Women Hold Up Half the Sky

WIPHN News

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One is not born a woman, one becomes one.

Simone de Beauvoir

CERVICAL CANCER IN SOUTH AFRICA

Cervical cancer is the most common cause of death from cancer among women in South Africa. It accounts for approximately 14% of these deaths. However, its relative importance in different groups varies greatly. For example, cervical cancer is responsible for 25% of deaths due to cancer in black women. This contrasts with the pattern in white women where breast cancer is the most common cause and only 3% of cancer deaths are due to cervical cancer (Bradshaw 1987).

Cervical cancer is a preventable disease. Cervical cytology screening tests detect precancerous states and early cancer, which are possible to treat effectively. This type of screening procedure is widely available in South Africa. However, the service is provided in a haphazard fashion, with the result that women who are least at risk of developing cervical cancer are most likely to be screened. This is the result of services being provided to affluent women by private general practitioners and gynecologists and to young women by obstetric and family planning services. There is little provision for screening of poorer, middle-aged and older women, who are at the greatest risk of developing cervical cancer.

These points are illustrated by two recent studies undertaken in Khayelithsha, a rapidly growing and poverty stricken peri-urban settlement near Cape Town. In the first study, a community-based survey, 37% of women reported that they had undergone a cervical smear. Many of these women had to be prompted before recalling the test. The level of knowledge regarding the test was poor, and the most common reason for having the test performed was that it was done when they were pregnant (74%). The most common reason for not having had the test was that they had never heard of it (Bailie 1992).

In a followup to this survey, a review of cytopathology records from health services in this area revealed that a maximum of 25% of women could have had a cervical smear between 1988 and 1992. The vast majority of smears had been done in women under the age of 30 (Bailie 1993).

sisters
(by phyllis mahon)

The successful implementation of a cervical screening program is complex. The difficulty in reaching high-risk women is compounded by the challenge of effectively following up those identified as having abdominal smears. The failure of "Project Screen Soweto" in a large African community on the outskirts of Johannesburg bears testimony to the difficulties of running such a program (Leiman 1987). The failure of this project was abscribed largely to the lack of an educational program for women in the community. The lack of awareness among women led to a failure to present for followup.

The official policy of the Department of Health of South Africa is similar to that of developed countries. This policy is impractical in a country where infrastructure and resources are inadequate. In areas where women who are most at risk live, cervical cancer control programs must compete for scarce resources with a number of other programs targeted at common causes of disease, e.g., immunization, nutrition and environmental health programs. Basic services such as adequate housing, water and sanitation are often not available. In addition to the lack of facilities to take smears, laboratory and colposcopy services (required for the further management of women with abdominal smears) are inadequate. As a result, the policy has not been effectively put into practice (Du Toit 1980, Gordon Grant 1981, Cronje 1985, Gordon Grant 1987, London 1991).

In this context, it is difficult to argue for an expansion of screening services. It has been suggested that the existing service should be used in a more effective manner. This could be achieved by targeting the women at greater risk, ensuring that women have a good understanding of the procedure, and that followup is effective.

The WHO has recommendations for screening in less developed countries. Where resources are deficient, the recommendation is to maximize coverage with one smear in each woman's lifetime between the ages of

35 and 40 years. Once this has been achieved, the frequency and age range for screening can be increased (WHO 1988). In the Khayelithsha study referred to above, it was estimated that with the level of screening activity and population figures at the time of the study, it would take 20 years for every woman to be screened (Bailie 1993). Taking a single smear from each woman at 35 to 39 years of age would halve the number of smears. It is argued that this could free resources for education and followup, and result in more effective service (Bailie 1993).

The African National Congress has presented a draft policy that states that smears should be offered during a woman's lifetime, subsidized by the state (ANC 1993). These will ideally be performed initially one year after the woman has become sexually active, secondly at the age of 25 years, and thirdly at the age of 35. This should be offered at all health services and made more accessible through the use of mobile clinics. Once established, the interval between smears would be decreased to an ideal of three years, as recommended by WHO.

The College of Gynecologists of South Africa recommends that smears be taken at the ages of 25, 35 and 45 years. This policy may be more practical and efficient.

Other methods to improve the early detection of cervical cancer are being investigated. They include the visual examination of the cervix (Singh 1992) and photographic evaluation. These methods have the advantages of requiring less in the way of laboratory services and skilled personnel.

An inexpensive and effective way of reducing the impact of cervical cancer will be of great benefit to women and families throughout the world, and particularly in developing countries.

Margaret Hoffman and Ross Bailie,
Department of Community Health,
University of Cape Town.

References may be obtained from WIPHN on request.

EVALUATION OF WOMEN'S KNOWLEDGE ON CANCER

Research to evaluate the cancer knowledge of women in the 30+ age group was carried out in an urban settlement of the Bornova Education and Research Health District in Izmir, Turkey. The study population was obtained by a random sampling method and involved 602 women; 16.4% of the sample population were immigrants from various Balkan countries.

The subjects were asked to define the symptoms of different forms of cancers. According to the results of this research, 59.5% of the women were classified as "knows well" in terms of cancer signs and symptoms. Breast, uterus and skin cancers were the three best known cancers. The percentages of correct definitions were 73.9% for breast, 64.8% for uterus, and 44.7% for skin cancers. The women who had information prior to the research were significantly more knowledgeable than the others (chi square = 83.44, p). The main sources of information were television, radio and public health education programs. The more educated women (chi square = 18.81, p) below 40 years of age (chi square = 22.52, p), and immigrants were more knowledgeable (chi square = 18.72, p). Immigrant women were mainly from Bulgaria and the former Yugoslavia. This reflects the cultural difference about the "understanding of health-illness values, beliefs, and patterns of behavior."

Using these data, the authors have organized public health education programs on the symptoms and signs of cancer and the early detection of breast cancer, including how to do a self-examination of the breast.

Dr. Gulsun Aydemir
Bornova, Izmir, Turkey

MATERNAL MORTALITY IN OUR NEAR NEIGHBORS

A recent study undertaken in the Solomon Islands estimated that, for every 182 pregnancies that come to term, one woman dies. The study was undertaken by trained interviewers who asked 2,580 women about the survival of their sisters (O'Brien et al. 1993). This method has proven useful where no other reliable sources of data exist.

Lesley Barclay
Sydney, Australia

THE MANEO HUNTER-GATHERS
Indonesian Island of Seram

Although the Maneo live in a remote location—divided between several villages, two days hike from the coast and two days walk from any trained health workers—they are not isolated. They have antibiotics and antimalarials; they even know about childhood immunizations (although few subscribe). Availability in no way guarantees appropriate use; they regularly asked us for pills—any kind, it did not matter—to make them smarter or walk faster.

Since the cessation of intertribal warfare, pregnancy, labor and postnatal complications pose the greatest danger to the Maneo, more so than hunting accidents or poisonous snakes. Mothers on the average lose half of their children in the first 6 months; most die in the first two weeks, with tetanus and malaria being likely causes. The high infant mortality contributes to the high maternal mortality rates, since multiple pregnancies increase the risk of dying in childbirth. Maneo women never sought our help or our cures for pregnancy-related problems. Pregnancy and labor are a private affair. They are guided by tradition, and even in the coastal Maneo villages, where professional help is available nearby, women choose lay midwives for assistance.

Maneo women give birth in their kitchens or in their garden huts off in the forest; some places are more propitious than others. Sometimes they are alone, but more often the mother is attended by a lay midwife, a biyang, who has no formal training but has inherited special healing skills. Her primary role is to tiup or spit a fine spray of saliva on the woman's stomach while massaging to facilitate labor. The biyang makes special tea from leaves found in the forest and sprinkles the woman's head with water from a taro leaf cup in order to alleviate discomfort and speed up contractions. Otherwise, the biyang does not actively participate in the delivery except to cut the cord with a sharpened piece of bamboo, dress the child's navel with the head of a betel nut and then bathe the infant. In case of breech delivery, midwives will massage the abdomen; they recognize the danger to the mother and child but they have no way of treating these and other potentially serious problems. If a women dies due to a retained placenta, people explain this as the consequence of an unconfessed act of marital infidelity on the part of either the husband or wife. The placenta that is successfully expelled is buried in the dirt floor of the kitchen and is considered sacred.

All mothers breastfeed; however, the colostrum is thought to be dirty and unsuitable for new babies. Sometimes the mother will ask a lactating sister to help with nursing; otherwise, she gives the infant sugar water or coconut juice for the first three to four days of its life. I encouraged women to nurse immediately after birth. Changing this, however, will require more focused education efforts directed at the biyangs since they have leadership status. No one uses modern family planning, nor is there any perceived benefit in limiting family size since population density is low and child mortality high. Often young women begin having children before they are married—they are not stigmatized—and continue to do so until their childbearing years are over. Multiple, closely spaced pregnancies (often more than 10) are common.

These two young women are waiting for their fathers to arrange marriage for them. Their potential husbands have to provide marriage payments adequately suited to their future father-in-law's request. Because the women are unmarried, the two babies are considered property of the women's parents.

The Maneo may be like many formerly autonomous groups on the margins of developing countries. In areas of health care, such as maternal and infant care, traditional beliefs and practices are still employed. (These include the use of herbal medicines and all-night seances). These methods are valuable not only because people truly believe in them (they are efficacious), they also form part of the

Maneo's cultural identity. In order to remedy the high incidence of maternal and infant mortality, education is needed. Rather than encourage them to change their customs and use western techniques, as a midwife in the public health field I would seek to develop programs that adapt modern nursing and midwifery to traditional practices. Embedded in age-old methods, new skills will be sustained over the generations and dependency on outside trainers should be short-term.

Jennifer Stern
USA

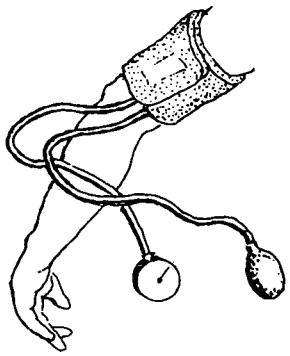
SPHYGMOMANOMETERS AND SPECULUMS NEEDED IN CAMEROON

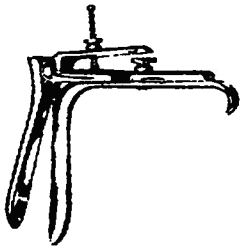
In a local survey of the numbers of sphygmomanometers available in the different institutions catering to pregnant women, it was found that the number of sphygmomanometers for each institution was totally inadequate for the number of patients seen per week. About half of the institutions have no sphygmomanometers.

Women are coming for delivery who have gone for regular prenatal consultations, have never had their blood pressure taken, not even once. The question is, if this is the case in urban setups, it must be worse in the rural health centers.

We would like to provide these health institutions with the sphygmomanometers and registers for measuring and recording the blood pressures of pregnant women. This will definitely contribute to the early diagnosis and management of hypertension in pregnancy. The sphygmomanometers would be sent to both urban and rural maternities in Cameroon in areas where the need is the greatest.

Also needed are vaginal speculums. Many women in Africa have never had the luxury of a speculum examination. That is one of the reasons for late reporting of cancer of the cervix. In a recent survey carried out in Yaounde, Cameroon, among women with cervical cancer, more than two-thirds had their first speculum examination at the referral hospital. Early in 1993, a gynecological survey in two rural communities of women of reproductive age found that only 2 out of 70 women had ever even seen a vaginal speculum. Two of the women had precancer cervical lesions. Women in Yaounde central maternity have the choice of buying a disposable vaginal speculum or using one that is rinsed under running water and dipped in a permanganate solution. This practice started before the AIDS pandemic. The prevalence rate of HIV seropositivity in the general population is 2%—50% among prostitutes in Douala.





Speculums are needed for use in health centers providing care for women. Vaginal speculums appear to be way down on the list of priorities of those with power to determine what should be hospital equipment. Also, disposable examination gloves are needed.

Dr. Lilian Wambua
Cameroon

This study underscores the current situation in many countries where there is much talk about safe motherhood but no essential resources available for prevention.

DONATE TO WIPHN SO WE CAN HELP OUR SISTERS GET MORE SPHYGMOMANOMETERS AND SPECULUMS

SOCIAL MOBILIZATION: TRAINING FOR DEVELOPMENT WORKERS

Gloria Davila of CIESPAL (International Center for Communication in Latin America) came to the United States to find ways to protect the children of Ecuador from devastating violence. She found help in The Social Mobilization training program at Tulane University's School of Public Health and Tropical Medicine. At the culmination of her training, Gloria and one of her colleagues, Ms. Chika Saito, were able to develop a program to meet this goal.

It can be argued that social mobilization holds the key to transforming development goals into societal action. It is a planned, broad-scale process that seeks to facilitate change and development. Relying on a range of players engaged in complementary efforts, social mobilization promotes political commitment, popular support, community involvement and decentralization action.

To meet the need for professionals with the diversity of skills to conduct social mobilization, particularly in the field of public health, Tulane University's International Communication Enhancement Center (ICEC), in close collaboration with UNICEF, has developed a Social Mobilization Certificate Program. The training provides participants with the necessary tools to facilitate change and development in a variety of situations and trains social mobilization strategists to assume program management and leadership positions.

The three-month, 18-credit Social Mobilization Certificate Program is targeted to mid-career development workers and covers research and eval-

uation, management, economics, communication and education. The credits can be applied toward up to 50% of a Master's Degree in Public Health, depending on the qualifications of the student.

Participants are encouraged to draw on and share their experiences and views, enriching the learning process. Faculty and resource persons are all internationally oriented with extensive experience in their respective specialties.

The first offering of the innovative program was so successful that UNICEF has asked for the program to be repeated this summer. The Social Mobilization Certificate Program will be offered by Tulane University in New Orleans, May 5 through August 5, 1994. Enrollment is open to candidates from development and governmental agencies.

Preference will be given to mid-career development officers and those who intend to enter child survival and other health-related programs. For information contact: ICEC, Tulane University School of Public Health and Tropical Medicine, 1501 Canal Street, Suite 1300, New Orleans, Louisiana 70112, U.S.A.

Dorothy Southern
USA

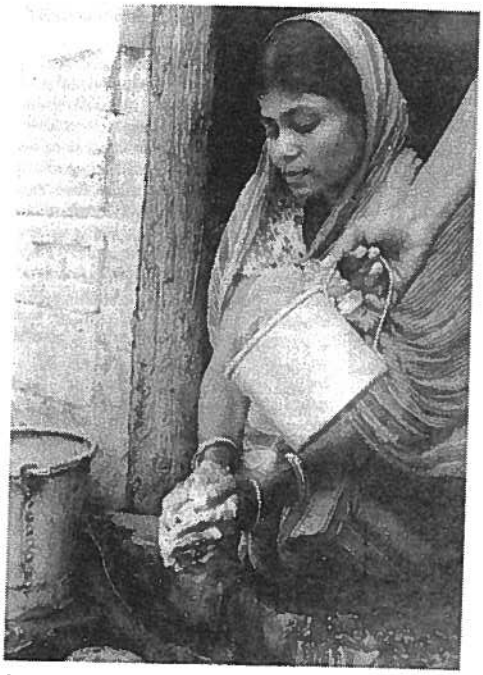
Using Soap, Mud or Ashes for Handwashing Improves Health

In rural Bangladesh, soap is not commonly used for handwashing. It is expensive and is used for cosmetic purposes. Hands are usually washed with water only. After anal cleansing following defecation, most rural people rub their left hand on the ground and rinse it with water. Ash is not widely used, although it is often promoted in health education programs.

In a five-day handwashing study, women were randomly divided into five groups to take turns using soap, mud, ashes, water only or not washing at all. The study showed that soap, mud or ash reduced contamination significantly and were found to be equally effective. The source and amount of water used for rinsing was also important, as well as the duration of hand rubbing. If women used their clothes to dry their hands, there was significantly more contamination than if hands were left to dry in the air.

Three key points were the result of the study:

- Everybody should wash both hands using an agent such as soap, mud or ashes.



Handwashing technique. Hands should be rubbed together at least four times using soap, mud or ashes. Plenty of clean water should be used in rinsing. Hands should either be dried with a clean cloth or left to dry naturally in the air.

- As much water as possible, preferably clean water, should be used in handwashing.
- Both hands should be rubbed as many times as possible (at least four times) during handwashing.

From "Dialogue on Diarrhoea", quarterly newsletter published by AHRTAG.

DONATE TO WIPHN'S SAVE A MOM CAMPAIGN

Wiphn's Save A Mom Campaign is going to supply Cameroon and some other maternities with sphygmanom-eters and speculums depending on funds donated. $30 can provide one sphygmanometer.

Send your donations and help make motherhood safer and improve women's health.

Number of prenatal consultations and spygmanometers per institution in Cameroon

Institution	Spygamanometers	Patients/week
PMI Centrale	1-0	250
Nkol-Ndongo	0 (1 yr.)	150
Tsinga	1-0	150
Briqueterie	1-0	125
CHU	1	130
Maternite Principale	1-2	340
Cite verte	1	100
Djoungolo	1	22

DON'T CALL ME MADAM!

Japanese women are beginning to assert themselves. Middle-aged women in Japan are called "oba-san," which means madam or aunt and which shows lack of respect. The word does not have good connotations, and almost all of the women felt degraded and insulted when they were treated as a no-longer young oba-san. However, some women thought that they had to accept the term since they were no longer young and beautiful. They thought that young women were forgiven even if they were impolite, just because of being young and pretty. They even suggested that if women dressed neatly and behaved well and improved themselves, they would not be labeled oba-san. Those that are oppressed and discriminated against think that they have to work harder to be treated better.

Sekiko Kikushima
Japan

THE HOTLINE—Trying to Raise Body Consciousness Through Telephone Counseling

The Women's Center Osaka has been holding a telephone advisory service for women for seven years. Three days a month, ten volunteers work on a roster to take calls for seven hours. Approximately 20 calls are received each day covering all kinds of concerns about women's bodies and health, from simple requests for information to problems that require counseling.

The callers are concerned about menstruation, having or not having it, too much or too often, and menstrual pains. The next most common questions are on women's diseases—vaginitis, uterine myoma (tumors), and endometriosis. The third main concern is menopause.

If the callers are not satisfied with the response, they can come in and have a face-to-face conversation with trained consultants.

Change could start with one phone call, though, and even if the callers do not get all the answers the first time, they might want to call again.

Kiyomi Kawano
Japan

FEMALE GENITAL MUTILATION AN ISSUE IN THE USA

A Nigerian woman went before federal immigration officials to plead that she be allowed to stay in the United States to protect her two daughters from female circumcision.

If officials decide to deport the woman, she would have to either give up her daughters, 4 and 6 years old, or take them back to her country where they face almost certain mutilation of their sexual organs.

The operation, mostly done without anesthetic, involves cutting away the clitoris and or the inner labia of the vagina. This procedure often causes infections and other complications due mainly to the use of nonsterile instruments.

Extracted from "The Washington Post".

BULLETIN—LET'S CELEBRATE

Philadelphia, Pennsylvania, has become the largest city in the United States to formally recognize the importance of breastfeeding. The Philadelphia Department of Public Health has hired a Lactation Consultant whose job will be to implement the Breastfeeding Promotion Policy (adopted in 1992), update the Philadelphia Breastfeeding Resource Guide (first published in 1992), and continue the work of the Breastfeeding Promotion Task Force (begun in 1992).

* * * * * * * * *

The United States has started a feasibility study to find a way to implement the Baby Friendly Hospital Initiative. Over 18 months, an Expert Work Group (convened by the Healthy Mothers, Healthy Babies Coalition with funding from the Department of Health and Human Services) will examine such topics as: Will the Ten Steps need to be altered? Can the UNICEF/WHO criteria and assessment process be applied to the United States? After these questions are answered, formal clinical trials of the process will begin in selected U.S. hospitals.

Once the data from the clinical trials is gathered and analyzed, the Expert Work Group will have six months to make final recommendations and to identify an organization that will implement those recommendations.

It is true that there are different types of hospitals in the United States with no one government body overseeing the whole system. Still, one wonders why a process being used elsewhere in the world will take so long to be evaluated here. Could there be a connection between the 2 or 3 years projected to complete this study and the fact that the Uninted States was the only country in the world to reject the WHO Code of Marketing of Breastmilk Substitutes?

Nikki Lee, USA

Cancer Facts and Figures

Every year some half million new cases of cervical cancer are detected worldwide. Most of these occur in developing countries. Approximately 80% are diagnosed when they have progressed to advanced stages. Many are not diagnosed at all. From 3-5% of all deaths in adult women are due to cervical cancer. Detected early, cervical cancer is nearly 100% curable (WAND ISIS 3/92 p.29).

Among women in developing countries, cancer of the stomach, cervix, and breast are the most common, whereas in developed countries colorectal and lung cancers are most prevalent. Although cancer begins in the reproductive years or earlier, it is most common in menopausal women.

In developing countries, 183,000 women die each year from cervical cancer. Approximately 77% of the world's 460,000 new cases per year are found in developing countries. Many more are not even identified. Low-income women are at highest risk of cervical cancer, which can be cured if detected early. Screening tests using cytology (Pap smears) and early treatment have greatly reduced the fatality of cancer.

The most useful screening method is the Pap smear, but other more economical methods such as unaided visual examination and aided visual examination of acetic acid-treated cervices are being explored. Treatment of preinvasive cancer is very successful and can be done through cryotherapy, loop excision and electrocautery. More advanced cases require surgery and or radiation, which is far more expensive. The goal is to screen every woman at least once in her lifetime between 35 and 40 years of age.

It is ironic that in most developing countries, midwives and nurses are not trained in gynecology so they cannot recognize common gynecological conditions, and even if they could, they have no speculums available for unaided screening.

INDIAN WOMEN BANDING TOGETHER SUCCEED IN HAVING LIQUOR BANNED

In Andhra Pradesh, through a grassroots movement, a campaign by poor, illiterate women has forced a large southern Indian state to ban the sale of cheap government-produced liquor called arrack. Not only did the women have to battle the state and the liquor industry but also their husbands. The women stated that their men were buying this cheap liquor, squandering the meager family funds and beating their wives and children. The All India Vigilance committee was one of the women's rights groups to help spur the movement.

Women shaved the heads of drunks and shamed them in a number of ways, attacked liquor stores and threw out liquor. Despite reprisals, the women persisted and have succeeded in getting arrack off the shelves. These destitute rural women have taken the power into their own hands. The battle has just begun!

Chronic Disease and Cancer

Women should know their own health and what is normal. They should know their bodies so they can recognize problems and how to prevent them. Menstruation (periods) is a case in point that needs to be emphasized. Most girls when they start menstruating are shocked as they have had no previous information or expectation. They need to know what is happening to them and what hygienic measures to use. They should also be able to know when to seek help.

Cervical cancer appears to be related to sex with men. Women who have never had sex with men have an incredibly low incidence of cancer of the cervix. During sex, something appears to be transmitted, e.g., a virus, that triggers cells to behave abnormally. Not all viruses are harmful but the papilloma virus is.

Women who start sex at an early age also have a high incidence of cervical cancer. Between 12 and 21 years, the cervix undergoes changes that may make this a dangerous period. Smoking has a negative effect on cervical cancer. Women who have several partners are also more at risk. Women who have many pregnancies are more at risk for cervical cancer. Women whose men have high sexual activity have also been described as having a higher risk for cervical cancer.

At present in most countries there are not enough facilities for treatment. Most women cannot get Pap smears. Transport to a good lab is scarce, and followup is difficult to arrange. Even if available, Pap smears are costly, and it is hard to determine the best age to do them.

The Pap smear is the best screening test, but it has a 20% error. Not all lesions on the cervix are cancer. The papilloma virus causes warts inside and outside the vagina. These need to be treated vigorously and screened frequently as they can cause cancer. These warts occur frequently in young girls who have many partners.

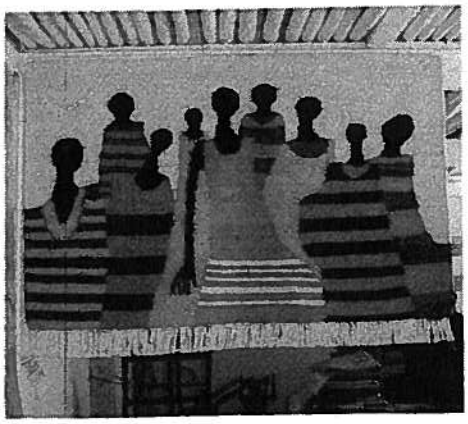
Women need to pressure governments and health services for screening and treatment. They need to be aware and organize themselves. There is a lack of services for women and treatment of cancer. All services are focused on family planning, and even then the services are not accountable.

AFRICAN RIGHTS—The Nightmare Continues... Abuses Against Somali Refugees in Kenya

The human rights abuses that Somali refugees in Kenya are currently suffering at the hands of bandits and the Kenyan security forces include killing, rape, robbery, torture, arbitrary detention, extortion and deportation. Both the Kenyan policy toward refugees and the failure of the United Nations High Commissioner for Refugees (UNHCR) to ensure protection for the refugees must be examined.

The pattern of abuses against Somalis reflects longstanding Kenyan government hostility toward refugees. Over the years, Kenya has refused entry to potential refugees; it has been reluctant to grant refugee status to asylum seekers; it has denied civil liberties to refugees; and it has regularly detained and forcibly repatriated refugees. When the Somali refugees started arriving in 1991, the government's first reactions were to deny them entry and to try to send them back. It refused permission for permanent and well-serviced refugee camps in northeast Kenya, thereby creating a preventable humanitarian crisis that killed tens of thousands of Somalis. Kenyan policy is currently aimed at removing the refugees as fast as possible from its territory.

In the refugee camps and the Kenyan cities, Somali refugees are subjected to an appalling range of human rights violations. Thousands of Somali refugee women have been raped. In five nights spent by an African Rights representative in the camps, no fewer



than 22 women reported having been raped. Most rapes were carried out by bandits, but many were also committed by the police and army, acting brutally and with total impunity. In one reported case a woman, Hibo, was raped by three policemen and then forced to flee with her child for fear of police reprisals when they discovered that she had reported the crime. Dozens of refugee men have been killed by the security forces. Police and army patrols routinely pick up refugee men and then kill them. In many cases, the bodies are then burned. Often, the police demand bribes for release. Detailed documentations of more than forty instances of murder by the police and army, five cases of "disappearance" in police custody, two cases of death following severe beating, four people killed by the police opening fire indiscriminately, and one killing by bandits are recorded.

The Kenyan police are renowned for their brutality. Somali refugees are especially victimized because of their vulnerability. Innumerable refugees, both women and men, have been beaten or tortured by the security forces. This is a common method used by the police to extort money, but there have been a number of major sweeps in Nairobi to locate refugees said to be illegally residing in the city and deport them to the camps.

The security services enjoy total immunity. No policeman or army officer has been charged with any crime committed against a refugee. UNHCR has not brought any cases to court, and does not provide any legal representation for refugees.

There are a number of ways that the Kenyan security services can be held accountable and for improving respect for the rights of refugees. Policemen who have committed rape, murder, torture and theft must be prosecuted. If the Kenyan government refuses to do this, UNHCR should initiate the prosecutions itself. Procedures for government should also make greater efforts to protect refugees from bandits, and pay particular attention to the protection of women refugees from rape.

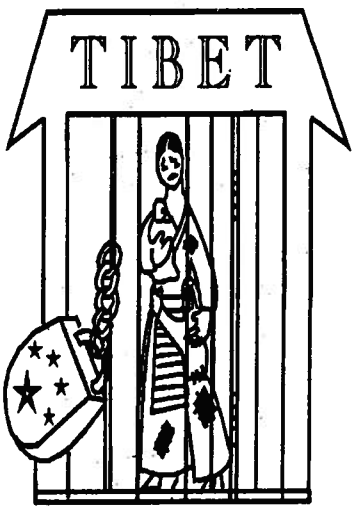
Rakiya Omaar and Alex de Waal
Co-Directors, African Rights

From a Report by African Rights. For a full copy of this article, please write to: African Rights, 11 Marshalsea Road, London SE1 1EP, England.

BREASTPUMP IN THE WHITEHOUSE!

Presidential assistant for political affairs Joan Baggett and head of one of the five key White House offices returned from maternity leave. She is breastfeeding and expresses at work. This is the first time there has been a breastpump in the office of the White house political director.

The Washington Post
Donnie Radcliffe



LETS CHANGE THIS

Women across Tibet and China are subject to draconian birth control programs that deny women the fundamental freedom of choice or control over their own bodies. If ordered by the state, a woman must submit to sterilization or abortion.

In Tibet, where the population is only 6 million, it is extremely difficult to understand why any form of abortion control is required, let alone one which features coercion tactics such as:

"In order to reduce the population use whatever means you must. With the support of the party central committee you have nothing to fear."

"The doctor said if you insist on having your child, it is all right; the financial punishment is small compared with the political crime you are committing. From now on, you will only get 30% of your salary. In the future, your salary will never increase, your child will not have the right to claim his ration card. The child will not be admitted to either nursery or school."

(Excerpted from Children of Despair, a report produced by Campaign Free Tibet.)

Write to your senator and the President about womens' concern of the regrettable decision of the UN to hold the 1995 World Womens Conference in Beijing despite China's appalling human rights violations against women. Join the Boycott Beijing Campaign, which is working with the Campaign to Free Tibet. For further information contact Campaign to Free Tibet, 30 Hollingbourne Gardens, Ealing, London W 13, United Kingdom.

BREASTFEEDING AND WORK

Dear Gabrielle Palmer:

Thank you for your strong response to my article "Thoughts on Contraception" in WIPHN News No. 12. You are correct in stating that the world needs to be educated to the fact that babies can go everywhere, as long as there is "a little basket and a ready breast" available.

Since her birth, I have taken my own baby with me to work; I have stood in front of a class while she has nursed, as has your friend Claire Schofield. I was wrong and am sorry for the statement about "... no returning to work or school." I wrote my essay in protest against the marketing of Norplant to the women with whom I work and also out of anger against a system that won't accept me teaching about the lactation amenorrhea method of child spacing. I have learned a lesson from your response that the passion I feel about one issue should not cloud my perspective on another.

Women need a healthy and free method of family planning which attachment-style mothering provides. For breastfeeding to work as a method of contraception, women and babies must be kept together, especially if the mother returns to school or employment outside the home. As for letting cultural pathology become dogma, I don't believe that the editorial staff of WIPHN will permit that to occur.

Thank you for teaching me something!

Nikki Lee, RN MSN

Reproductive Health Of Women In The Slum Area Of Karton Kassala, Sudan

The aim of this study was to understand the most important factors influencing the reproductive health of the oppressed and deprived women in the slum area of Kassala.

The nutritional status of women is one of the important risk factors determining their health. The nutritional status is directly related to women's impoverishment and deprivation. The position of women in the family also makes them more vulnerable to malnutrition than men, since the intrahousehold distribution of food is controlled by men. Women have increased nutritional needs due to menstruation, pregnancy and lactation.

Nutritional anemia is one of the common diseases associated with pregnancy; it is caused by lack of iron, vitamin B12 and folic acid. It leads to diminished work capacity, fatigue, lowered resistance to infections, and increased complications during pregnancy and childbirth. Maternal toxemia can result from a mother's undernutrition when she becomes pregnant, poor weight gain during pregnancy or irregular weight gain patterns. Infants with low birthweight are more susceptible to infectious diseases.

Long hours of work can cause a woman to hemorrhage or even miscarry (20%). When women were asked to prioritize the eight most common maternal diseases, they mentioned hem-

orrhage, vaginal infections, malaria with pregnancy, toxemia, tetanus, eclampsia and syphilis.

Another serious problem is the lack of sanitation or personal hygiene, which is the cause of infectious diseases, such as malaria and schistosomiasis, prevailing in poor communities. These can lead to iron deficiency and anemia in pregnancy.

Vitamin A deficiency is also common due to nutritional taboos. Vaginal infections are also common. Health education is an important preventive tool that can be used to avoid such diseases.

Women in poor communities tend to marry young, and this leads to maternal depletion and anemia, which can lead in pregnancy to hypertension and obstructed labor. Women are not free to decide how many children to bear, since usually the men are the decision makers.

Infibulation (with partial or complete removal of the clitoris and labia minora) is one of the common traditional practices that is most harmful to women's health and leads to the humiliation and oppression of women. It is done in the belief that it protects the girls chastity and dignity and on the assumption that it decreases libido. Another reason is that men refuse to marry uncircumcised women because infibulation gratifies their sexual satisfaction regardless of their wives' feelings. It leads to infertility, painful menstruation, dyspareunia, prolonged labor, prolapse and vesicovaginal fistulae. For the majority of women in poor communities, children are delivered by TBAs due to the inaccessibility of adequate obstetric services. The most common complication in these TBA-assisted births is hemorrhage. Sepsis and tetanus caused by the use of unsterilized instruments is another problem frequently encountered.

Appropriate birth spacing is done using traditional methods such as lactational amenorrhoea, periodic abstinence and sexual abstinence. Modern methods of contraception and tubedectomy are used more rarely. Sometimes contraception is done secretly without the husband's knowledge.

Dr. Eiman A. Mahmoud

Full report available from WIPHN

Lift the U.S. Embargo of Cuba for Humanitarian and Public Health Reasons

Cuba, with its limited resources, has achieved universal quality health care for all free of charge and educated its population.

As a result of the loss of preferential trade with the former Soviet Union, imports and exports from Cuba have declined, and the gross domestic product has plummeted. Added to this have been some natural disasters. Cuban imports from U.S. subsidiaries prior to the implementation of the Torricelli legislation were small, and 75% of the imports were for food and medical needs.

The current U.S. blockade of food and medicines has had adverse effects on the population. There are shortages of a large number of essentials, e.g., pesticides, chlorine for water systems, drugs such as dilantin, insulin, antibiotics, and essential medical supplies and reagents.

The blockade is affecting the health of the population. A 10 lb average weight loss in the adult population has been recorded. A recent epidemic of ocular neuropathy was mainly due to vitamin B deficiencies. The incidence of anemia in pregnant women has increased, and the incidence of low birthweight infants has risen. These are just a few of the effects of the blockade.

As usual, it is the mothers and children who suffer.

In 1988, Cuba imported $140 million from capitalist countries; in 1992, it imported only $46.4 million.

Stop the blockade against Cuba by writing to your congressman or senator, as the blockade is not humanitarian.

Naomi Baumslag

For more details contact WIPHN

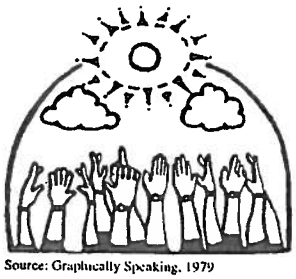
BABY FRIENDLY HOSPITALS INITIATIVE IN CUBA

Cuba has endorsed the Baby Friendly Initiative and will implement it from the hospital to the community. Doctors and nurses at all levels are being trained, and the family practitioners follow up. The family practitioners live in the community and look after about 600 persons. Until recently, Cuba provided every child a liter of milk for up to 7 years. The milk shortage makes breastfeeding more imperative. Ninety-nine percent deliveries are in hospitals, and the mothers come with a relative or friend comadrona who bathes, comforts and feeds them. There are rocking chairs in the ward and in the newborn nurseries. Formula is not available, and there are no advertisements.

Due to a concerted countrywide effort, the rate of exclusive breastfeeding has risen from 63% in 1990 to 91%.

STRAIGHT FACTS

There is no good evidence that breast cancer is linked to abortion despite the propaganda by an antichoice group. For analysis of the 75 studies examined write The National Women's Network, 1325 G Street NW, Washington DC 20005 or write WIPHN.



Source: Graphically Speaking, 1979

PREPARATIONS FOR THE FOURTH WORLD CONFERENCE ON WOMEN, BEIJING 1995

Preparations are underway for the UN Conference on Women. During March 11-18, the country delegates at the UN refined the document focused on action for equality, development and peace.

Nongovernmental organizations (NGOs) also met and made some very valuable additions. Health will receive more attention thanks to the women's caucus (NGO) that met before the plenary sessions at the UN. Breastfeeding is not mentioned. The U.S. is one of the few countries without a National Commission on women. The women's bureau in the labor department is fulfilling that role presently. Write to President Clinton to appoint a National Womens Commission.

Each country develops its own action plan. If you want to contribute to the U.S. position paper, call the state department and speak to Sharon Kotok, phone 202-647-1155 or Arvonne Frazer, who is head of the delegation at 612-379-451.

BREASTFEEDING BRIEFS

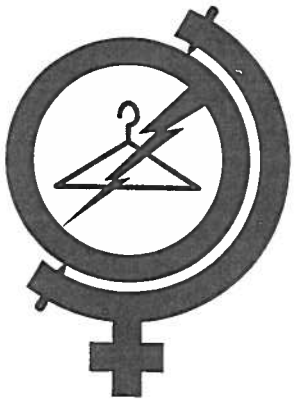
Breastmilk has been called the "Cinderella substance of the decade." After years of neglect, researchers are learning that human milk contains large numbers of substances waiting to be discovered. No group is keener than the baby food industry to identify breast milk's components. The literature is filled with an ever increasing number of breastmilk studies, many of which are funded by the milk industry. Slowly the information about the benefits of the biochemical components of breast milk is reaching the public. In order to maintain or increase market share, the milk industry continues to look for new ingredients to add to its milk formulas.

Currently, much research is dealing with the nutrition of low-birthweight babies. The formulas for these infants are manipulated in various ways to try to simulate breast milk. Before the new artificial formulations go on the market, they must undergo clinical trials. The researchers say that breastmilk is the standard against which the artificial milks are judged. Their studies show that artificial formulas fall short of breast milk. Yet the food industry would rather continue to invest in testing artificial formulas than invest time and resources in helping mothers to give their own breast milk to their low-birthweight infants.

When researchers in Brazil analyzed the proportion of deaths due to diarrhea, they found that feeding of milk other than breastmilk presented a 21 times greater risk of death for acute diarrhea and a 10 times greater risk for persistent diarrhea. Twice as many deaths were due to persistent than to acute diarrhea.

SEVENTH CALL FOR ACTION
International Day of Action for Women's Health
May 28 1994

Campaign for the prevention of Maternal Mortality and Morbidity



All women should have access to SAFE AND LEGAL ABORTION

SEVENTH CALL FOR ACTION

Action to prevent maternal mortality and morbidity. For a copy of the pamphlet call WIPHN. If you organize any activities for women's health day, please send information to WIPHN with photos, etc. We will publish them.

Drawn by Jan Pana. Cards with this illustration are available from Tui Bevin, 129 Signal Hill Road, Dunedin, New Zealand. Proceeds support breastfeeding in the Pacific.

TRAINING IN APPLIED RESEARCH: LISTENING TO INDIAN WOMEN TALK ABOUT THEIR HEALTH

The Ford Foundation and the Department of International Health at the Johns Hopkins University School of Hygiene and Public Health are conducting a project entitled "Building Social Science Research Capacity for Women's Reproductive Health in India." The project addresses an initiative by the Ford Foundation/India to increase knowledge regarding women's reproductive health and to increase the capacity for health-related research and training in India. The project emphasizes training and support in action-oriented qualitative research aimed at exploring Indian women's own beliefs and perceptions about their health and how these perspectives influence their health-seeking behavior. The network of approximately 15 participating Indian organizations includes both nongovernmental "action" organizations that provide direct health services to women and health research and training groups, including private organizations and selected investigators/departments within universities and research institutions.

The project has five objectives: (1) familiarization of participant organizations and individuals with the concepts, methods, and approaches of applied qualitative research, (2) assistance with focused information-gathering on women's reproductive health, (3) documentation, management and analysis of information acquired through research activities, (4) providing a forum for discussion of key concerns and issues relating to the conduct of research in women's reproductive health, (5) contributing toward the long-term development of social science in health by stimulating research in service and academic institutions and disseminating the research conducted in India to a wider audience.

These objectives are met through four key activities: workshops in which participants receive training in qualitative data collection methods, management, analysis and writing, and share their experiences in a group setting; technical assistance visits during which project faculty offer individualized assistance to member groups; development and dissemination of information and training materials so that knowledge collected by participants can be shared effectively with others and with a wider audience; and curriculum development at institutions currently involved in training for health-related social sciences methods.

To date, five workshops have been conducted; the two most recent focused on building training capacity within Indian academic institutions in the areas of medical anthropology and qualitative research methods, and on using the Participatory Rural Appraisal (PRA) method in the field and sharing experiences and viewpoints about the usefulness of this methodology. Planned future workshops include "Social and Sexual Aspects of AIDS/STDs in India" and "Going From Data to Action." Principal publications resulting from network activities include "A Protocol for Using Ethnographic Methods to Investigate Women's Health" (J. Gittelsohn, Ph.D.; M.E. Bentley, Ph.D.; K. Bhattacharyya, Sc.D.; J. Russ, M.P.H.; M. Nag, Ph.D., authors), "Use of Qualitative Research Methodologies for Women's Reproductive Health in India" (M.E. Bentley, J. Gittelsohn, M. Nag, P. Pelto and J. Russ, authors), chapter in the book "Rapid Assessment Procedures: Qualitative Methodologies for Planning and Evaluation of Health Related Programmes" (N.S. Scrimshaw and G.R. Gleason, eds, 1992) and a monograph, "Socio-Cultural Aspects of Women's Reproductive Health: Issues and Evidence from India" (J. Gittelsohn, Ph.D.; M.E. Bentley, Ph.D.; M. Nag, Ph.D.; P. Pelto, Ph.D.; A.D. Harrison, M.P.H.; and L.T. Landman, editors), which includes submissions from seven of the participating Indian NGO's and an introduction and overview written by project investigators. Publication of the monograph is anticipated in late 1993. One of the participating institutions, Tata Institute for Social Sciences (TISS) in Bombay, has taken the initiative and published five issues of the "Qualitative Research Methods (ORM) Newsletter," an outgrowth of network participants' expressed need for a forum through which they can share and disseminate their substantive data on women's reproductive health and health-seeking behaviors, their experiences, and their concerns and ideas about the process of collecting, managing and analyzing qualitative data. Ultimately, network management and training activities will be completely transferred to the participating Indian organizations.

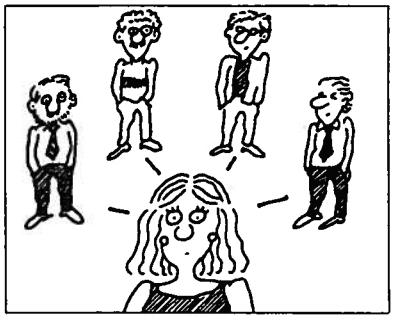
Sanjeeta Mookherji, M.H.S., and Joel Gittelsohn, Ph.D.

For further information, please contact: Dr. Joel Gittelsohn or Dr. Margaret Bentley, Department of International Health, Division of Human Nutrition, Johns Hopkins School of Hygiene and Public Health, 615 N. Wolfe Street, Baltimore, MD 21205; 410-955-2786; fax: 410-955-0196.

Risk Factors for Cervical Cancer

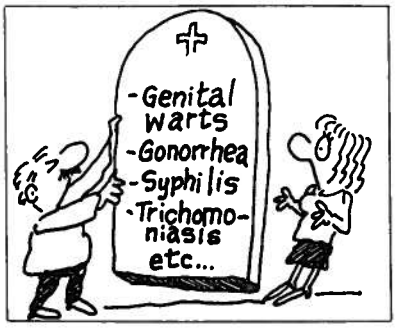
● EARLY PARTICIPATION IN SEXUAL ACTIVITY

All studies strongly link the early beginning of sexual activity with male partners to the development of cervical cancer. The reason seems to be that physical changes in the types of cells which line the vagina occur especially during the teen years, when more vulnerable softer cells are gradually replaced by tougher cells. If intercourse begins before these changes are complete, cells are more vulnerable to whatever may cause cellular changes.



● MULTIPLE SEXUAL PARTNERS

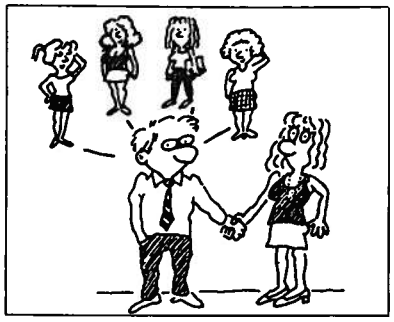
Another major risk factor for cervical cancer is multiple male sexual partners. According to some studies, the risk applies to multiple steady partners in relationships lasting three months or longer. Among certain groups, the existence of visiting partners into middle age, which prolongs cervical stress, is thought to explain why the incidence of cervical cancer remains high into late middle age.



● SEXUALLY TRANSMITTED DISEASES (STDs)

A number of sexually transmitted infections can contribute to abnormal cervical changes. Infections such as herpes, gonorrhea, syphilis, chlamydia, trichomoniasis and condyloma are high risk for cervical dysplasia.

Studies among women with a high risk of STDs have found a much higher incidence of abnormal cervical smears among women at STD clinics than among women at family planning clinics. Studies among women at low risk of STDs found a lower incidence of abnormal smears in lesbian women as compared to bisexual women. The incidence among bisexual women was found to increase in relation to their heterosexual experience.



● THE MALE FACTOR

Men's sexual behavior is also important. Some populations have a high incidence of cervical cancer despite the fact that women have few sexual contacts. Husbands of women with cervical cancer report having significantly more sexual partners and histories of sexually transmitted infections than husbands of women without the disease.

● HUMAN PAPILLOMA VIRUS (HPV)

Investigations show an increasing link between certain types of human papilloma virus (HPV) and cervical cancer. Some researchers go so far as to say that HPV is the causal agent for cervical cancer, or that HPV is the organism that most predisposes women to cervical cancer. Whatever the differences, all agree that HPV is an important risk factor for cervical cancer.

There are many types of HPV — approximately 50 to 60 — and it is important to note that not all produce lesions of the genital tract. Even among those that do, the level of risk for developing cervical cancer ranges from low through medium to high. The HPV types which carry the highest risk for the development of cervical cancer are No.16 and No.18.

HPV often has no symptoms and can therefore remain undetected. While the presence of genital warts is a definite sign of HPV, these, too, can go undetected since they may appear within the vagina, away from view. Visual self-examination therefore is not a reliable method of checking for the presence of genital warts.

HPV on its own does not lead to cervical cancer. It does so only in association with other risk factors. Of these, the most important is heavy smoking. Some researchers have also found a link to herpes simplex No.2.

● NEW THREAT FROM HIV

HIV infection, the virus associated with AIDS that attacks the functioning of the immune system, is linked to an increase in the prevalence of HPV and the development of cervical lesions to cancer. This poses a new threat to women, for we can assume that as HIV infection continues to rise, cervical cancer will increase.

● MULTIPLE PREGNANCIES

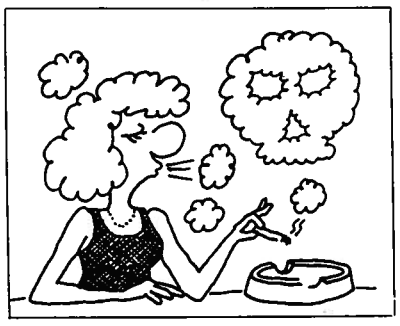
Some studies have shown that women who have multiple pregnancies — or more particularly, multiple live births — have an increased risk of developing cervical cancer. Several reasons for this have been suggested, among them the cervical trauma associated with a vaginal delivery. The study of cervical cancer in four Latin American localities referred to earlier found that with 10 or more live births, the risk of cervical cancer is four times greater than with one or no live births.

NO SCREENING AVAILABLE

● NUTRITIONAL DEFICIENCIES

Some investigations suggest that a deficiency of folic acid may be associated with a higher risk for mild and moderate dysplasia, and that there may also be increased rates for women with low beta-carotene consumption. One study has found that women who have been exposed to a virus that causes cervical cancer are five times as likely to develop precancerous lesions if they have low levels of folic acid. This discovery may help explain why cervical cancer is more common among the poor, who usually eat few of the vegetables and fruits that are prime sources of folic acid.

A lowering of folic acid in pregnant women is one of the explanations suggested for the link between multiple pregnancies and cervical cancer.



● SMOKING

Smoking has been found to increase the risk of cervical cancer both on its own and in association with HPV. In both cases, the highest risk seems to be among women who are long-term heavy smokers.

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ORGANIZATIONS THAT HAVE JOINED WIPHN

Center for Women Policy Studies, an independent feminist policy research and advocacy institution. Write: 2000 P Street NW, Suite 508, Washington, DC 20036, USA.

Women's International League for Peace and Freedom, 1213 Race Street, Philadelphia, PA 19107-1691, USA.

PRODEMU, a governmental organization working in all the regions of Chile for the advancement and development of women through educational workshops on communication, athletics, arts, literature, etc. The goal is to create a support network among women and to provide them with more and new opportunities for leadership roles within their communities. Contact: Sallie Cira, PRODEMU, Alcazar 419, Rancagua, Chile.

ACT/WID (Association for Creative Teaching/Women in Development) is an NGO working for the improvement of grassroot women in rural communities by carrying out training programs for women in human resources development. Contact: Mrs. Mary Chu, P.O. Box 148, Mamfe, Manyu Division, South West Province, Cameroon.

SEMINARS, SYMPOSIUMS, COURSES AND MEETINGS

"Safer Practice, Safer Lives", Conference and Annual General Meeting of the Action for Safe Motherhood (UK), April 30, 1994, Queen Charlotte's Hospital. Contact: Sharon Slowther, MIDIRS, 9 Elmdale Road, Bristol BS8 1SL, U.K. Phone: 0272 251791, fax: 0272 251792.

5th Annual Millennium Conference, Urban Health Challenges for the 21st Century, Sheraton City Center Hotel, Washington, DC, June 21-24, 1994. Sponsored by INMED, 45449 Severn Way, Suite 161, Sterling, VA 20166, USA.

21st Annual International Health Conference, Hyatt Regency Hotel, Crystal City, Arlington, VA, June 26-29, 1994. Organized by NCIH, 1701 K Street NW, Suite 600, Washington, DC 20006, USA.

Breastfeeding: Defining the Future, 22nd Annual Seminar for Physicians on Breastfeeding, Boston Copley Place, Boston, MA, July 14-16, 1994. Sponsored by La Leche League International, Department of Continuing Education, P.O. Box 1209, Franklin Park, IL 60131, USA.

Managing Health Programs in Developing Countries, June 20-August 12, 1994 at the Harvard School of Public Health, 677 Huntington Avenue, Boston, MA 02115, USA. Contact: Ann Matthew at 617-432-4515 or fax 617-432-4494.

11th Annual North America-Nicaragua Health Colloquium, August 17-27, 1994 in Nicaragua. Opportunity for technical and personal exchange with Nicaraguan health professionals. Teaching workshops, tours of Managua and Puerto Cabezas. Contact: CHRICA, 347 Dolores Street, #210, San Francisco, CA 94110, USA, 415-431-7760.

7th Annual Women's Health Conference, October 23-26, 1994, Atlanta, GA, USA. Organized by the National Association of Women's Health Professionals in collaboration with the Centers for Disease Control and Prevention. For more information call 708-869-0195 or write: NAWHP, 1007 Church Street, #307, Evanston, IL 60201, USA.

"Reclaiming the Fire: Honoring the International Year of the Midwife," the 12th annual international conference of the Midwives Alliance of North America, will feature birth reformers from around the world at the Congress Hotel in Chicago, September 29-October 2, 1994. Speakers include Sheila Kitzinger, Nicky Leap (G.B.), Beatrijs Smulders (Netherlands), Holiday Tyson (Canada), Ina May Gaskin and Rahima Baldwin (USA). For information write: Vicki at Community Midwives, 2459 W. Bertau, Chicago, IL 60618 or phone 312-283-2361.

PLEASE CREDIT WIPHN IF YOU QUOTE OR USE OUR MATERIALS

PUBLICATIONS BY WIPHN MEMBERS OR ASSOCIATES

Aborto, Uma Abordagem da Conjuntura Nacional e Internacional by Paula Portella, December 1993, published by SOS Corpo, Rua Major Codeceira 37, Sto. Amaro, 50.100-070. Recife, Pernambuco, Brazil.

African Rights, The Nightmare Continues, Abuses Against Somali Refugees in Kenya.

Arise, No. 10, July-October, 1993, a women's developmental magazine published by ACFODE, ACFODE House, Bukoto, P.O. Box 16729, Kampala, Uganda.

Cairo '94, UN International Conference on Population and Development, a media bulletin from the U.S. Network for Cairo '94, 1400 16th Street NW, Suite 230, Washington, DC 20036, USA.

CEDPA Network, newsletter published CEDPA, 1717 Massachusetts Avenue NW, Suite 200, Washington, DC 20036, USA.

Dialogue on Diarrhoea, the international newsletter on the control of diarrhoeal diseases, published by AHRTAG, 1 London Bridge Street, London SE1 9SG, England.

Disasters, Preparedness and Mitigation in the Americas, news and information for the international disaster community, Pan American Health Organization, 525 23rd Street NW, Washington, DC 20037-2895, USA.

Earth Negotiations Bulletin, interim report on the preparation for the International Conference on Population and Development. Published by the International Institute for Sustainable Development, c/o ICPD Secretariat, 220 E. 42nd Street, 22nd Floor, New York, NY 10017, USA.

The Fourth World Journal, December 1993, newsletter published by Fourth World Movement/USA, 7600 Willow Hill Drive, Landover, MD 20785, USA.

Footprints, a publication by Save the Children, 52 Wilton Road, Westport, CT 06880.

Healthy Mum, Healthy Baby, a booklet prepared by the Nutrition Unit, Ministry of Health and Medical Services, SAVE PROJECT and funded by UNICEF, P.O. Box 1149, Honiara, Solomon Islands.

The Hosken Report: Genital/Sexual Mutilation of Females by Fran P. Hosken, Women's International Network News, 187 Grant Street, Lexington, MA 02173, USA. This is a very detailed and informative work. It is estimated that more than 110 million women and girls in Africa and the Middle East are affected. FGM has been recognized as a health hazard and is now prohibited in Kenya. History of, facts and case studies are covered. The book costs $35 for individuals plus shipping and handling. Write: WIN News, 187 Grant Street, Lexington, MA 02173, USA.

In Touch, newsletter published by the Public Health Association of Australia, PHA Secretariat, GPO Box 2204, Canberra ACT 2601, Australia.

INTRAH: List of Free Materials in Reproductive Health, 1993 Supplement to the 5th Edition by INTRAH, The University of North Carolina at Chapel Hill, School of Medicine, 208, N. Columbia Street, CB# 8100, Chapel Hill, NC 27514, USA.

MCH Newspac, published by the Pacific Basin Maternal and Child Health Resource Center, University of Guam, P.O. Box 5143, UOG Station, Mangilao, Guam 96923.

News and Views, newsletter of the Women's Environment and Development Organization. Published by Women USA Fund, Inc., 845 Third Avenue, 15th Floor, New York, NY 10022, USA.

NGO Summit Newsletter, World Summit for Social Development, Copenhagen, Denmark, 11-12 March, 1995. International Council on Social Welfare, Koestlergasse 1/29, A-1060 Vienna, Austria.

NU, News on Health Care in Developing Countries, published by the International Child Health Unit, Department of Pediatrics, University Hospital, Uppsala University, S-751 85 Uppsala, Sweden.

People's Perspectives on "Population", report on an international symposium in Comilla, Bangladesh, December 12-15, 1993. Organized by UBINIG, 5/3, Barabo Mahanpur, Ring Road, Ahaymoli, Dhaka, Bangladesh.

Population and Development Policies, Report on the International Conference "Reinforcing Reproductive Rights", Women's Global Network for Reproductive Rights, NZ Voorburgwal 32, 1012 RZ Amsterdam, The Netherlands.

The Prevention and Management of Unsafe Abortion, Report on a Technical Working Group, 12-15 April, 1992, Maternal Health and Safe Motherhood Programme, Division of Family Health, World Health Organization, 1211 Geneva 27, Switzerland.

Program and Legislative Action, published by the Women's International League for Peace and Freedom, June/July 1993, 1213 Race Street, Philadelphia, PA 19107-1691, USA.

Quality/Calidad/Qualite, Gente Joven/ Young People, A Dialogue on Sexuality with Adolescents in Mexico by Magaly Marques, published by the Population Council, One Dag Hammerskjold Plaza, New York, NY 10017, USA.

SAVE A MOM

Help a maternity

There has been a lot of rhetoric about saving moms, but the effect of this has been meetings and strategies but no resources. Not surprisingly, maternal mortality figures remain unchanged.

Please donate as much as you can to WIPHN and help us send speculums and sphygmanometers to needy maternity clinics in less developed countries. A donation of $30 helps bring a much needed sphyg to a maternity in Cameroon or Ghana, projects we are supporting. We would like to demonstrate that resources make a difference.

During a woman's childbearing years, the chance of dying of pregnancy-related causes is estimated as 1 in 20 in many of the developing nations, compared with only 1 in 10,000 in the United Kingdom. Each year, over 60 million women suffer serious maternal health problems.

CONTRIBUTORS TO WIPHN'S SAVE A MOM CAMPAIGN

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Nancy Worcester, USA

Rape, a leaflet prepared by SAVE PROJECT following the PNG Women and Law series. Ministry of Police and Justice and the Solomon Islands National Council of Women, P.O. Box 1149, Honiara, Solomon Islands.

Safe Motherhood, newsletter published by the Maternal Health and Safe Motherhood Programme, Division of Family Health, World Health Organization, 1211 Geneva 27, Switzerland.

U.S. National Report on Population, report prepared for the U.S. Department of State in preparation for the 1994 International Conference on Population and Development by the Population Reference Bureau.

Women and Development, Report FYs 1991 and 1992, U.S. Agency for International Development, 320 Twenty-First Street NW, Washington, DC 10523, USA.

Women and Population Policies, published by the Latin American and Caribbean Women's Health Network, c/o ISIS International, Casilla 2067, Correo Central, Santiago, Chile.

Women Envision, newsletter published by ISIS International, P.O. Box 1837, Quezon City Main, Quezon City 1100, Philippines.

Women's Declaration on Population Policies, Women's Voices '94, March 4, 1993, in preparation for the 1994 International Conference on Population and Development, The International Women's Coalition, 24 East 21st Street, 5th Floor, New York, NY 10010, USA.

Women's Suffrage Centenary, South Australia 1894-1994, newsletter sponsored by Women's Suffrage Centenary Secretariat, GPO Box 2308, Adelaide 5001, Australia.

World Alliance for Nutrition and Human Rights, Newsletter , Norwegian Institute of Human Rights, Grensen 18, N-0159 Oslo, Norway. For information contact: Erik Ivas.

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7100 Oak Forest Lane, Bethesda, MD 20817, USA

MEMBERSHIP FORM

To join, please fill in this form (print clearly) and include your membership fee: $20 for individuals, $45 for organizations.
Organizations or individuals in developing countries who cannot afford the fee, please send cloth or artwork of the same value as the fee.

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The Women's International Public Health Network

The Women's International Public Health Network was formed as a grassroots 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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