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Women's International Public Health Network News

Austin Helza

Women Hold Up Half the Sky

"Throughout the world there exists a group of women who feel mightily drawn to giving care to women in childbirth. At the same time maternal and independent, responsive to a mother's needs, yet accepting full responsiblity as her attendant, such women are natural midwives. Without the presence and acceptance of the midwife, obstetrics becomes aggresive, technological and inhuman."

Professor G.J. Kloosterman
Chief of Obstetrics and Gynecology
University of Amsterdam Hospital

Midwife Means "With Women"

The impact of midwifery on maternal/infant health worldwide has largely been ignored in recent times, yet it is the midwife who is credited with the lowest maternal/infant mortality rates throughout the world (WHO). Countries with the lowest mortality rates utilize midwives as the principal and only birth attendant for at least 70% of all births and report operative deliveries at a rate 2-3 times lower than countries who do not offer midwifery care to the majority of women.

The practice of midwifery is as old as humankind. Throughout history, more midwives have assisted women in childbirth than any other health professional. The Chamberlayne brothers, who introduced obstetric forceps in England in the 17th century, were largely responsible for the introduction of technology and medical professionals into the area of childbirth in the West. The rise of technology and the medical professional over midwives is significant historically because it involved the destruction of the supportive women's "healer networks" which had served women traditionally in their communities. While midwives were usually an integral part of a woman's community and operated within a network of information sharing and mutual support, medical professionals often saw knowledge as a kind of property, to be concentrated within an elite group and marketed. As childbirth became more "medicalized," women lost control of the childbirth experience and the kind of support and caring that the local midwife usually provided. In Europe, midwives were organized, trained and registered. Florence Nightingale was responsible for the registration and training of midwives in England during the 1870s. In the United States, between 1900 and 1930, midwives were almost totally eliminated from practicing by organized medicine, however, consumer demand for midwifery services increased during the 1970's causing a resurgence of midwifery practice. In Canada, midwifery was banned and is still illegal.

Most cultures have a special name for the women who attend women in childbirth. In the Philippines they are called "hilots," in Malaysia "bidans," in Latin America "parteras" and "comadronas," in India and Afghanistan "dais," in the United States "granny midwives" or "lay midwives," in many English speaking countries "traditional birth attendants" or "TBAs," and in Zimbabwe they are called "vanabuyas."

A midwife can be anyone from a completely illiterate traditional birth attendant, to a highly trained obstetric nurse-midwife. All the various grades between are valuable, however, and all can be improved by training, supervision and cooperation. The pattern of training birth attendants needs to be individualized to local needs. Training in the past for midwives has often concentrated too much on "navigation of the birth canal." Midwifery training should include nutrition, infant and child care, related home economics, management of breastfeeding, the organization of clinics (ante and postnatal), domiciliary deliveries, home visiting, and some knowledge and understanding of fertility control.

We wish to thank the Carnegie Corporation of New York, Grantee D89003, 437 Madison Avenue, 38th Floor, New York, New York, 10022, (212) 371-3200, for funding this issue of our newsletter. Corporation does not take responsibility for any statements or views expressed in this newsletter.

Midwives have a profound role to play in childbirth and in all areas of women's health, especially in the prevention and management of common health problems. National and local health care policies, designed to improve maternal/infant health, should provide for the maximum utilization of all levels of midwives.

Sources: Karen Moran, Midwife, *Mother and Child Health, For Her Own Good* and *In Labor.*

Margaret Pettibone and Madiama Dampha, TBA in Jumansarr Koto, The Gambia

TBAs and Midwives Developing Respect and Understanding: Building Bridges Along the Gambia River

The Gambia is a small country in West Africa split in two by the river Gambia across which there are no bridges. The population of 800,000 live predominantly in small rural villages, farming rice and peanuts. While the capital city Banjul (on the South bank) has more developed services such as hospitals, paved roads, electricity and telephone services, the north bank has few if any.

Since 1980, the Gambian Ministry of Health has been implementing Primary Health Care for villages of 400 or more. One of the serious problems they seek to change is the high maternal mortality rate. Two year records from a ten village area revealed a maternal mortality rate of 16/1000 live births.

In this region women have hemaglobins in the 7-9gm/dl range. Poor nutrition, repeated bouts of malaria and childbirth contribute to this state. Each of the four women who died in these study villages would have been able to survive childbirth had they not been anemic to start with. Almost 95% of the births to women in these remote villages take place on the floor of the hut or in the yard behind and are usually attended by the traditional birth attendant and a number of village women.

The Ministry of Health's Primary Health Care scheme provides the TBA's with 6 weeks training, emphasizing clean hands and sterile blades when cutting the cord. The TBAs on graduation are given a UNICEF delivery kit which contains plastic ground cloth, apron, soap, sterile blades, ergometrine and iron tablets. While competent and respected in their community, TBAs are often intimidated by health providers at hospitals and in clinics. This makes it difficult for them to be effective advocates for early referral of pregnant women at risk to deliver in their villages.

In one instance an anemic para 17 woman in labor was transported with the TBA to the health center but the lying down routine and shiny instruments spooked the mother and TBA and they ran out of the center while the irate midwife wanted to know why the mother had waited so long to come. The fact that the midwife did not speak the same language as the patient added to the problem. Fortunately a girl was born fifteen minutes later and both were fine .

Problems such as this led to the setting up of a TBA internship at the local health center which was supported by Save the Childrens Fund.

The internship sought to foster better relations between the TBAs and midwives. Participants were housed at Eddy's Hotel (the best hotel on the North bank) in rooms with fans, electricity (sometimes) and running water (sometimes). There was also a very luxurious courtyard garden with a bar and disco. The TBAs spent 2-3 days working with the midwives at the health center and observing or assisting at deliveries. It was a way for them to gain confidence in a new environment and also gave health staff an opportunity to know them as part of the health care team and not as adversaries. In the evenings there was a happy hour and women who might have sat in the dust outside selling mangoes were having a new experience and exchanging information on case management.

The bridges built at the happy hour in the garden of Eddy's Hotel extend all the way back to each village woman who needs referral and across the Gambia river to Banjul for hospital care.

A TBA With Her Apprentice

by Margaret Pettibone. Margaret served in the The Gambia in 1984-1987 as a Peace Corps volunteer and then with Save the Children.

"The coverage and effectiveness of the health care system needs to be measured not by the number of clinics in existence, but by the number of women being served and the number of lives saved."
Dr. A. Lucus, Carnegie Corporation.

A Nigerian TBA Participant in an ACNM Training Session

American College of Nurse Midwives Providing Innovative Training for TBAs

The American College of Nurse-Midwives(ACNM) with funds from USAID, is assisting African nations in developing maternal and child health and family planning programs for traditional birth attendants(TBAs). The ACNM has provided assistance to many nations including Zaire, Tanzania, Sierra Leone, Nigeria,Ghana and the Ivory Coast. All of the programs share a common goal: to better the lives of women through improved midwifery services and education. ACNM believes that TBAs play an important role in the health care system. Programs are designed using the principles cited below:

1. TBA training needs are specific to each country and sometimes specific to regions within the country.
2.The training curriculum for TBAs is developed in country by the trainers of the TBAs and the trainees.
3.Ideally the trainer and supervisor is the same person.
4.The trainer is a provider of MCH\FP services, with experience as nurse or midwife.
5.Lesson development and practice teaching is included. Training of TBAs takes place in their own environment with resources available to them.
6.Training of TBAs begins with what the TBA knows and practices. Practices are categorized as harmful, harmless or beneficial.
7.Teaching makes use of "live examples" and repetition and review is considered important.
8,The trainers are given assistance in developing plans for supervision and evaluation. For more information contact: The Special Projects Section, ACNM,1522 K Street,NW,Washington,DC 20005, USA, telephone (202)289-4005

Traditional Birth Attendants in West Africa

Broad generalizations must be used to describe the traditional practice of midwifery across this wide expanse of land and many diverse cultures and tribal groups. This article is not intended to be an extensive or definitive work on TBAs in West Africa and covers Liberia, Sierra Leone, Ivory Coast, Ghana and Nigeria.

Who are traditional birth attendants in West Africa?

TBAs are typically illiterate women aged 40 and above who are respected by their communities.(In Ghana there are a number of male TBAs.) They have learned their trade by apprenticeship. The art may be passed through the family. A young woman may also be "called" through a sign or dream. TBAs may also practice traditional medicine. A new and growing group called " spiritualists" practice Christianity with a mixture of African beliefs which include healing and birthing services provided to the congregation. In Liberia and Sierra Leone, and in areas where the Sande (secret traditional women's societies) exist, the TBA might also be a "zoe" or head of the society which is responsible for instilling the cultural beliefs and practices of the tribe and assisting young girls with the transition to womanhood . As head of the Sande society the TBA oversees or performs the ritual female circumcision (typically partial or full clitorectomy with removal of the labia minora.)

What TBA's do

Most TBAs provide midwifery as a community service as they support themselves primarily through other occupations such as farming or petty trading. They usually assist at births only for their immediate community and might average 4-7 births per month. In West Africa it is the TBA that assists 60-80% of the births.Payment for deliveries varies from gratis, to a bucket of rice, jar of palm oil, a chicken, work on the TBAs farm or money. An increasing number of TBAs are requesting monetary payment.

By definition, delivering babies unifies the practice of all TBAs. It is not a solo practice situation since either her apprentices or neighbors who have had children provide assistance. Besides birthing,the tasks TBAs perform vary considerably. The amount of antenatal care given is often limited to specific requests for care or questions from pregnant women in the community. TBAs may provide cultural information on appropriate diet and behavior as well as taboos during pregnancy, but rarely provide risk assessment or other types of preventive care.

The amount and type of support given during labor varies tremendously between tribal groups and individual TBAs. Where the TBA has other primary responsibilities she may arrive just in time to "catch the baby." The TBAs responsibility is dependent on the parity of the woman and the amount of support (other women family members) she has at home. Birthing procedures are usually non-interventionist with few TBAs performing vaginal exams. However, fundal pressure(pushing down on the top of the uterus) and application of herbs/leaves to the perineum or in the vagina are not uncommon procedures for the TBAs to perform. It is also common for women to be given herbs (in drink or food) to speed labor.The traditional positions for birth vary from squatting,

to birthing stools, lying supine, lying with a woman sitting behind who is acting as a chair or holding onto a hanging rope with knots in it. The TBAs usually support the head as it emerges(the Tiv in Nigeria may use their foot to control the head) and newborns are resuscitated by sprinkling water on them, blowing on them, smacking or rubbing them and they are bathed soon after birth. Cord cutting procedures and cord care vary tremendously and there are many rituals for disposal of the placenta.

After birth the TBA checks on mother and baby at least once, and often daily, for a week or longer and culture specific advice is given.

Additional services include (if healers) advice and treatment of infertility and counselling.

Western medicine does impact on the practices of the TBAs and the extent is probably dependent on the contact the TBA has with practitioners of midwifery/obstetrics at clinics or hospitals. When this is done without adequate understanding of the proper use of a technique (i.e.use of latex gloves or the administration of injections) this may be unfortunate.

Are the practices of TBAs beneficial or harmful?

The great majority of TBA practices are beneficial or harmless. This is true especially where women do not have access to other medical care which westerners would consider "safer". Even when this so called "safe care" is available, it is not used. A minister of health noted that TBAs must be doing something right since a large percent of the urban dwellers who have access to western services continue to be delivered by TBAs who have moved to the city. He believes that this is related to the trusted and caring environment provided by the TBA and the fact that she will perform traditional rituals necessary for the safety, happiness and fulfillment of the newborn, mother and family. Western medicine also has something to learn from TBAs namely, their accessibility to the community, the fact that most home births are without complications and the use of herbs and massage.

A few practices used by TBAs such as use of an old knife to cut the cord or demanding that a woman begin pushing in early labor can cause the mother and baby harm.Unfortunately the dangerous and unsafe practices tend to be remembered more vividly than the many valuable services they provide. Another frequent concern about TBAs is their lack of knowledge about the cause and effect relationship between problems of pregnant women and their poor outcomes, as well as their inability to recognize danger signs for mother and or infant. It is both these areas that the training of TBAs should address.

The TBA is an important health provider in West Africa and given the health care manpower structure, training of TBAs should continue.

Deborah Armbruster CNM, MPH
Kathy Krasovec MPH Sc.D.

Mother with headscarf delivered twins weighing 1.2 kg each. One lived 2 days , the other 16 days. She was severely malnourished and of short stature. She had gained no weight in her pregnancy.

"Ninety nine percent of deaths in maternity occur in the developing world where 85% of the world's births occur. This implies radical changes in the way maternity services and their staff operate in the developing world. Unfortunately, training, practice standards and patterns of health delivery are often modelled on the developed world and so the problem is a joint one." Joan Bently

Traditional Birth Attendant as a Primary Health Care Worker

Indonesia like other developing countries, has a problem of insufficient manpower. The geographical situation adds to the problem as Indonesia consists of more than 2000 islands spread over 2 million square kilometers and a large population - the fifth largest in Asia.As a result, TBAs still have their role in the MCH programs especially in rural areas where transportation is the main problem.

Most deliveries are attended by TBAs. In some provinces (Yogyakarta, Bali, and North Sulawesi) a 1986 household survey revealed that more than 50% of births were attended by health personnel. In these areas both maternal and infant mortality rates were low. In the other provinces where TBAs conducted deliveries and where transportation was poor, the mortality in infants and mothers was high. (See Table below).

DELIVERY IMR AND MMR

	Deliveries attended by: health worker	trained TBA	untrainod TBA	(%) IMR	(M
Yogyakarta	54.6%	21.9%	23.5%	27.1	1
Bali	60.9%	11.4%	22.7%	53.4	2
North Sulawesi	50.2%	26.4%	23.4%	52.2	2
Bengkulu	42.8%	12.6%	44.6%	75.0	4
West Kalimantan	16.1%	12.8%	71.1%	72.9	5
Maluku	29.1%	14.3%	56.6%	66.1	4
West Nusa Tenggara	17.3%	31.7%	51.0%	120.9	-

Source: Household Survey Ministry of Health, Republic of Indonesia, 1986.

Although TBAs have great potential as health workers, they also have negative characteristics; most are illiterate, aged, and many are resistant to change. In Ujung Berung (West Java) Alisjahbana et al, use special training methods, such as modules and guidelines as well as reporting and recording cards, using pictures so that they can identify and follow high risk cases. They are trained to refer high risk cases at an appropriate time and to appropriate levels of health services.

As long as the number of health personnel in Indonesia is limited, accessible TBAs will have to be trained by the Health center staff in the areas where they are derived from in order to reduce maternal and perinatal mortality. By Dr. Soetjiningsih, Indonesia.

An Indonesian Nurse Midwife

Training Traditional Birth Attendants in Karnataka State India

The training of traditional birth attendants (TBAs) is very important for the training of women leaders in this community health program. Although almost indispensable in the birthing process, TBAs in India are seldom recognized for what they are, because they are poor, illiterate and of low caste. Their training , therefore, is an effort to affirm their contributions to the health care in the village and their leadership potential which can no longer be ignored.

A church related community based health development program was started with the main goal of a self-sustaining program using locally trained primary health care workers to provide a combination of traditional and western medicine. Women's groups were organized by the pastor's wives and other interested young people formed the work nucleus which now covers thirty five villages and a population coverage of 50,000. For this area there is one part-time physician, one fulltime public health nurse, three full time coordinators and ten PHWs. Fifteen volunteer TBAs and ten part-time PHWs work in their villages and are expected to perform a host of activities, including high risk screening, counseling, and normal deliveries.

Selection of women trainees starts with the organization of women's groups called sanha. These then select trainees that are interested to serve, love the people, do not have favorites, are courageous and able to stand for the peoples rights, honest, communicate with others, and willing to learn. The training program although only 6 weeks, takes two years to complete because week long sessions are scheduled before or after planting or harvest season in order that women do not loose their daily wages. They are encouraged to bring their babies if breastfed to the training. In one instance the sangha built a hut especially for the purpose of training. They were not paid a daily allowance and although some asked for it, most voted against. For most the opportunity for training and new opportunities was enough compensation.

The curriculum development included the women's perceived needs. Workers were taught to recognize common diseases and current and correct treatment, and basic organizational and management skills. Five years after the initiation of this program, the health and leadership training has changed the local situation, increased political action for community benefit, and improved the outlook for the future. The project underscores the need for hope, the incorporation and recognition of traditional beliefs, and for involving other sectors of the community. By Ester Galima Mabry

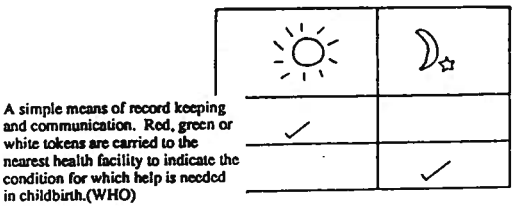
"Maternal health care should be provided in the context of family health care-it should be socially acceptable, scientifically sound, and as simple as possible."
Dr. A. Lucus, Carnegie Corporation

South African Midwife

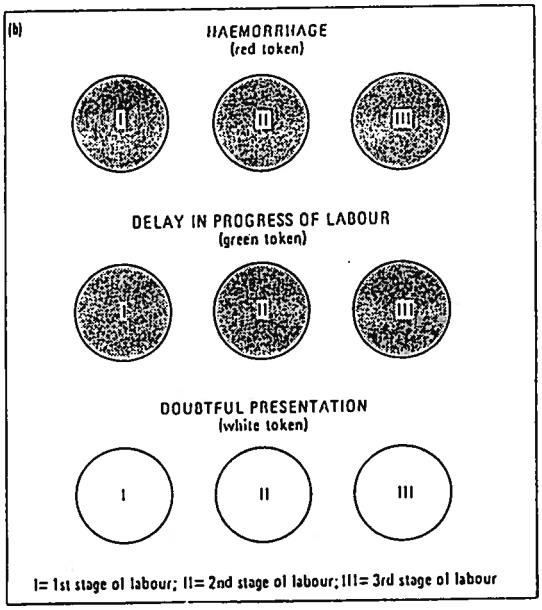
One of the three presidents of the United Democratic Front, Albertina has led a life of extreme hardship since the imprisonment of her husband, Walter Sisulu, in the 1964 Rivonia trial. Despite periods of detention and ten years under house arrest, she has brought up five of her own children and two of her sister's, working as a nurse and midwife. Campaigning now to bring women's groups together in the struggle for liberation, Albertina says: "I pray to God that one day I will see my people free."

Albertina Sisulu

Appropriate Technologies in Childbirth



A simple means of record keeping and communication. Red, green or white tokens are carried to the nearest health facility to indicate the condition for which help is needed in childbirth.(WHO)



Dr. David Morley informs us: **The SISTERHOOD MORTALITY METHOD** of identifying levels of maternal mortality has been developed by Dr. Wendy Graham at the Department of Demography, London School of Hygiene and Tropical Medicine. A booklet describing the method is available for those who are interested. The method identifies maternal mortality through a questionnaire to women on what happened to their sisters during childbirth. Write: Dr. Wendy Graham, London School of Hygiene and Tropical Medicine, 30 Guilford Street, London, WCIN 1EH, England.

AMEMIA

Dr. Harrison in Nigeria found that exsanguinated late arrivals require 60 units of blood per bed/year, compared to only 8 units of blood per bed/year in the United Kingdom-a more than sevenfold difference.

CERVICOGRAPH

Philpott has devised a chart, called a cervicograph, to help semiskilled workers define cases requiring transfer for specialized care. The chart uses "alert" and "action" lines based on progression of cervical dilatation and advancement of the head over time. By using the chart, midwives in isolated villages are able to refer cases earlier, allowing enough time for transportation to the hospital. Supervision remains a key component of this method.

PATH

The Program for Appropriate Technology publishes Health Technology Directions three times a year. The most recent issues are: Sexually Transmitted Disease and Technology Introduction: the Safe Birth Example. Single copies are obtainable for free. Write PATH, 4 Nickerson Street ,Seattle, Washington,98109-1699 USA. Tel:(206)285-3500.

WOMEN'S VOICE

This publication deals with a wide variety of subjects affecting women including politics and health and can be obtained from Katura, Windhoek 9000, Namibia, Africa.

WIPHN Members Making a Difference

INTERNATIONAL PROJECTS ASSISTANCE SERVICES (IPAS)

The focus of this non profit organization is primarily on the treatment of health consequences of incomplete and septic abortion. The production division provides services in about 90 countries worldwide and distributes manual vacuum aspiration equipment. The program division is training health providers at a variety of levels in the health structure. IPAS collaborates with a number of women's and family planning organizations. The organization also has available a special fund (The Leonard Laufe Fund) that provides support to requests for activities providing innovative obstetric and gynecological services to women in developing countries. For further information contact: IPAS, PO Box 100 Carboro , North Carolina, 27510,USA. Telephone (919) 967-7052. WIPHN member Julia DeClerque is the Director of the Research and Evaluation Division.

Midwives Making the Difference

Some examples where TBAs have made an immense difference as a result of retraining are: In Lulongwe, Malawi one illiterate midwife has set up a maternity of huts in the bush. One hut is for washing, one with a sloping floor is used as a birthing room, one for antenatal care, and one for postdelivery. The fifth hut is used for low birth weigh infants. Formerly, these usually died when they were taken home. Now they are kept in Nestles condensed milk cardboard boxes (appropriate technology) serving as incubators and with hot water in bottles with paper stoppers. The infants are given vegetable oil on a rag to suck and within two to three days they are given breastmilk, once sucking is established. According to a TBA the babies now live when they go home. In Ghana, TBAs are trained to help reduce tetanus. Sterilized thread from banana trees are used to tie the umbilical cord.

"There are women everywhere with fragments Gather fragments, weave and mend When we learn to come together We are whole."
Anne Cameron, Daughters of Cooper Women

"WIPHN's First Birth"

We congratulate the Women's Association for National Development (WAND)

Women in Sierra Leone recently organized a four day seminar on "Women and Self Development." The idea was to set up a national nongovernmental machinery to promote , link and support all women and nongovernmental organizations.

A subsequent technical meeting established the frame work for this "national nongovernmental women's organization ." Women from the capital city, Freetown, and representatives from three provinces, as well as fifteen female nongovernmental organizations participated. The aims of the organization include the participation of women in all aspects of the life of the nation; a center for action; the promotion and support of a national network; influence policies on women's issues; initiate and assist self development projects; create awareness among development agencies that women should have an equal share of available resources; liaise with international NGOs on women in development issues; and to identify and promote training programs to support women. The formation of WAND is exciting as it will undoubtedly be the springboard for promotion of women's development which will improve health and nutrition and lower mortality rates. All members of WIPHN are therefore invited to take an active interest in WAND and to join us in wishing our newly born association all the best for achieving its objectives. Dr. Moira Browne is on the advisory board of WIPHN and a founder of this new WIPHN associated organization. Contact person: Dr. Moira Browne, Chief Medical Officer, Ministry of Health, Freetown, Sierra Leone, West Africa.

Women Owned Firms Influence the Direction and Quality of Women's Health Services

Initiatives is a women-owned, internationally-focused organization, founded in April 1987, with a mission to work with and help health care providers and managers as they carry out maternal and child health programs in their countries.

Initiatives' staff and associates are nurses, midwives, doctors and managers who come from all over the world. They assist organizations to create environments in which staff are encouraged to grow professionally and rewarded for making a full contribution to the organization's success. Typically, Initiatives associates assist organizations to establish management systems and procedures which will influence staff performance such as supervision, performance appraisal and training. In addition, Initiatives works with country counterparts to prepare and deliver training, thereby ensuring local support and continuity. In keeping with Initiatives committment to its mission, staff members donate ten percent of their time to working with those who cannot pay.

Since Initiatives has only recently emerged as a small business, the experiences that have shaped it are still fresh. Jenny Huddart and Joyce Lyons, Initiatives officers, are interested in sharing their experiences with others. "The *lessons we have learned during the last year and one half may prove useful to other professional women who are currently considering a similar venture. We would enjoy discussing our experience with others and hearing from those of you who are further along in the process of establishing organizations designed to influence the quality of health services, particularly for women."*

For further information contact: Initiatives, Inc., 239 Commonwealth Avenue, Boston, MA, 02116, USA.

Oganization of Nigerian Women in Health Related Professions

This nonprofit organization, founded in 1987, is devoted to the promotion, improvement and protection of the health of all Nigerians. The organization hopes to be an umbrella to unite all the Nigerian women in health professions into a powerful force for creative change in health problems facing Nigeria. The organization also hopes to combine forces with other women's organizations in addressing common health issues facing third world countries especially in Africa.

Goals include the initiation and implementation of health education projects; to serve as a resource center and network. The organization is open to all Nigerian women in the health related fields.

Information can be obtained from: Dr. Catherine Uzoma- Onunkwo, President, 4632 4th Street ,NW, Washington ,DC 20011 USA
Phone (202)636-7930

Marta Voge-Kealey with young women's group in Totnicapan, Guatemala.

Introducing Health and Nutrition to Men in Agriculture in Guatemala

It is a given that women are interested in health and nutrition, but it should also be the responsibility of men. In Guatemala, development extension agents, "agronomos" encourage people to diversify their crops (most people plant corn and beans) and emphasis is on production for markets or export, not for consumption by the families themselves. They do not put a lot of thought into the nutritional value of the vegetables they are promoting, nor are they aware of the nutritional value of foods.

In order to change this, one day workshops were provided for agronimos and other technicos to educate them on the importance of nutrition, and how they can reduce high maternal and infant mortality and malnutrition in their area. The workshop not only covered crop production but also maternal nutrition and infant health and mortality. Educating men that women's need for protein and calories during pregnancy and lactation are greater than a man's is always surprising to them. The one day workshop has generated a lot of enthusiasm in Totnicapan. An effort is now being made to use this seminar throughout DIGESA (Guatemalan Agriculture Agency).

By Peace Corps Volunteer and WIPHN member Marta-Voge-Kealey

International Lactation Consultant Association

The International Lactation Consultant Association (ILCA) is a world-wide organization for lactation educators , researchers and clinicians representing 1200 members in 27 countries.The organization offers an accreditation exam. ILCA sponsors an annual Conference and a peer reviewed quarterly Journal of Human Lactation . Last summer ILCA introduced the lactation consultant declaration which reaffirms commitment to breastfeeding rights and delineates practices for support of breastfeeding . This declaration is in keeping with the WHO Code on infant feeding and strives to attain breastfeeding for all mothers and infants without formula manufacturer's interference. The next meeting will be held in Toronto, Canada July 7-9, 1989. For copies of the Lactation Consultant Declaration and other information contact: ILCA at PO Box 4031, University Station, Charlottesville, VA , 22903 USA. President, Jeanine Klaus

The Center to Prevent Child Malnutrition

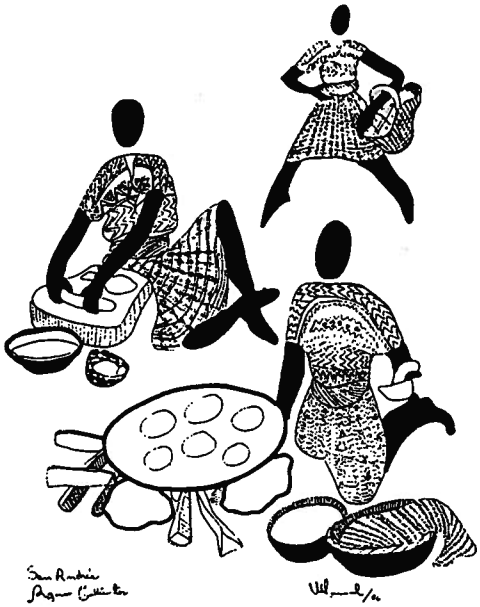
The Center is a nonprofit organization that works to improve child nutrition worldwide. The center funds small-scale, self help projects that communities themselves design. By evaluating these grass roots efforts, the center is able to share the results of successfull projects with other agencies. Many of the center's projects are directed towards women because they are aware of the health problems that their children face. The center currently works in Peru, Ghana and in the USA. For information contact: Sandra Huffman, President, Suite 204, 7200 Wisconsin Avenue, Bethesda, MD USA 20814 Phone (301) 986-5777.

Women Organize in Lima, Peru

In 1984 there was a program launched to reduce malnutrition called Vaso de Leche - the glass of milk program and popular family kitchens. Through this program hundreds of thousands of women were mobilized and became active community participants. When the authorities tried to take "the glass of milk program" from the independent local women's committees and put it in the "mothers club" controlled by APRA (the governing national party), the women organized a huge rally to protest. Although they were attacked by armed police with tear gas, water hoses, and guns, through their protests and unified effort they have kept control of the program. Clearly, from this women's movement has come more than just food. Women have been drawn out of the isolation of their homes and forged into a united force with other women.

Eritrean Rebels Emphasize Women's Rights

For most women born in Eritrea (North Ethiopia) problems start at birth. When a male infant is born visitors bring many things - coffee, sugar, but nothing for a girl. Being female means being promised in marriage at 8 and married to someone you have never seen by 12. A woman cannot speak in



public, own property, or be seen by a visiting man. From the age of seven she must grind flour, fetch water and work as her mother . For her school is taboo, but for women who have joined the Eritrean Peoples Liberation Front, women's rights are emphasized. A women's union which runs its own adult education program, teaches women how to read and write and improve sanitary conditions. Many of the women in the camp are training to be barefoot doctors. Most programs in developing countries ignore women's health needs . Menstruation is one example . China is one of the few countries in the world where women can obtain sanitized paper for menstrual discharge cheaply and easily. This also appears to be the case in Eritrea. "In the hills of Eritrea among the tiny rebel factories, one is turning out sanitary napkins at the rate of 10,000 an hour- progress in a region where women were often banished to separate tents or confined to holes dug in the sand during menstrual periods." John Kifner, New York Times, Aug 25, 1988. Here too, female circumcision has been stopped and women are able to choose their mates.

The old saying "just as there is no donkey with horns there is no such thing as a woman with brains" has fallen by the way.

Let's Change This

Ellen Israel writes; the Demise of Midwifery at Boston City Hospital, the oldest and largest inner city midwifery service in Massachusetts, folded in June 1988 after a long struggle by staff, consumer groups and clients to save it. The issues are: Is midwifery different, but as safe as medicine? What is the effect of competition between residency (teaching) programs and midwifery? What part does the threat to MD fees posed by the patient's choice of midwifery play in the conflict?

"We are continuing to fight for the rights of low income women in Boston to choose a midwife for her care. Contact use with information and suggestions." Ellen Israel CNM, Women Care, 2464 Mass. Ave, Cambridge, MA, 02140, USA.

Happy Birthday Dr. Cicely Williams!

Dr. Cicely Williams will be 96 years old on December 2, 1988. Please write and wish her happy birthday at: 24 Wyndham House, Plantation Rd, Oxford, England.

WIPHN Update

This year's annual NCIH meeting was a tremendous success for WIPHN. Our booth, shared by the National Council of Negro Women's International Division, was a center of constant activity. The WIPHN Women's Caucus and our panel on "Health Care in South Africa" were well attended. The party was a lively event, full of spirit and sharing, with wonderful music by the South African Women's Choir.

In July, we participated in the ILCA annual conference in Philadelphia, and a keynote presentation on AIDS and Breastfeeding was given.

A Spanish edition of our newsletter has been published and is available. Individual memberships have continued to increase tremendously from all over the world. New organizational memberships include: IPAS, Center for Prevention of Child Malnutrition, The Indian Health Service, ILCA and The Medical Mission Sisters.

We have recently received grants from the Carnegie Corporation of New York and the Engelhard Foundation. We also participated successfully in the AID RFP for Maternal Health and Nutrition as a subcontractor with John Snow, Inc.

At the APHA Annual Meeting in Boston we will have a booth, a panel featuring Dr. Rosita Arvigo, an herbalist specializing in woman's health, who has worked with a Mayan bush doctor in Central America for many years and we will feature a keynote speaker at a general session.

In December of 1988 we are assisting with the planning and coordination of an international meeting on breastfeeding promotion, sponsored by NCIH and UNICEF. The meeting, "Breastfeeding, A Passport to Life," will be attended by many world experts on breastfeeding and will take place at UNICEF in New York on December 10th.

We welcome Margarita Papandreau of Greece and Judy Canahuati of Honduras to our Advisory Board. We wish to give special thanks and appreciation to all those who have helped us over the past six months, with special mention to Pat Biro, Ann Thompson, Sandy MacIntosh, Elayne Clift, Joyce Lyons, Charlene and Sophie Engelhard, Sam and Betsy Holdsworth and Kathy and Chris Krasovec.

To all those who have joined us, we thank you for your support! We look forward to an exciting year in 1989. Be in touch, we value and need your input. Please send WIPHN publications, reports and information on TBAs, midwives and maternal mortality in your country. A working document will be compiled on these subjects and made available on request.

A selected bibliography on midwives and TBAs is available through WIPHN on request.

Readers are invited to send articles, comments and information for our next newsletter (the "theme" will be breastfeeding) due by April 1989.

Pat Biro, Pam Putney, Sophia Neiza, Naomi Baumslag and Phyllis Gestrin at the WIPHN Booth at NCIH.

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.

"The trouble with women's work is not that it is never done, but that too much of it is never started." Dr. Cicely Williams

WHO IS IT FOR?

◆ Any woman working in public health. Men genuinely interested in supporting the goals of this women's network are welcome to join.

WHAT ARE OUR 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 to share knowledge and experiences with, instead of being isolated.

◆ Promote women in international public health and identify women's issues such as: safer motherhood, maternal and child health, employment, training, legislation, policy formation and project funding.

◆ 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 health related issues.

◆ Serve as an exchange forum through which women health care providers can publicize ideas and events, problem solve and obtain information form one another worldwide.

◆ 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.

How to Join

Annual Membership Fees

Individuals	$15.00
Organizations	$35.00

Women in developing countries, please donate whatever is possible. Membership will not be denied to individuals or organizations with limited resources. We are establishing a special scholarship fund in honor of Dr. Cicely Williams to provide leadership, management and technical training for women health professionals from developing countries. We welcome donations to the fund.

Please Print Clearly

Name (including title and degrees)

Address

Telephone Numbers

Current Work/Institutional Affiliation/Employer

Special Interests/Comments
Send to:

Women's International Public Health Network (WIPHN)
7100 Oak Forest Lane, Bethesda, MD 20817 USA (301) 469-9210

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