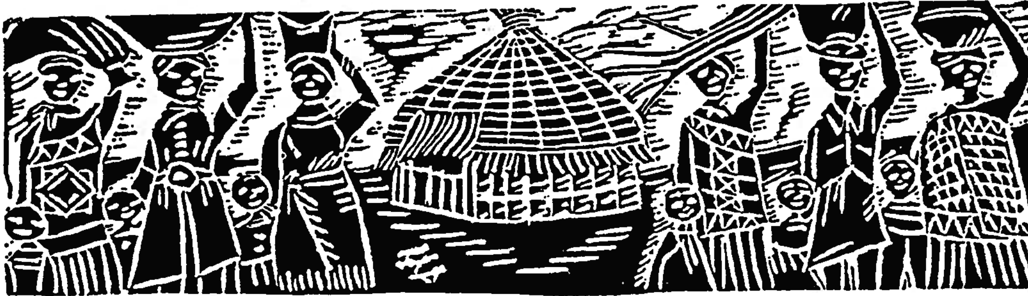
Austin Helza

Women Hold Up Half the Sky

WIPHN News

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"Too often 'public health' enthusiasts will approach a disease, if it is widespread, as though it could be corrected by mass methods alone..."

Cicely D. Williams

Women and AIDS
Future Directions

Throughout the developing world, women comprise about half the number of people with HIV infection. In the US, women are the fastest growing risk group. In New York City, AIDS is the leading cause of death in women aged 25-29.

Considering the enormous impact of HIV on women's health, appallingly little has been done to date to learn about and address AIDS related issues unique to women.

If one looks at the area of AIDS research it quickly becomes evident that women have been overlooked by researchers. For example, it has been known since at least 1984 (perhaps earlier) that nonoxynol-9, an ingredient in many spermicides, is viricidal in vitro against HIV. Six years later, outside of a small prostitute study which was not generalizable to women as a whole, there have been no studies done to determine what dosage, if any, would provide efficacy in the body for prevention of HIV infection.

If one considers the lack of control women have over whether or not men wear condoms, compared with the amount of control they have over inserting a sponge, suppository, foam, etc. into their own vaginas, the impact of this knowledge on the empowerment of women to take control of their bodies becomes clear. There are enough women who do not have access to using condoms for reasons ranging from spousal battering to economics, that this needs to be a high priority for research.

In countries such as the US, where access to promising new medical treatment is primarily through clinical trials, women are systematically excluded from trial participation, thus resulting in lack of access to new therapies. Many trials automatically exclude women of childbearing age. Over 90% of women with AIDS fall into this category. At trial sites, there usually is no child care available, no transportation assistance, and rarely any multilingual or bicultural personnel. Consequently, most new drugs studied are not studied on women, so when they are approved little is known about how they affect women. The assumption is generally that the effects are the same as they are for men. Community advocacy groups are pressuring for changes in these areas.

> "Women are the key to achieving health for all"
>
> Dr. Hiroshi Nakajima, World Health Organization

Beyond the need for specialized research, women have specific needs as well; the most significant of which often relate to their children. Many women with AIDS come from cultures where being a mother is the primary way in which women attain status and self esteem. Counseling women who are HIV infected regarding pregnancy becomes complex when one layers the odds of delivering an infected baby (approximately 30-50% depending on which study you read) over the cultural value of motherhood.

Additionally, when the mother is ill, if there isn't sufficient extended family or social service support, the children wind up neglected as a result of the mother's physical incapacity to care for them. This has negative psychological consequences for the mother as well as the children. Acceptable systems of respite and support that fit within differing cultural contexts need to be developed. Women also need assistance with addressing the painful issue of who will care for their children once they've died.

HIV/AIDS is a serious threat to the health of women. It is time to take our heads out of the sand, raise our voices, and demand that serious attention be paid to the AIDS related needs of women.

Laurie Novick, USA

Women and AIDS
Health and Welfare Needs

Knowledge about the epidemiology of AIDS is evolving, but perhaps not as fast as the disease itself. At the end of the first decade of our experience with the global pandemic, it is becoming clear that the impact of HIV and AIDS on the

health and welfare of women and children is far more extensive than had been anticipated. Not only is the heterosexual spread of the disease more widespread than had been thought and directly affecting more women, but the broader social psychological and economic impact of the disease on family life is also indirectly having a serious impact on the lives of women.

WHO estimates that over 1,500,000 women are infected with HIV. Approximately 1,250,000 of these are likely to be in what have generally been termed Pattern II countries (in Africa alone, it is estimated that 1,000,000 women are infected). In Pattern I and III countries it is estimated that prevalence of HIV infection among women is 250,000 and 25,000 respectively. As with all HIV infection estimates, however, these figures are probably conservative; certainly the risk of transmissions to women continue to be high and in certain communities is probably increasing.

Many HIV/AIDS prevention programs continue to labor under the very early assumption that HIV is not easily transmitted through heterosexual relationships. In most countries women have not been targeted with information and education particularly suited to either their needs or the constraints under which women in many cultures function. Conversely, many risk reduction initiatives concerning condom use are addressed to women even though they are not the ones who use them, and in many situations have few opportunities to insist on their use. There have also been suggestions that in many countries women may not be participating in, and benefitting from clinical trials of new therapeutic substances to the same extent as men. Similarly, few psychological support programs are acknowledging the extent of the roles and responsibilities of women and the fact the HIV infection in the spouse or partner invariable means additional tasks and work for the woman. Where she too is infected, the combined effect may be especially debilitating to her health and quality of life.

As concern for HIV and AIDS declines (as it appears to be doing in many countries), it will be important that the health and welfare needs of women in relation to this epidemic not be neglected but in fact be given even greater attention than before. If not, then the health of women as individuals will be adversely affected and with it, family life in general.

Manuel Carballo, WHO Geneva

Positive Prejudice HIV and Breastfeeding

Imagine the following case coming before the courts. In March 1989 Ann had negative HIV test. By May Ann's test is positive. Since she had sexual intercourse only with George between March and May, Ann claims that her George must have infected her with HIV. However, further investigation reveals that Ann has a long history of drug abuse, she had been losing weight and had clinically-diagnosed lymphadenopathy since January 1989. What does this suggest about her March test? Would anyone suppose that George must have infected her?

If your answer is that most likely her March test was a false negative, that George could not possibly be held responsible for her infection, I suspect you would be in the mainstream of medical thought. It is still widely held that the risk of infection via normal heterosexual intercourse is reactively low, and that there is no justification for a complete ban on sexual activity by infected males. Penetrative sexual intercourse matters, particularly for men. (Though this is highly individual, sexologists have been telling us for years that women are more readily satisfied that men with other kinds of sexual activity). And because penetrative sex matters, it is considered very important that each case of putative heterosexual transmission is fully documented, to allow us to assess the real risk involved, and create appropriate guidelines that permit a valued human activity to continue despite the fact of risk. Absolutely correct.

But if the above case would not be accepted as proof of HIV transmission via semen, why is it that the medical mainstream accepts a closely analogous case as "providing" transmission via breastmilk? To quote from the Stockholm abstracts: "A 22 year old woman with a past history of intravenous drug use presented with a four-month history of weight loss and lymphadenopathy. She was still breastfeeding her 11 month old infant. Anti-HIV serology, negative 8 weeks before was now positive. The infant was also positive." The objective of this abstract was "To describe an instance of postnatal HIV transmission via breastmilk." It was assumed that the mother infected the baby in the 8 weeks before her positive test, although the baby had never been tested prior to its positive test at 11 months. While this may be so, or the mother may have infected the infant in the previous eight months, it is also perfectly possible, and perhaps more likely, that the baby was infected in utero.

What this indicates is that evidence which would not be deemed sufficient to implicate a male body fluid is more than sufficient to incriminate a female body fluid. Other cases on record (and there are remarkably few) are equally incomplete in their documentation of breastfeeding as the only possible transmission route, yet equally well-accepted as "proving" breastmilk transmission. This could be shrugged off as just another example of the male bias, sexism, and cultural insensitivity that has

been evident in many areas of the HIV Establishment around the world. Except that in terms of its importance to world health, breastfeeding matters far more than the act of coitus. To advise against breastfeeding by infected women requires at least as much careful study and good scientific justification, and should be done just as reluctantly, as mandating total celibacy for infected males.

The nexus between medicine and industry alluded to earlier explains a great deal about the profession's willingness to discard breastfeeding as an irrelevance before asking and answering many important questions about the immunological role of breastmilk even in HIV. Yet some researchers have stated both publicly and privately that despite the best equipment they cannot replicate the claimed finding of intact HIV antigen in breastmilk, although antibody can be demonstrated and PCR tests indicate that viral fragments are present. (We do not know whether those viral fragments serve to infect or to immunize: their presence proves nothing of their function.) We do not know that breastmilk contains many sophisticated anti-viral defenses, both general and specific. We know that some of those specifically destroy enveloped viruses. (HIV is an enveloped virus).

Recently researchers at Johns Hopkins demonstrated that breastmilk contains a factor, not found in either blood or cow's milk, which inhibits the binding of HIV proteins and receptor molecules? This discovery naturally hardly rated a mention in most of the major newspapers. These are the same newspapers that had trumpeted stories about infected babies by breastmilk transmission without publishing any details. Why does WHO not set up a central registry of putative cases of breastmilk infection, where detailed discriminant analysis could be applied? Why do we not investigate the possible benefits of women's milk as prophylactic and therapeutic? (Is it because women freely give their milk to those in need, so there is little likelihood of any billion-dollar profit?)

At present when it comes to infant feeding women lack the basic knowledge that would permit them to make any rational choice. So women are subject to the moral blackmail of an ignorant medical profession which assumes that to give up breastfeeding is a trivial matter for mother and infant alike. One of the most powerful statements I have ever been privileged to hear came from a Ugandan woman. She showed a slide of a woman breastfeeding a three-year-old child, both obviously wasted. She said that some in the audience would see only pathology and assess the progress of the disease, whereas what she saw in the picture was the most powerful reason why women should not be advised to avoid breastfeeding even if HIV-positive. She obviously referred to the communication and comfort that both the mother and the child experienced in the act of breastfeeding. Any woman who has experienced the power of breastfeeding knew exactly what she meant. Only our impoverished Western world, with its denial of the value of breastfeeding, produces people who see pathology where others see love; and who lightly advise women to castrate themselves as mothers. Emotive language, and I don't apologize for it. Would gays have achieved what they have purely by "objectivity" and passive dependence on politicians and doctors? It's about time women learned that in some games if you don't challenge the rules, you'll always lose.

Maureen Minchin, Australia
For references write WIPHN

Catholic AIDS Link

From AIDS Action, AHRTAG, Dec.1989

More Questions than Answers!

Women are the world's caregivers. We care for everyone and are inclined to leave our own care for last. We are neglected medically and we are, regardless of age and race, an economically deprived group. So why should things be any different in the AIDS pandemic?

It is time for us to make OUR voices heard in protest against neglect of women with AIDS, against the labelling of women only as VECTORS of the disease rather than the recipients of the disease from others through sexual abuse and violent rape. Perhaps society should pay some attention to the devastating infections peculiar to women with HIV infection, perhaps some compassion should be shown for these long-suffering people with AIDS.

There is no doubt that it IS time that the Centers for Disease Control added the opportunistic infections that specifically attack women with HIV infection in their criteria for diagnosis of AIDS; namely; chronic pelvic inflammatory disease, chronic vaginitis, candidiasis and chronic obstructive pulmonary disease, nephritis and nephrotic syndrome.

Do the Federal and state governments regulate sperm banks as strictly as milk banks? If not, it is time they started to do so. "Sperm donors" are really sperm sellers; they are paid for their sperm. What kind of men sell their sperm? (Blood banks do not buy blood any longer because people "selling" their blood were at higher risk for all sorts of diseases!) We know that semen carries large amounts of HIV and that it definitely transmits the virus

to recipients.

The Government, meanwhile, regulates human milk banks. Human milk is donated by healthy mothers who are not paid for the milk they give. There is no scientific evidence showing human milk to transmit HIV and the anecdotal reports are on very shaky ground. Yet for some unknown reason, the human milk banks are being systematically regulated out of business.

It seems odd that the white fluid produced by males, scientifically proven to transmit HIV, is being protected as if it were sacrosanct; while the white fluid produced by females that has not been proven to transmit HIV is viewed with hysterical suspicion and condemned for no reason or at best flimsy circumstantial evidence!

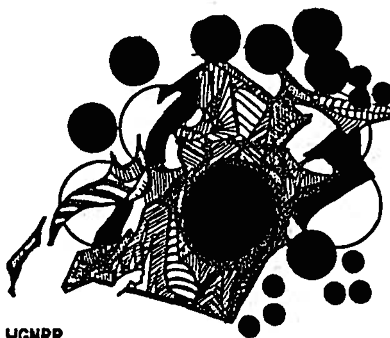
These are some of the situations that need to be changed:

- *the exclusion of women from clinical drug trials*
- *the exclusion of women from proper diagnosis of AIDS and therefore treatment and benefits*
- *the regulation of human milk banks beyond common sense, thereby denying lifesaving nutrition to needy premature and sickly infants*
- *the allowance to spermbanks to continue collecting their arsenals of potentially lethal semen.*

If the male dominated medical system does not want to give women the care they need for altruistic reasons, perhaps the motivation to give women equal attention may come out of selfishness...

If there is continued neglect of women during the AIDS pandemic, who will take care of everyone else when all the women are dead?

Charlene Stokamer, USA



WGNRR

FACTS AND FIGURES

Teenage Pregnancy in Jamaica

In a Jamaican study it was found that urban teenagers without father figures were nearly 2.7 times more likely to have been pregnant, than those who were living with adult male relatives. Father figure absence and low self-esteem may combine as risk factors for teenage pregnancy in urban Jamaica.

Arlene Keddie, Jamaica

Prostitutes in Thailand are given "green cards" for clearance in the sex industry as if HIV testing eliminates AIDS and precludes the use of condoms.

In Hong Kong as the number of legal abortions increased, the maternal mortality dropped.

A survey on the prevalence of urinary (or stress) incontinence showed 8.5% of women 15-64 years old suffer from urinary incontinence, compared to only 1.6% of men in the same age group. The main contributing factor for this higher .percentage in women is childbirth.

Mary Dolman, United Kingdom, WGNRR

Needles in Demand

At a recent Soviet American Women's Summit held in March 1990 in New York and Washington, the deplorable state of maternity care in Russia and the lack of family planning availability were underscored. Women have an average of 5 to 8 abortions. Syringes and needles are reused. On the last day of the meeting, Russian delegates requested donations of syringe needles to take home. AIDS from reused syringe needles is a real problem.

The Battered Women's Movement:
Possibilities for Cooperation

In Mexico, violence against women is not a public health priority, despite widespread reports of battering. When women in developing countries such as Mexico see that they have legitimate demands and the power to oppose domestic abuse, they may extend these lessons of legitimacy and power to other issues that affect their lives, such as employment or housing. Organizing women around this issue may develop networks among women that can be used as organizing tools to demand further social change.

Mexican border region groups, such as CECOV in Nogales, have attempted to form networks with US battered women's groups. In Mexico City, the Kollontal Collective has visited shelters in San Diego, Los Angeles and New York to evaluate the shelter model for adaptation in the capital. Mexican organizations offer US institutions a network for battered women in the US with ties to Mexico, development of Spanish educational materials, and adaptation of US technical assistance for use throughout the Latin American region.

Elizabeth Shrader Cox, Mexico

Effect of Breastfeeding on Antibody Response

The antibody levels in breastfed infants immunized with conjugate Hemophilus Influenza Type B vaccine, were significantly higher than in the formula fed group at 7 months and at 12 months. This is strong evidence that breast-feeding enhances the active immune response in the first year of life, and therefore the feeding method must be taken into account in the evaluation of vaccine studies in infants.

Lancet 1990; 336:269-70

CARE IMPROVES WHEN MORE BABIES ARE WANTED

France

France has a program of pregnancy surveillance and bears the costs of the care. Women once diagnosed as pregnant are issued with **maternity booklets** with instructions on appropriate care and coupons for free check up visits.

Women are advised to make five minimum visits at four, six, eight and nine months and a post natal visit, with costs covered by the French Social Security. Mothers are given $160 per month regardless of income if they make these visits, from the fourth month to ten weeks after delivery and an additional two weeks if there is a certified need.

In addition, to get mothers back in shape, the state pays for ten physical therapy sessions for her. The "sage femme" - a maternity nurse with four years training at medical school, makes home visits and checks on mother and child. This investment has had a direct effect on lowering IMR to 7.7/1000 - among the lowest in the world.

France is willing to pay for healthy babies, spending money early in an attempt to minimize expensive neonatal and pediatric problems later.

Abstracted from the International Herald Tribune, May 1st, 1990.

IBFAN Africa Statement on Breastfeeding and AIDS

Should women who test positive for AIDS or HIV virus be advised to breastfeed their babies? Since mother's milk is the perfect food for infants providing antibacterial and antiviral factors to protect the child against particularly gastroenteritis and acute respiratory infections, the answer is definitely yes.

The greatest likelihood of transmission of AIDS or HIV to the fetus would be transplacentally during pregnancy or during birth. Interestingly, among babies born to AIDS of HIV infected mothers who may test positive for HIV antibodies at birth, 50% or more will be found to test seronegative some months later.

Many infants born to HIV infected mothers have been breastfed without developing signs of AIDS and without showing seropositivity after the placentally transmitted antibodies have been eliminated.

"For the 25% to 50% of infants born to mothers with AIDS, and who are already infected with HIV before or at birth, withdrawal of protection afforded by breastfeeding may greatly add to their risk of various infections, which in turn will accelerate their development of AIDS."

Increased morbidity is associated with artificial feeding even in industrialized nations. Substitutes for breastmilk in less developed nations can lead to malnutrition and even mortality.

Copies available from WIPHN.

> Mothers should continue to breastfeed their babies, whether their babies have HIV infection or not.
>
> World Health Organization

*Remember to renew your membership and get others to join! We are non-profit and need your support to stay afloat and make our projects a reality. Contribute to our **Save A Mom campaign**. WIPHN, 7100 Oak Forest Lane, Bethesda, MD 20817, USA.*

WIPHN'S "SAVE A MOM" CAMPAIGN

WIPHN is currently asking for donations for this project. The first project is getting under way in Zambia. In partnership with the NGO Coordinating Committee Zambia, WIPHN plans to adopt a labor ward and monitor changes and cost incurred. We are very excited about this, because it will allow us to do similar projects in other areas, if successful. We hope to make a difference at a sustainable level.

WIPHN is also supporting the use of low cost technology for maternity. Presently kits for TBAs are costing in the vicinity of $46-$50. They are heavy to transport. The Masai have made matchbox kits for TBAs. The matchbox is the container and it has a new razor blade, sterilized cord tie, a sliver of soap and a match. This costs at most 5 cents. It is easily transportable and so $50 can reach 1,000 women.

COMMUNITY BASED AIDS PROGRAMS

Community based efforts to fight AIDS in South Africa have been given a major boost by the African National Congress and allied organizations. An AIDS task force has been set up. This was spurred on by the 4th International Conference on Health and Welfare in Southern Africa at Maputo in April. The Maputo Statement on HIV and AIDS adopted by the Conference states: "The HIV campaign waged by the state has been grossly inadequate. Communities have not been involved, nor have representative organizations been consulted. Too few funds have been allocated to HIV prevention and the care of people with AIDS. The media and education campaigns have promoted fear stigmatization." The Statement calls for government support for community organizations, involvement of credible leadership, abolition of discriminatory legislation against gays, commercial sex workers and foreign migrant workers.

Pharmaceuticals for AIDS: Scarce Supply Versus Potentially Unlimited Demand

The Problem

The rising number of AIDS cases worldwide present serious problems for health care providers and planners. Women who carry the virus are the major source of infection for infants, and the current trends in Africa and other countries portend disastrous consequences for thousands, if not millions of children and their mothers. It is estimated in the US that babies infected with AIDS cost from $18,000 to $24,000 to care for each year. With such staggering numbers, how can we best provide quality, yet affordable pharmaceuticals?

It is an emotion filled, controversial issue to even discuss the relative benefits of treatments for some of the incurable conditions that AIDS patients present. Given limited funds, most public health systems are forced to make some painful decisions and policies regarding treatments by:

1. Determining Priority Health Problems

AIDS forces us to make some hard assessments of what is expected from treatment. Providers must develop an awareness of both the short-term versus long-term benefits that are significant in terms of quality of life and quality of care. For example, pneumonia is a common infection in AIDS patients and can easily and inexpensively be treated with penicillin at a cost of less than $1.00 for a course of therapy. With pneumonia, there can be dramatic results that improve the quality of life for the patient using an inexpensive drug. The net result is a high therapeutic value, high impact for the patient, at a low cost.

On the other hand, cryptococcal meningitis, common in AIDS patients, is often treated with Amphotericin B. The cost of this treatment is about $500, it is difficult to administer, and has serious toxic side effects for the patient. The net result is questionable therapeutic value, questionable impact for the patient, and high cost for the drug. In this case, the cost on all levels might out weigh the benefits, and guidelines might suggest not to treat this condition.

An example of a public health disease is tuberculosis which is rampant among AIDS patients and highly contagious to the population at large. In this case, treatment is moderately expensive depending upon the drugs selected, but the benefits to public health could be large. On this basis, TB might be considered a priority disease and the TB related drugs also given high priority for purchase.

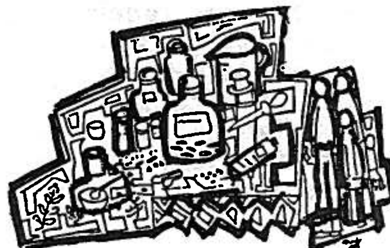
2. Establishing treatment guidelines

Standard treatments or treatment guidelines are being increasingly employed in health delivery programs worldwide. Action is being taken to develop treatment guidelines for AIDS prevention and control programs. The World Health Organization is developing draft treatment guidelines for AIDS related conditions.

In summary, the treatment of AIDS related health problems and the use of each drug must be put in context with its associated cost and benefit, some of which are short term and recurring, but providing relief and enhancing the quality of life for the patient. The ABC Cost Analysis, and the VEN System of Priority are tools that can help health planners and providers determine the consequences of their decisions both therapeutically and economically.* The next decade will force us to make difficult decisions regarding treatments and pharmaceuticals. By carefully determining protocols and policies, Health for All can still become a reality.

* Cost analysis determines how much money is being spent for each drug product and pre-set drug priority classification. VEN (Vital Essential and Non-Essential) are classifications to help make rational utilization of limited funds.

Patricia L. Foreman, Management Sciences for Health, Drug Management Program, USA. For full copy of paper or references write WIPHN



ZAMBIA

Zambia has since 1986 to date recorded over 12,000 cases of AIDS. So far over 300 patients have died. Cases of AIDS continue to rise and we also have the unknown cases. With the above statistics in mind one has to reflect the impact that AIDS has made on women.

AIDS in Zambia like in all African countries is heterosexually transmitted. It has to be borne in mind that an African man is polygamous by nature. In this respect therefore it is possible that an HIV infected man may have 3 wives and 3 or so concubines, who may fall victims to this deadly virus.

Indeed we have had instances where both husband and wife die one after the other within one year or so. In a case of a young couple the baby may also be HIV positive and so may be born to die soon after.

The other very important factor to consider is that African women are most vulnerable, as most of them lack education to enable them to get into wage employment. In this regard, it is out of desperation that they have to engage in sex for some payment. Women engaged in this practice are mostly young women from the age of 15 to 30. Some of these young women are divorcees; heads of households or unmarried mothers with dependents. It is this category of women that NGO Coordinating Committee is mostly concerned with considering that, if someone offered such a group of women with an alternative method of earning their bread and butter, they would actually be willing to change their behavior.

In Zambia, 50% of our population of 8 million people are young people below the age of 18. Indeed, the youth are sexually active and hence vulnerable to this epidemic.

It is with this in mind that, as people of one world, we should stop to think on what and how we can better tackle this problem of AIDS.

Christine Y. Ng'ambi, Chairperson, NGO/CC, Zambia

Ikajurti - The helper
Midwifery in the Canada Arctic

This excellent video depicting delivery of Inuit women was produced by the Inuit Women's Association and illustrates how people in isolated areas cope with deliveries.

In the early 1970s Inuit women, who previously delivered their infants in igloos assisted by TBAs, were forced to deliver at poorly staffed and unsafe nursing stations. To avoid this, pregnant women went to large hospitals in eg. Edmonton or Montreal, etc. They had to leave their family's support and culture for two to five months and were not only stressed and alienated, but also exposed to new infections. Teenagers "at risk" were sent even earlier. The situation was not satisfactory.

Now, at the insistence of the community, there has been a move to establish more accessible birthing centers. The first one has been established on the Hudson Bay area and it has been very well received. The midwives are Inuit and have received advice from TBAs in the region. Travel time and cost has been reduced: families can participate and birthing is more culturally acceptable.

What is more appropriate for a normal delivery: a large hospital, a small hospital, a birthing station, a home or a nursing station? Write WIPHN if you have an opinion in this regard.

Blanca Keogan

Wretched Maternity Conditions in Nepal

In Nepal there is a lack of sanitation and hygiene with no knowledge of germs or germ transmission. Defecation occurs around homes and where children play. Animal quarters/garbage area/food preparation may take place in a single room. Cow dung and wine are used as antiseptics. Children's body products are considered pure, eg. diarrhea, nasal discharge,etc. Food distribution is prioritized as follows: Husband, sons, mother-in-law, sister-in-law, daughters, daughters-in-law. Childbirth and women's uterine blood are seen as polluting. Women often must give birth out with the animals and by themselves in order to avoid polluting others and incurring the need for purification and ritual debt of helpers. It is believed that nine months of menstrual blood, retained during pregnancy, is bad blood that must come out in childbirth.

These cultural factors add up to high rates of infection generally; poorly nourished girls, and especially (pregnant) daughters-in-law; high risk of PPH and infection in childbirth.

Gender discrimination from birth is the crux of the safe motherhood issue. Education for mothers-in-law may be significant part of solution.

Female nurse-midwives work at only three of the nine health posts in the Kabhre District. There are maternal/child clinics at four health posts. Women actually come for care only if the grapevine says I will be there. What does this mean? The answer must be education, with women demanding/assuming the respect they deserve.

Maureen Minden, Nepal

Condoms and Evaluation

Migrant Malawian mine workers in South Africa received AIDS health education and condoms. When the project was evaluated they found that, yes, they used condoms, but with the tips cut off.

HIV - IUD Link?

Italian researchers reported that women who had used either condoms or oral contraceptives for birth control had a decreased risk of HIV infection, while use of an intrauterine device carried a threefold to four-fold increased risk of contracting the virus.

HIV Prevention: The need for methods Women can use

Current public health strategies for the prevention of sexual transmission of HIV focus on four issues, partners selection, partner number, mode of sexual expression and the use of condoms. These strategies though proved effective to some degree are inadequate. With condoms active male cooperation is crucial. Logic dictates that the educational message about condoms, to effective, must be targeted at the man or couple. If targeted at the woman, she in turn has to persuade her partner, and therein lies the difficulty.

The most effective methods of pregnancy prevention have depended on women. Empowerment of women is crucial for the prevention of HIV transmission to women. Prophylaxis must include procedures that rely on the women and are under their control.

Esther Kazilimani

From Action for Development. Kampala

COMPASSIONATE CARE

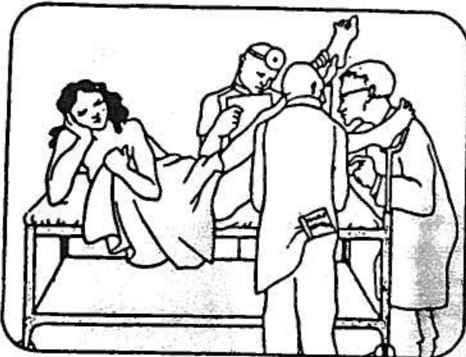
TASO is an AIDS support organization based in Kampala Uganda. It provides hope and compassion and practical support to families affected by AIDS. Many of TASO's volunteers are themselves HIV positive or have lost relatives with AIDS . These volunteers are supplied with kits which include rehydration salts to prevent diarrhea dehydration, home care kits containing soup; antiseptic cream and protective rubber gloves.

Counselling sessions and home visits are carried out by trained volunteers particularly to families who cannot read government posters and leaflets. The main aim of TASO is to support AIDS victims.

TASO volunteers have found that when time is spent with family members, explaining how the disease is caught and talking through their fears, they are better able to cope with caring for their sick relatives; a traditional practice which is being threatened by fear of AIDS.

TASO is also developing a widow project , which will enable women who have lost their husbands to become economically independent. TASO volunteers visit families daily. In addition to material support mentioned they provide eggs and milk to patients for protein and selected low cost medicines which include herbal remedies. They have a project for grandparents who support orphaned children e.g. money and schooling. The program trains health workers, religious leaders and volunteers in basic counselling skills and even provides employment to AIDS victims.

This extraordinary program was started by a woman who nursed her AIDS affected husband.



"What are you looking for, fingerprints?"

AIDS and STDs

Studies in the United States have shown that transmission of the AIDS virus during vaginal intercourse is usually quite difficult, especially from female to male. Research in Africa has shown that when a woman with the AIDS virus also has a genital ulcer, the chance of AIDS transmission to a man in a single act of intercourse may be as high as 5 to 10%. When partners do not have STDs the chance is only a fraction of 1%.

There is also evidence that suggests that the lack of male circumcision may increase the risk of transmission. This is because uncircumcised males are more likely to have infections or small breaks in the skin of the penis, and the foreskin traps virus-containing fluids. Uncircumcision, combined with the presence of genital ulcers, increases the risk of a single sexual encounter to 15% or more.

It is therefore imperative that STDs be identified and treated early for the sake of women and infants.

Esther Kazilimani

> AIDS should be considered within the context of sexually transmitted diseases and not singled out for special attention.
>
> Sheila Rothman

Post Partum Problems and Wellness

Morbidity in the postpartum period is many times higher than the maternal mortality. For each woman who dies from hemorrhage, prolonged labor or toxaemia, there are many more who survive, but with significant morbidity and very often with long term sequelae that can have a devastating effect not only on their health but also on their status in society. The morbidity statistics from the health facilities, however, are very scanty and unreliable and do not give a full picture, and few published studies are available that give a representative picture of the problems.

The methods of improving or maintaining the well-being of the women *after* the childbirth are basically not very different from those necessary to reduce *maternal mortality*, i.e.: better antenatal care and screening for high risk women, better obstetrical care and post-partum care, help to postpone or space pregnancies; but also: *improved nutrition of women, better general health care for women, better social and family support, education of the community and of the women themselves, social legislation to protect mothers, etc.*

We need to emphasize that the health and well-being of the women is critical for development. It is not enough to look upon the woman as a producer of healthy babies. In order to help her fulfil her potential role in development we need to give a stronger emphasis on continuous support and appropriate health services throughout the reproductive cycle, i.e. before, during, after and in-between pregnancies. This continued support must be there particularly for: the youngest, the poorest and those living in remote areas. It is time for us to stop looking at only the postpartum period as a good time for advice on family planning and breastfeeding, and to recognize that this is the time when we have to concentrate on *helping the woman back to the road towards health and meaningful survival.*

Karin Edström
Sri Lanka
* For complete article write WIPHN

CAN PRENATAL CARE REDUCE MORTALITY?

In WIPHN News Volume 7, Spring 1990, Mary Renfrew and Iain Chalmers asked: "Which elements of prenatal care offered to women without symptoms do you think reduce the risk of maternal death effectively? Our members took the challenge and here are some of their replies.

BANGLADESH

The question raised by Mary Renfrew and Iain Chalmers is an interesting one, and I would agree that there is no one answer to this because of the tremendous global variation in cultural practices related to pregnancy and childbirth. It is also a question which will elicit different responses from individuals in the same cultural setting. In Bangladesh, nearly all women are anaemic, 50% or more of infants are born at home (a high percentage are low birth weight) without any modern facilities and delivered by untrained dais. A high percentage of mothers are malnourished primups 18 years or less. Many areas have no referral facilities to deal with emergencies. Cultural beliefs inhibit the woman's movement outside the homestead. These are generalizations for Bangladesh as hard data exists only for certain areas of the country, as there are many births and deaths are unaccounted for.

Risk factors can present at any time during pregnancy. A child lost at delivery or soon thereafter will be replaced as soon as possible at the cost of the mother's health. The relationship and trust which can develop between the mother and the health worker during pregnancy can be very valuable. Information and support is extended to the mother, and she is made to feel that her pregnancy and her health have some value. Women's status here is very low so this is additionally important. Respect for the health worker and familiarity with the health care system, be it TBA, field worker, paramedic or doctor, encourages her to follow suggestions about diet, hygiene and child spacing. I do not feel that prenatal care should be considered as merely a physical check-up. Field-based TBA-provided prenatal care is not costly. The TBA is taught to identify the risks and refers mothers when these are apparent.

An illustration from Susan's midwifery manual

Evaluation will teach us more and answer the question with more substantial supportive evidence. I believe in the need for integrated services. Each contact the mother has with the health worker can be valuable, often for reasons not easy to measure scientifically. In the meantime, in this setting, it is not easy to determine with confidence that a mother , even asymptomatic, is not at risk. As conditions improve and change here, there will undoubtedly be a need for a different prenatal strategy.

Fiona Duby

INDIA

The question of antenatal care in developing countries is a difficult one, because of lack of outreach of the health services, poor facilities and training of health workers and the work load of women. Pregnancy is considered a normal function of the body, not needing any special attention. However, the suggestion put forward in the last newsletter, that only symptomatic women be given antenatal care has several snags. Poor women, living in adverse circumstances, often consider their state of health, tiredness, lack of energy, etc. as normal. In India about 60-70% of pregnant women, are anaemic and on questioning, have symptoms like lack of energy, tiredness, breathlessness, etc. but they do not report to any health facility. The only way to contact them is at the household level - not just for antenatal care but for various other services. I wholly agree that transplanting the hospital antenatal clinic to the rural environment is meaningless.

In India, as in many other countries, immunization programs are a top priority, but immunization alone will not improve health. In a recent paper, I have outlined some of the services we may offer along with the two doses of tetanus toxoid to the mother and five contacts with the child. Most obstetricians still advise five contacts with a pregnant woman, and that becomes government policy. However, the reality is very different. Not more than 10-20% of women get any care. Anaemia prophylaxis programme has been available for more than two decades, but because of poor implementation, it has made no impact at all, and anaemia remains one of the important causes of maternal mortality and possibly low birth weight.

Appropriate care during childbirth presupposes identification of any risk factor or otherwise. The latter can safely be delivered by a trained TBA. The use of a safe delivery kit by several NGOs (sterile blade, cord ties, cotton swabs) which is given to the pregnant woman towards the tail end of her pregnancy, has helped to greatly reduce infection and tetanus.

Many laudable programs have failed to give dividends and medical termination of pregnancy (MTP) is one of them. The programme

ensures a safe abortion to women who do not wish to continue with pregnancy, but because of poor information dissemination and some other bottlenecks, it has not made much impact and women continue to die of septic abortion.

Shanti Gosh
*references can be obtained from WIPHN

AFGHANISTAN

I am an American midwife who has been working with Afghan refugees in the Northwest Frontier Province of Pakistan for almost 2 years. Part of this time has been spent in direct care; part in the development and implementation of a short maternal-child health education course for Afghan women in their homes; and in writing and teaching MCH curriculum to Afghan male midlevel health workers.

Afghanistan has one of the highest maternal mortality rates in the world (UNICEF).Though these statistics are notoriously difficult to obtain, there is some evidence that the greatest cause of this mortality is hemorrhage. Anemia plays a large contributory role in maternal mortality and is extremely high in childbearing women.

Because of cultural and religious traditions, large families are the norm. The idea of contraception is unacceptable to the traditional, conservative Muslim religious leaders, who wield much power, especially now that large numbers of the population have died as a result of the Soviet-Afghan conflict. Children are usually born 2 years apart or less and maternal nutritional depletion by frequent childbearing is common.

More than 90% of the population live in rural villages with difficult or no access to trained health care. The cultural tradition of the seclusion of women is even stronger now that the traditional way of life has been threatened by a protracted war with the Soviets. Women are generally not allowed to see male health care providers. This is especially true if the problem is related to pregnancy or to a problem of the female reproductive tract. But women are also not encouraged or allowed to receive an education or to work outside

their homes. The inadequate health care that does exist is not available to most Afghan women who live in rural villages. The few female physicians or trained midwives in Afghanistan work in the cities.

Currently, the existence of referral centers with physician (especially female physician) coverage and surgical capacity accessible to most of the population is nonexistent. Therefore, prenatal care which aims at identifying and referring high risk pregnancies has little meaning in the present situation.

In my opinion, the element of prenatal care for women with or without symptoms that can do the most to effectively reduce the risk of maternal death in Afghanistan at this time is the prescription of iron, folic acid, and vitamins to all pregnant and lactating women. This, along with nutrition and hygiene teaching to mothers and traditional birth attendants, can be accomplished by male (basic and midlevel) health workers until it is possible to pass this responsibility to village women.

Judy M. Carlson

INDONESIA

The maternal mortality rate is very high in Indonesia (450/100,000), the frequency of prenatal care is very low , the incidence of anemia among those pregnant mothers is high (70%) and in the rural areas, 60%-80% of deliveries are still assisted by TBAs. In Indonesia maternal mortality is mainly caused by toxaemia, hemorrhage and infection. Practically all these causes of maternal mortality are preventable.

In order to reduce maternal mortality in Indonesia, prenatal care is not the main priority.

Most mothers have poor education and as a result they are unaware of important signs, for instance headache. Most mothers do not complain about headache as they do not realize headaches may be a result of anemia or hypertension.

From the three frequent causes of maternal mortality in Indonesia, only maternal mortality from toxaemia can be prevented through prenatal care. However, maternal mortality caused by infection and hemorrhage must be prevented at the time of delivery.

More than 60% of deliveries in Indonesia are assisted by TBAs because of the limited number of midwives and transportation is very difficult, because Indonesia consists of more than 13,000 islands.

A priority to save a mother is to develop and strengthen the referral and support system through:

1. Crash-programs for training selected nurses as midwives.
2. Equipping and upgrading rural hospitals and health centres in the peripheral areas for safer deliveries.
3. Upgrading the skills of staff so that they are able to handle obstetric emergencies; carry out risk screening and train and supervise TBAs.
4. Maximizing the use of TBAs as an efficient link between the community and the formal health system by training them to recognize high risk pregnancies and deliveries using a simple checklist and providing them with basic training in safe delivery procedures,

and prenatal care. They must be given simple equipment suitable for their circumstances. They must know their own limits of competence. They must have access to a reliable referral system for high risk cases and for emergency use. In Indonesia around 100,000 TBAs have been trained in 66,000 villages.

5. Establishing a chain of referral from the grassroots level as 70% of the population live in rural areas.

6. Providing access to family planning devices even at health posts to prevent maternal mortality caused by illegal abortion.

Dr. Soetjiningsih

NEPAL

I am working in the mid-mountain region of Nepal: scattered villages, difficult terrain and a largely Hindi population. Here the question is not one of extending but of offering prenatal care. The "women without symptoms" qualification is not useful. Even where medical care may be available, there is no perception of symptoms as medical indicators. Bleeding, for example, may be "bad blood that must come out".

I don't really understand how to interpret "appropriate care during childbirth" as an entity separate from the prenatal period. The stage is often set in pregnancy and recognition of high risk factors and possibility of referral to a medical centre are implicit in appropriate care. "Safe abortion" is no small problem here. Water is often in short supply, sanitation and hygiene virtually unknown at village level. Women are generally in poor health and family planning methods are unavailable. Abortion is against the law and in some groups contravenes religious dictates.

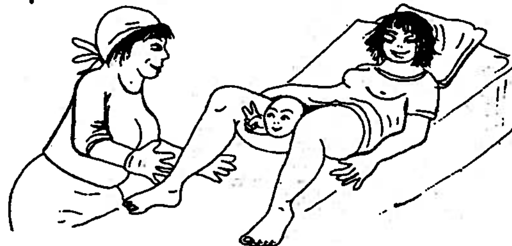
Maternal mortality cannot be extricated from perinatal and infant mortality rates. Families of ten need to assure themselves of several living children and certainly of a son. These factors affect the number of pregnancies even when family planning is available. Many sociocultural factors contribute to the poor health of girls and women.

Offering prenatal care to all women is a priority here. Firstly, it provides the opportunity to teach hygiene and sanitation, nutrition, some anatomy and physiology, recognition of problems, etc. Also, tetanus immunization may be given, high risk mothers and pregnancies can be detected through clinical exam, preventive or corrective measures taken, eg. for anaemia, referral to a medical centre arranged if indicated (one or two days, by foot only).

My answer is a gross over simplification which is based on work in our district's nine health posts, and teaching about 150 village women.It appears to be corroborated by a number of other studies. I would expect prenatal care to significantly reduce maternal deaths.

Maureen Minden

* For references write WIPHN



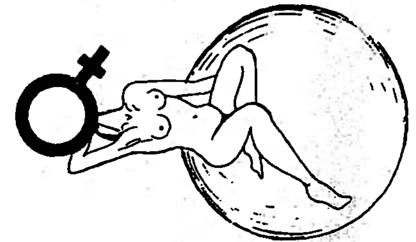
USA

I enjoyed reading the spring issue of the WIPHN News. In response to your question about the comments on prenatal care, I agree in part with what you say. Clearly, ensuring that access to safe abortion procedures should be a priority where abortion is legal as is working to change the law when it is illegal. Similarly all women should have access to emergency obstetrical care for obstructed labor, postpartum hemorrhage, ruptured ectopic, etc.

What is absolutely clear is that promoting more prenatal care where no referral systems are established and where little or nothing can be done when someone is identified as high risk makes little sense and is an inappropriate allocation of resources. Where such referral is possible then prenatal care does make sense both for those with symptoms and those without. Since many obstetrical complications occur among women who have no symptoms until the complication occurs, one would prefer to offer prenatal care to all women.

In setting priorities, I would attempt to ensure that first level referral systems are in place to manage obstetrical complications, including incomplete abortions (before sepsis has set in), and, ideally, provide safe abortion procedures wherever possible.

Allan Rosenfield, Columbia School of Public Health



LET'S CHANGE THIS

Episiotomy?

Routine episiotomy has not been proven scientifically to be of merit nor are there real indications for it.
Maternal Mortality and Morbidity, A Call to Women for Action, Special Issue, 25th May 1990.

Male Promiscuity

Married women in Africa are concerned that they are helplessly exposed to AIDS in those communities where their husbands pursue outside sexual relationships and will not use condoms at home. The fear of AIDS is of chronic concern to many faithful wives who are powerless to protect themselves. Let's stop concentrating on prostitutes, but on dealing with perverts and permissiveness.

Priorities?

AIDS illustrates the continued discrimination against women and underscores the need to recognize that women have rights. Women often are the victims, but are blamed as vectors, and affected individuals are discriminated against, especially in the work place. Problems include confidentiality, deep seated prejudice, revenge mentality (affected males who deliberately infect as many others as possible). AIDs patients lack practical assistance, legal and psychological counsel, social support, essential drugs as well as research in key practical areas. What is needed is an emphasis on educational materials to effect change in sexual behavior and life style.

Naomi Baumslag

Credit: Sojourner Sisters Inc., USVI

AIDS IN UGANDA

Uganda could be considered a microcosm of the African AIDS situation. Of a population of 17 million people in Uganda, it is estimated that 1 million adults in Uganda are HIV-seropositive; about 8000 AIDS cases have been reported. Serologic surveys in 1896 identified two high risk groups with high seropositivity rates: barmaids (67%) and truck drivers (32%). Another survey in 1989 found a greater than 20% rate among pregnant women and blood donors in Kampala, the capital of Uganda.

Opportunistic infections accompanying AIDS reflect environmental exposure. Thus Uganda patients with AIDS reflect the prevalence of specific pathogens in the local environment. They include tuberculosis, cytosporidia (producing chronic diarrhea and wasting, known as "slim disease"), salmonella, shigella, giardia, amoeba syphilis cytomegalovirus, toxoplasmosis, and hepatitis B. Several of these infections, like TB, are latent before and during HIV infection. P. carinii pneumonia is rare. HIV infection may confer a risk for the development of severe cerebral malaria.

Hospitals in Uganda have reported AIDS as one of the most common causes for admission among adults. There continues to be a profound shortage of drugs, equipment, laboratory facilities, and properly paid health care personnel. Care differs considerably from CDC recommended protocols. Experience has shown that with use of nine relatively inexpensive drugs, plus anti-tuberculosis chemotherapy, a high degree of palliation can be achieved for many patients with AIDS.

There is a strong feeling on the part of most patients and many health care workers that informing the patient of his or her diagnosis is not an appropriate part of the care provider-patient encounter. Honesty and openness is difficult to achieve in this context. The consequences of silence and deception make counseling about infections and their prevention difficult as the country braces for an anticipated 10,000 new cases of AIDS per month during the 1990.

Sandy Mackintosh
USA
Abstracted from the New England Journal of Medicine, 323:383-89, August 9, 1990.

Organizations that have joined WIPHN

Guatemala Health Rights Support Project, funds self help health and development projects in Guatemala and Mexico. The Project has a two fold mission: to educate people in the U.S. about the critical health needs of the Guatemalan people, and to provide direct material aid and financial assistance to projects in primary health care and those encouraging self reliance in nutrition, traditional medicine, midwifery and training of community based health workers. For more info write to: 1747 Connecticut Avenue, NW, Washington, DC 20009, USA;

La Clinica de la Raza, 1515 Fruit Vale Avenue, Oakland, CA 94601, USA;

Ahead,P.O. Box 2049, Rockville, MD 20852;

Worldwatch Institute, 1776 Massachusetts Avenue, NW, Washington, DC 20036, USA;

Pan American Health Organization, Documentation Center, 525 23rd Street, NW, Washington, DC 20036, USA;

The World Bank, Population and Human Resources Department, Population Health and Nutrition Division, Room S-6141, 1818 H Street, NW, Washington, DC 20433, USA. The World Bank supports women's health, particularly through it's Women's Health Initiative. It has sponsored conferences around the world, supported research in women's health problems and designed appropriate delivery strategies. Their lending program now supports over thirty projects in 1990.

TRAINING AND RESEARCH

Teaching AIDS at Low Cost have produced three sets of excellent slides on HIV infection-clinical manifestations; virology and transmission, prevention and counselling. These slides are for doctors and health workers and can be obtained from TALC, P.O. Box 49, St. Albans, Herts AL1 4AX, U.K.

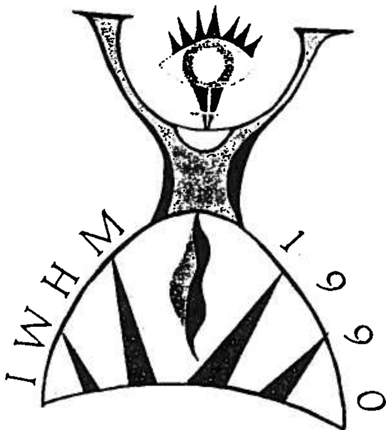
The Takemi Program in International Health offers research and advanced training fellowships. Applications and proposals must be received by January 15, 1991. Write to: Dr. Michael M. Reich, MD, Director, Takemi Program in International Health, Harvard School of Public Health, 665 Huntington Avenue, Building 1, Boston, MA 02115. Phone: 617-432-0686.

MEETINGS

World Conference on Health Education, 16-21 June 1991, Helsinki, Finland. Conference Secretariat, The Finnish Council for Health Education, Karjalakantu 2/C 63 SF 00520, Helsinki, Finland.

XIII World Congress of Gynecology and Obstetrics, Singapore, 15-20 September, 1991. For more information: Dr. P.C. Wong, Secretary General, c/o Department of Obstetrics and Gynecology, National University Hospital, Lower Kent Ridge Road, Singapore 0511, Republic of Singapore.

World AIDS Day 1990, December 1st 1990. For more information write to: World AIDS Day, World Health Organization, 1211 Geneva 27, Switzerland.



Sixth International Women and Health Meeting, November 3-9 1990, Manila, Philippines. Write: Sixth IWHM Secretariat 1990, P.O. Box 35, U.P. Dilliman, Quezon City 1101, Philippines.

PUBLICATIONS BY WIPHN MEMBERS

Guidelines for Breastfeeding in Family Planning and Child Survival Programs, Georgetown University, Washington, DC, USA, January 1990.

Breastfeeding, Protecting a Natural Resource, Institute for International Studies in Natural Family Planning, Georgetown University and Impact, 3800 Reservoir Road, NW, Washington, D.C. 20007, USA, July 1990.

Maternal Mortality and Morbidity, A Call to Women for Action, Special Issue, International Day for Action for Women's Health, Isis, Casilla 2067, Correo Central, Santiago, Chile, 28 May 1990.

AIDS Action, Issue 9, AHRTAG, 1 London Bridge Street, London SE1 9SG, U.K. Excellent review of Women, HIV and AIDS. It also has useful educational materials and the WHO Global programmes report on AIDS, December 1989.

Breastfeeding Endorsed: IBFAN Africa Statement on AIDS, IBFAN Africa, P.O. Box 34308, Nairobi, Kenya, December 1989.

Maternal Mortality and Morbidity, Society for Women and AIDS in Africa, (SWAA) UTH, Dept. of Pathology and Microbiology, P.O. Box 50110, Lusaka, Zambia, 28th May 1990.

Matterson, N., Is He Biting Again? A humoristic look at the art of breastfeeding, Marion Books, P.O. Box 415, Woodend 3443, Victoria, Australia, 1984.

Renfrew, M., Fisher, C. and Arms, S., Bestfeeding: Getting Breastfeeding Right for You, Celestial Arts, P.O. Box 7327, Berkeley, CA 94707, USA, 1990.

Muecke, M., Cambodia Trip Report, 22-29 December, 1989. Dept. of Community Health Care Systems, School of Nursing SM-24, University of Washington, Seattle, WA 98195, USA, 1990.

Baumslag, N. and Michels, D.L., Women and Work from Milk, Money and Madness: The Breastfeeding Battle, working paper. Distributed by WIPHN, 1990.

Bani, L. and Baumslag, N., Breastfeeding and Women's Employment, A Critique of Methodology and Policy Application, July 1990.

Gosh, S., A Feasible Strategy for a public health care package. Indian Pediatrics, p. 327, Vol. 27, 1990.

TRADITIONAL HEALERS are being involved in AIDS education and spiritual support in Zimbabwe. Women and AIDS, Women's AIDS Support Network, P.O. Box 3378, Harare, Zimbabwe, 23-24 Nov. 1989.

Dr Wendy Holmes

Traditional healer

From AIDS Action, AHRTAG, Dec.1989

AIDS RESOURCES

AIDS Education - A Beginning, Population Reports, The Johns Hopkins University, 527 St. Paul Place, Baltimore, MD 21202, USA, September 1989.

Network, Volume 11, No. 2, Family Health International, P.O. Box 13950, Research Triangle Park, North Carolina, 27709, USA, April 1990.

Preventing a Crisis, AIDS and Family Planning Work, International Planned Parenthood Federation, Planning and programming document for senior Family Planning Association staff, February 1989.

Asilweni Lawo Sisonke, AIDS: Let us Fight it Together, Women's Action Group, P.O. Box 135, Harare, Zimbabwe, Nov. 1988.

World AIDS, No. 10, PANOS Institute publication, excellent. 9 White Lion Street, London N1 9PD, UK, July 1990.

Talking AIDS, a guide for community workers promoting sexual health and who need to confront STDs and AIDS in their daily work. Excellent practical advice. International Planned Parenthood, 1988.

Family Health International Network, Vol. II, No. 2, HIV and Breastfeeding risks and realities by William R. Finger.

FHIN, Population Reports AIDS Education, A Beginning, Series L, No. 8, "Against AIDS, education is the only vaccine." Sept. 1989.

Population Information Program, Center for Communication Programs, The Johns Hopkins University, 527 St. Paul Place, Baltimore, MD 21202, USA. AIDS Action, Dec. 1989.

The WHO Global Programme on AIDS. Major predictive indicators are initially behavior change, self efficency, perceived risk, self esteem and attitudes towards condom use. Consistent behavioral change was related to supportive environment, such as peer acceptance of sexuality and peer support networks. The report also contains information of Women and AIDS current knowledge.

A. Perkel and A. Strebel, AIDS Report in Psychology Resource Centre Bulletin, April-June 1990, Vol. 1, University of Western Cape, Republic of South Africa.

Recommended by one of our members: Owen, B., Roger's Recovery from AIDS, DAVAR, P.O. Box 1100, Cannon Beach, OR 97110, USA.

The National AIDS Information Clearinghouse, centralized resource for information on HIV/AIDS programs, services and materials.
1-800-458-5231, Fax 1-301-738-6616.

> "While American medicine is regarded as the most technologically sophisticated is the world, it cannot guarantee adequate care for pregnant women or their babies."
>
> Robin Herman, International Herald Tribune, May 1st, 1990.

Integrating Resources

Belize is a country with limited resources and bureaucratic inertia. The Red Cross assumed a dynamic crucial role and integrated AIDS into their Child Survival Program with the use of a highly motivated training team. Volunteers, TBAs and Red Cross youth were trained to survey community attitudes and promote messages at the household level. The success of the program was due to non-didactic training and committed volunteers.

The Women's International Public Health Network

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

Who is it for?

Any woman working in public health or related field.

What are the objectives?

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

What do we do?

o 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.
o Promote women in international public health and identify women's issues such as: safe motherhood and health rights.
o Network with other women's organizations. Publish a newsletter that addresses international women's health issues, programs and opportunities.
o Participate in policy development related to women's health and publish position papers on specific issues.
o Serve as an exchange forum.
o Maintain a speakers bureau and sponsor programs, panels and meetings at conferences.
o Provide technical assistance.
o Offer information on existing training, resources and materials for identified needs.
o Act as a resource for funding information and opportunities for members.
o Research neglected women's health areas.
o Provide employment information through a job bank.

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