maryland 20892.

THE 8th INTERNATIONAL CONFERENCE ON AIDS in Amsterdam, The Netherlands, July 19-24, 1992.

Congressional Causus for Women's Issues

Statement of Women's Health Principles

1. Health care coverage should be available to all, regardless of income, employment status, pre-existing conditions, or eligibility for other forms of public assistance.

2. Any basic health benefits package must include important preventive, diagnostic, and treatment services for women. Such services include (but are not limited to): prenatal care and delivery services, mammography and pap-smears, family planning services, and substance abuse services. Well-baby and well-child services (through adolescence) should also be included. Where appropriate, outreach and follow-up services should be available.

3. Women must have access to full information, including referrals, about all treatment options and alternatives to treatment in order to make informed choices.

4. Health care services should be available in a wide range of settings, including (but not limited to): outpatient settings, the home, hospice facilities and long-term care settings.

5. Services should be available through a wide variety of providers, including physicians, nurse practitioners, nurse midwives, and physician assistants. Training programs should encourage more women providers at all levels of health care.

6. Services should be based on individualized care appropriate to each patient. Public and provider education should be available to eliminate gender stereotyping which results in inappropriate or missed diagnoses of illness in women.

7. Primary care services should be community-based. Where appropriate, support services such as transportation, language translation and caregiving arrangements should be available to assure access. Wherever possible, pediatric and maternal care services should be coordinated.

8, Health care reform should include research on the best way of promoting health and preventing disease in women, including data on health and illness in women, service delivery modes best suited to meeting women's health care needs, health consequences of women's social and economic roles.

Congressional Caucus for Women's Issues, 2471 Rayburn Building, Washington, D.C. 20515, (202) 225–6740

Note: WIPHN was part of this.

The Women's International Public Health Network

In March of 1987, 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, to provide all women working in the field of public health an opportunity to work together to improve women's health worldwide.

Who is it for?

Any woman working in public health or related field.

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.

ISBN No. 1 SSN 1050–1908I

WIPHN
7100 Oak Forest Lane
Bethesda, MD 20817

To: