Women's World

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women and health

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IN THIS ISSUE

Editorial

Greetings from the new Isis - WICCE office in Kampala, from where we proudly present to you your first issue of Women's World for 1994.

Some of you have asked for information on various topics from the Documentation Centre. We regret to inform you that the Documentation Centre is not yet operational. We will inform you as soon as it opens. We are therefore unable to give you in this issue, a complete list of recent publications that we have received.

As you might be aware, the theme for this year's Exchange Programme is ***Women's Health:- an integrated approach.*** The extension *"an integrated approach"* is to emphasize that it is impossible to look at women's health in isolation. We also have to take into consideration those factors that affect the health of women, including the attitude of women towards their own health.

The articles in this issue of Women's World, are centred on the Exchange Programme theme: hence the reason why we did not concentrate on a particular health issue. The topics are diverse and try to make us all aware of how each health issue is in its own way related to the lives of women. In most societies, women have been brought up viewing themselves as child bearers. Women devote a great bulk of their time to raising children, doing household chores, and mothering the whole family. Many times we have neglected our health because of an ailing child, husband/ partner, cousin, grandparent etc. This we do because we have been brought up believing that marginalising our needs is the right thing to do. Most aches and pains that women suffer are hardly ever clinically treated. Either women diagnose themselves or they learn to live with the pain and discomfort. Is this the way we would like to continue handling our health?

Improvement of the health status of women can only be initiated by women. It is up to us to exterminate the assumption that women are nothing more than just care givers, (this is the main reason why there is only a handful of male nurses in any hospital). We are expected to be an inexhaustible source of energy, at the disposal of everybody to draw from.

The Exchange Programme endeavours to look at how social, economic and cultural factors are determinant elements on the health of women. By making ourselves aware of the above mentioned factors, we will initiate the creation and definition of health facilities that are specifically tailored for women.

We hope that the articles in this issue will lead to a discussion in your environment, on how to relate the health of women not only to current research activities on Women's Health, but also women's daily activities. We hope that from the point of view of women, you will be able to say what we as women would like to see done, in order to ensure that our health is taken seriously globally and not as an afterthought.

In the next issue of *Women's World* , we shall be looking at such topics as Women and Mental Health, Occupational Health, Women and Disabilities. Your comments and articles on these topics will be greatly appreciated.

Health: A Right

Women are a common feature at most health centers (photo: populi)

"HEALTH for all by the year 2000" is a slogan that has ingrained itself in our heads. However, the term *"all"* has certainly not encompassed the needs of women. Its meaning has been subtly left to mean good health for men and children, and good reproductive health for women.

The Mother and Child Health programme, Primary Health Care programme and The Safe Motherhood Initiative are a few motivating activities that are heavily funded by international donors, in an effect to curb infant and maternal mortality rates in Developing countries. These organisations are also expected to provide information on reproductive health issues, increase awareness of and demand for family planning among women and men as well as to promote women's reproductive rights.

High on the agenda of these organisations is pregnancy monitoring. This is done by community members including Traditional Birth Attendants. The monitoring includes ensuring that women attend antenatal clinics. Very few women in remote rural areas have been known to attend antenatal clinics. This has resulted in high maternal mortalities. In such cases, the infants have been forced to live in orphanages, even in situations where the extended family could have assisted.

A lot of health education material, especially in family planning and child nutrition has been produced. This has been done with the assistance of grassroots women who are the target group for these organisations.

In countries such as Uganda, Ghana and Nigeria, the activities of the above mentioned organisations have created great awareness in terms of family planning. The number of

For Every Woman

contraceptive use in 13 districts in Uganda has increased from 5% in 1988 to 10% in 1993 among women in the reproductive age group.

Thus women have been targets for these programmes while they are still reproductive. The health of the mother in such cases is important in so far as it is linked to child bearing and child health. This has left the health needs for a woman virtually insignificant in the health system. More so for women who can not bear children and those who have passed the reproductive age.

Health in its holistic sense has remained an alien concept. If anything, most women have grown used to neglecting their health needs, in order for them to play the *"mothering"* role.

There is therefore a need to reconceptualise the meaning of health among women. The belief that motherhood is the only way through which to express and experience the joys of being a woman has to be redefined. There is more to the life of a woman than just being a mother.

The concept of health has to be centred on our needs as women. The Health Information Programme, of Women's Action Group, Zimbabwe, (WAG) was initiated to ensure that rural women in Zimbabwe are conscious of their health needs.

This programme, is the only one of its nature in Southern Africa. A health information needs assessment in all districts of Zimbabwe, was carried out over a period of two years. The information was collected through workshops and meetings .

The needs of the participants are certainly well defined. What

was also significant was the variety of issues of concern to women from different areas. These varied from general aches and pains, menstruation and reproduction, to menopause, cervical cancer, and breast cancer among others.

According to Women's Action Group, the women, who are semi-literate, were eager to have their health defined in its own context. WAG said most women, some of them in their 40s, had never had their reproductive system explained to them. Some were not even sure of how conception occurs.

To date, WAG has produced booklets based on the information collected. Of great importance was the role played by the women in identifying their needs, which were not connected in any way to mothering.

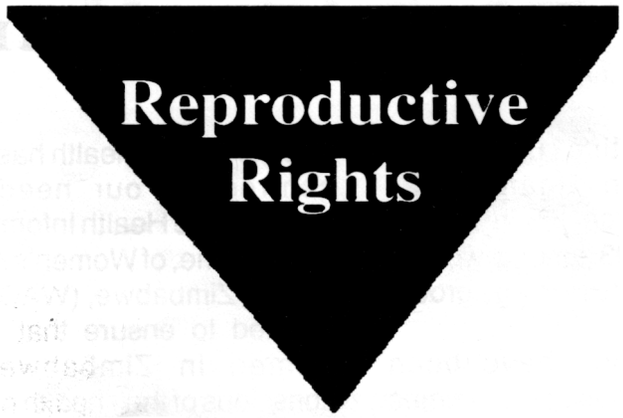
The women have expressed great satisfaction with the booklets, which explain that women are not simply health agents. But rather, they are individuals with needs that also need to be addressed. Some adult literacy groups have taken advantage of this phenomenon and are using the booklets in order for the women to be confident when they visit health care centres. The booklets

entitled ***Our Bodies Ourselves*** are in simple English. They have also been translated into vernacular languages.

Women's groups in Asia are taking women's health education as a priority. In the Philippines, ***Woman Health*** has been campaigning for the adoption of national policies that support women's health needs. Health workshops and seminars have been held with women from different parts of the country, including students and bar workers.

A ***Woman Health Clinic*** has also been set up in Quezon City. The clinic which was set up to celebrate International Women's Day in 1988, started as a pilot project. The major aim of the clinic is to ensure that women have greater management and responsibility over their own health. Also situated at the clinic is a documentation centre which has a variety of information on women and health.

The organisations mentioned above serve to explain the possiblity of divorcing motherhood from womanhood. Culturally and traditionally, the child bearing role is extremely important. However, it should not be allowed to continue to over shadow the need for women to have a right to full information and facilities that specifically address their own health.



There are many women who would like to have total control over their own sexuality. However, a lot of social issues bar us from having this control. It is not only the usual story of tradition and culture, but also a lack of economic power amongst women. The following is a story extracted from *BALANCE*, by Fiji Women's Rights Movement. It vividly explains one of the many reasons why women involuntarily become baby making machines:

"I have six children and about to have my seventh one. I do not know how to explain to my husband that I do not wish to have any more. I realize that I am getting older and I am not able to move around as quickly as I used to. I remember the day I asked him if we could stop having children because it seemed that as soon as I had had one, another would be on its way.

"I tried to explain to him that I was the one that was doing all the housework and looking after the children, and whenever I got sick I still had to do the work. He didn't want to listen and told me to stop nagging. He added that as he was my husband and the breadwinner of the family and that a man was a real man by exercising his virility. He went on to say that there were plenty of women out there who were willing to have many, many children and look after the house. He warned me to watch what I was saying or he might just be tempted to look for another woman.

"I thought to myself that this was a stupid way of thinking because we women were the ones who ended up doing the child rearing. But I would never bring that subject up again for fear that he might leave me and find another woman, then where would I go with all my children; who would want to look after us and feed us?

"Whenever I visited my mother and father, I would tell them that I was unhappy and they would tell me to go back and be the good

wife, and anyway I should be proud that in my old age I will have plenty of grown up children to look after me.

"I was sad, hurt and angry. I didn't know what to do. I thought that I had a right to say what or how many children I wanted. But it didn't work that way. My mind would go racing as soon as I heard him climb into bed or as soon as I got into bed all tired he would start trying to have sex with me

"I realise now that no matter what I will always have to live by my husband, because I fear for my life and my children's. I look forward to the day when my children will all be working so that I can break away from this `keeper'. My children and I are very close and I enjoy spending time with them. But I don't know how long I can go on producing children for I feel like a baby machine where you press a button and a baby pops out.

"I wish I had a job. I wish I could just leave to avoid insults and attitudes about having children. I'm sure that one day when I wake up, this would have been just a nightmare".

The Situation In The South Pacific

The conditions of women's reproductive health vary considerably among Pacific island countries, and also within countries, such as between urban and remote rural districts and between cultural or religious groups. Overall, the worst conditions are in Melanesian countries, followed by high fertility regimes in parts of Micronesia and Polynesia. While there can be benefits to women who bear many children - particularly where they provide lifetime assurance of support - overall, high fertility regimes are associated with economic, social and health disadvantages for women.

Fertility rates in parts of Melanesia and Micronesia - particularly the Marshall Islands - are among the highest in the world, and in Melanesia are probably even higher than reported. In the Marshals, 40 per cent of recorded birth intervals in 1989 were less than 24 months.

National population growth in Polynesia is declining through emigration but fertility rates remain quite high. High fertility is associated with short birth intervals and attendant risks to both mother and child. Total fertility rates (TFRs) of four and less are recorded in only five of the 24 countries in the region (Fiji, Tuvalu, Cook Islands, Guam and Palau). We know that child-rearing occupies a significant portion of most Pacific women's lives, limiting their participation in other spheres of society.

Maternal morbidity and mortality

The chances of illness or death of a Melanesian mother during pregnancy and child-birth are high. Official (ie. under reported) rates for Vanuatu and the Solomons are 3/1000 and 3.5/1000 respectively, and the reported rate for PNG, a woman has a 1 in 26 chance of dying from pregnancy, and this chance rises to 1 in 15 for women who live in rural areas without access to health services. Maternal mortality is low in Western Samoa and Fiji (both 0.4/1000), Tonga and Cook Islands and medium level in all other Pacific island countries. UNFPA estimates that for every death, 10-15 other women suffer permanent damage or illness. Leading causes of maternal death and illness are haemorrhage, obstructed labour, with uterine rupture and septicaemia, and abortions which have been badly conducted often because they are illegal. Other than inadequate access to health care, contributing causes are poor nutrition, anaemia, heavy physical work burdens, frequent pregnancies and locally endemic diseases, such as malaria. Together, these contribute to a "maternal depletion syndrome", particularly prevalent among Melanesian women. High levels of anaemia among pregnant women are common elsewhere in the Pacific because of inadequate diets or worm infestation.

Access to contraception and an informed choice of method

While most governments promote the supply of contraceptives, there are many barriers against access, including distance and unreliability of supply. Other barriers include opposition to contraceptive use that is mooted in the name of religion or tradition, legal controls on the distribution of contraceptives or the professional status of service providers, and less formal policies which make contraceptives unavailable to unmarried people or to women without their husband's consent.

Restricted contraceptive supply for unmarried women

is particularly worrying in light of teenage pregnancy rates which are rising throughout the region and the health, economic and social consequences for these young mothers.

While health service providers may say they provide a range of contraceptive choices to women, in practice only a few methods are promoted - now mostly hormonal pills, Depo-Provera, sterilisation or IUDs

because of their ease of application by medical authorities and because long-acting contraceptives provide family planning programmes with quantitatively better results. Sterilisation aside, these methods often produce serious complications but diagnostic services for side-effects are virtually non-existent. Despite knowledge elsewhere about its dangers, Depo-Provera is being strongly promoted in the South Pacific as a safe contraceptive and women have very little access to any information to the contrary. It is, for example, the most commonly used method by rural women in the Solomon Islands, aside from sterilisation.

Opportunities to choose status other than motherhood

These opportunities are very unevenly distributed within the region, but are defined less by access to contraception than by access to education and to economic resources beyond the household. When fertility rates fall, this is not necessarily because small family size becomes a universal norm. As opportunities for women become more diverse so too does their fertility behaviour, lowering average rates. That there remain significant restrictions in women's access to education, training and employment throughout the region has been well documented. As population growth outstrips economic growth in many Pacific island countries, opportunities for women to move out of the subsistence economy where they generally have more children, may become even more scarce. In Kiribati, for example, the formal job market can not absorb the annual number of school leavers, let alone promise employment for workers who will be retrenched as the Nauru phosphate mines close. Many Kiribati men work abroad as sailors and fishermen, and the Kiribati Government is building upon these opportunities by providing training in these fields - both almost exclusively male occupations. There are very few training and employment opportunities for Kiribati women, and little choice beyond remaining in the village. Kiribati may well become the stereotypical remittance society dependent on male worker migration, with women required to sustain the subsistence sector and care for the very young and old.

OVERSEAS VIEWS *Taken from Reproductive Health Matters, No. 1, May 1993; Pp.8-12;*

The effect on women

Women are always caught in the middle. Praised for and encouraged to have children on one hand, but condemned as perpetrators of population growth on the other. Asked to reduce their number of pregnancies on one hand, but denied access to contraception on the other. Encouraged to say no to sex and early marriage on one hand, but denied the

alternatives that education, paid employment and financial independence would bring on the other hand.

Women in Mexico are encouraged to use contraception and be sterilised on one hand, but refused safe abortion on the other, a common reality in many countries.
Women in India are pressured to be sterilised on one hand, but denied reversible contraception on the other.

Towards consensus

Both men and women need to be more informed in order to take increased responsibility for the individual child-bearing decisions that they will continue, in any case, to make. However, people without resources do not have choices, and people without rights cannot be asked to take responsibility. This includes women above all.

It is often men, families and society who decide how many children women have, not women themselves, while it is women who take the responsibility.

Social and male responsibility for the use of birth control and for unwanted pregnancies also needs to become a major focus of policy and action.

How slow to act are the legislators and the employers to make laws and policies that support women's rights as well as responsibilities?

Along with the empowerment of women, governments, global institutions and men must take a greater share of responsibility for all the children coming into the world. Plans for the future need to take account of caring for future numbers, not just write them off.

The Realities Of Abortion

An article published by WGNRR Newsletter, 42:23 states that World Health Organisation (WHO) estimates that up to 500,000 women die every year from pregnancy related causes worldwide.

It is estimated that as many as one quarter to one third of these deaths may be as a consequence of unsafe abortion procedures. However, it is very difficult to establish proper statistics on the number of women who die, or are forced to put their health at risk from illegal and unsafe abortions. Usually it is only the small minority of those who are hospitalized that are ever reported.

From surveys carried out in Tanzania, Nigeria and Kenya, the number of cases that are admitted to hospitals with complications arising from unsafe, illegal abortions are enormous. There are many more women who do not go to hospital for fear of recriminations. These women suffer in silence, and will often die unreported.

A report by Reproductive Health Matters says, "abortion has increasingly become an interesting issue for many women in developing countries". It is expected that the number of abortions in these countries will rise with urbanisation, modernisation, and early engagement in sexual activities.

Despite all these realities and the definite evidence of increases in illegal abortions in many countries, the issue is not yet acknowledged as a health and social problem.

Surveys carried out, in Indonesia and Colombia, show that abortions are seemingly safe but still illegal. A study carried out at a clinic in Bogota, Colombia, shows that women still face the personal trauma and fear associated with the illegality of abortion. In Indonesia, the law on abortion has become so vague and non-committal that not even professional doctors know where they stand, let alone the pregnant women who will often have little or no access to such information.

It is now a well known fact that keeping abortion illegal does nothing to stop women from having abortions. It merely forces them to travel abroad (for those who can afford it), or have back-street abortions. Back-street abortions, which are in most cases done by quack doctors are likely to be extremely dangerous. Cases of uterus perforation, pelvic abscesses and death are just some of the complications arising from illegal abortions.

After so many years of frustration trying to legalise abortion, there is now a new compromise being developed in some countries. This is the compromise of safe, but still illegal abortion. In some countries there are clinics which offer pre- and post-abortion counselling. Governments are fully aware of the existence of these clinics, and the important role they are playing in curbing post-abortion complications. The few women who have access to such clinics still have to summon a lot of courage before they visit them. However, as mentioned above, this attitude has severe limitations. As Francis Kissling argues;

"Abortion is much more than a medical procedure. Women's well-being is more than the absence of mortality and morbidity. It includes social, psychological and - so long as abortion is illegal - political dimensions."

The risks that women are still forced to run when going for an illegal abortion, and the fear that results from this, are just one aspect. When abortion is still illegal there are other dimensions to women's suffering that arise from the guilt and conflict that are dictated by the "rules" of society and many religions and cultures. This is well documented in the history of campaigning for abortion in Ireland, a strictly Catholic society. Women from Ireland have to travel to Britain for an abortion. The

From CAFRA NEWS

journey is secret, and in most cases, there is no post-abortion counselling and follow up. However, there are still a lot of women in Ireland who can not afford to travel to Britain for a safe abortion.

The psychological conflict that women have to go through before obtaining an abortion, or choosing to carry the pregnancy through to term, can be as harmful to women's overall well being as the actual abortion itself.

According to a study carried out in Australia, it is not the abortion itself that causes the trauma, it is the process that women have to go through in order to get an abortion that is the problem. Where abortion is not only legal, but also easily accessible, along with free and accessible information on contraception, the trauma associated with abortion is markedly less.

It is also interesting to note that when the conditions of safe, legal and accessible abortion are met, alongside full information on contraception, the number of abortions declines. However just having contraception available is not enough. Full information on the choice of contraceptive methods and how to use them properly is also a necessary factor. A survey carried out in Tanzania in 1992 showed that contraceptive knowledge was low. Government policy as well as social attitudes towards use of contraception by single women, made access very difficult. Contraceptives were only available to very few single women through their married friends. Though sexually active but with no access to contraception, women in Tanzania are not expected to become pregnant.

Safe, legal and accessible abortion is needed alongside information about, and access to, contraception. These conditions would go a long way to enabling women to have control over their own bodies and reproductive capabilities.

May 28th is the Seventh International Day of Action for Women's Health. The theme this year is "all women should have access to safe and legal abortion". All over the world women will be taking action to bring this issue to the forefront of debates on women's health. Concrete and reasonable decisions have to be made now by society in order to bring to an end the unnecessary and tragic suffering of all those women who still have to die - because they have no other choice.

Poster by Latin American and Caribbean Women's Health Network, Women's Global Network for Reproductive Rights and Catholics for Free Choice.

Photo: Vaccination against pregnancy; Miracle or Menace

"Vaccine" Against Pregnancy; for Whose Benefit?

MARIE-ANN Quill is 18. She has reached that time in her life when she has to choose a *"safe"* contraceptive for herself. Her choice ranges from oral contraceptives to injectable ones. Lately she has heard about a new contraceptive, an antifertility *"vaccine."* The "*vaccine*" according to some researchers, is the "best" contraceptive devised so far.

For the past two decades, a number of researchers on contraceptives have been developing this "*vaccine*". Immunological contraceptives, also known as *antifertility vaccines,* are being developed primarily for women in Developing countries (Latin America, Caribbean, Africa, Asia and the Pacific).

The aim of developing *antifertility vaccines,* is to induce temporary infertility. The *"vaccine"* will treat signs of conception as a disease. Thus the immune system is forced to turn against body components which are essential for human reproduction. A variety of immunological contraceptives - mainly for women - are now being tested in clinical trials.

A threat to women's health

Speaking to participants at the 7th International Women and Health Meeting, in Kampala, Uganda, Nicolien Wieringa, of Health Action International, said this *"vaccine"* will be harmful to the health of most women. She said, "The *vaccine* is more of a threat than it is a help to the health of women."

The *"vaccine"* is meant to neutralize the human pregnancy hormone hCG (human chorionic gonadotrophin). This is a hormone produced in a woman's body by a fertilized egg shortly after conception. This hormone is altered, then coupled to a bacterial or viral carrier such as diphtheria or tetanus toxoid. This is done so that the immune system mistakes the natural pregnancy hormone for an infectious germ and reacts against it. The body does not get a signal to prepare for pregnancy. In turn the fertilized egg is expelled.

Other immunological contraceptives are developed to interfere with the production of sperm, the maturation of egg cells, the fertilization process, or the implantation and development of the early embryo.

Mass administration

In 1993, Judith Ritcher, wrote a

book on the implications of using the *"vaccine"* for contraceptive purposes. In the book, ***'Vaccine Against Pregnancy: Miracle or Menace',*** Judith said, *"Immunological contraceptives will not give women greater control over their fertility, but rather less. Immunological contraceptives have a higher abuse potential than any existing method. They will stay in the body for periods varying from one year to a life time. They cannot be "*switched off*" and they are easy to administer on a mass scale because they will be injectable or used as a single pill."*

Research has proved that there is wide-spread acceptance of anti-disease vaccines in Developing countries. She said this could lead to easy introduction and acceptance of antifertility *"vaccines."* This is causing a lot of concern to many health workers in Developing countries. The fear that most people have is the danger of mass administration of the *"vaccine"*. There is also the possibility that the "*vaccine*" will be administered without the knowledge and consent of the people involved.

There is also the danger that recipients of the *"vaccine"* will react adversely as already happened in India. Judith said, "In India, anti-hCG formula, did not work for 20% of the women. The effect of the "*vaccine*" lasted from six months to over two years in other women." The *'vaccine'* has the potential to cause life-long sterility.

Clinical trials

Research on antifertility *"vaccines"* began 20 years ago

Clinical trials have taken place in India, Brazil, Sweden, Finland, Dominican Republic, Chile and Australia Trials are currently taking place in India and are planned for Sweden also.

According to Nicolien, the trials that are taking place now are unethical. Judith and other health workers in Developing countries, have expressed great concern about these trials. In her book, Judith also says, *"The women are asked to sign a consent form in English, although only a few of the women can understand and read English."* This has been a trend with most drugs trials in Developing countries.

There is need to translate consent forms into local languages to ensure understanding among the women who get the *"vaccine"*.

Other contraceptives believed to be unsafe and yet being administered on women in Developing countries are Depo Provera and Norplant. Both contraceptives are known to have side effects, including cancer of the cervix and a high risk of sterility for Depo-provera.

Norplant

Women And AIDS:- Female Controlled Barrier Methods

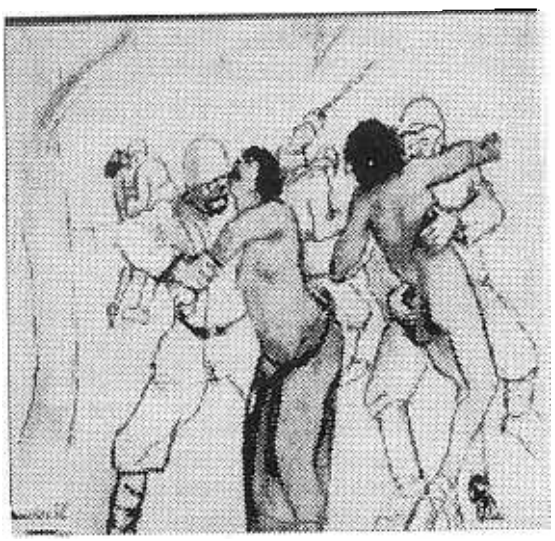
In DECEMBER 1993, World Health Organisation (WHO) reported that 15 million people throughout the world will be infected with HIV by the year 2000.

The same report says most of those who are likely to be infected live in Africa, the majority of them being women. The report further states that 60% of the infections will occur among those aged between 15 and 24 years.

A marked rise of infection in other parts of the world is also very likely to occur. Reports from Brazil say in Sao Paulo, between 1980 and 1992, out of a total of 20 824 AIDS cases, more than 3 000 were women. This figure is likely to rise taking into consideration that 71% of Brazilian women aged between 15 and 54 are sexually active, with only 2% of them using condoms. Of those who are already infected, 48% of the cases were through heterosexual sex.

In India, truck drivers are said to be at a greater risk of infection. It is estimated that there are two million truck drivers on India's highways everyday. Most of the truckers (who are married) spend an average of 10 days a month at home. Casual sex workers are their partners during the period that they are away from home.

Civil wars in most developing countries have also exacerbated the spread of HIV/AIDS. Among other countries, Lebanon and Cambodia have reported a marked increase in AIDS cases. It is reported that in November 1993, there was a rise in HIV infection among the United Nations (UN) peacekeeping forces leaving Cambodia. Out of the 22 000 soldiers, 3 000 cases of Sexually Transmitted Infections were reported. About 150 of the soldiers were said to be HIV positive. A lot of young women who are prostitutes in Phnom Penh are believed to have contracted HIV from the troops, as no condoms were issued to the soldiers during a great part of their stay in Cambodia.



From: Panos World AIDS

Urgent reaction

The reality of these figures does not only ring alarm bells for most people, but indicates the urgent need to speed efforts to provide women with some form of protection. The condom has not been very useful for many women, as they have very little control over its use. It has however been very effective with casual sex workers, because of the relationship between them and their clients. Theirs is a perfunctory relationship.

Married women and those in serious relationships have very often found themselves in compromising positions. Men, especially those who paid a bride price, are unwilling to use a condom with their wives. Women are then left with no choice but to totally submit themselves to men. If they do not, they face the risk of losing financial support and being ostracised by society.

Great risk for young girls

Young girls are at a greater risk because of the belief that they are

AIDS free. A report from Cambodia said virgin girls were in great demand with soldiers. Some of the soldiers were willing to pay as much as US$700 to have sex with a virgin.

There is no doubt that there is need to change society's attitude towards women. Women should be viewed as more than just sex objects. They have a right to say no to sex. The norm in most societies is that a man is the power base in any situation including sexual activity. Men have the right to say when, where and how to have sex. In some cases men even have the choice of who to have sex with.

It is situations like this that have to be redressed. We have to start from our social structures, which are in most cases partriarchal. This leaves women vulnerable to men, perpetuating the spread of HIV/AIDS.

Value women

There are many ways through which women can be empowered to have control over their own sexuality. Among others, there should be efforts to promote the education of women, to value girl children as much as boys, and ensure that there are policies that distribute resources equally between men and women.

The process to change society and eliminate gender inequality takes time. Looking at the rate of HIV infection among women, we do not have that time. The first AIDS case in the world was published in 1981. By 1984 more that two million cases of infection among women were recorded through out the world.

In an effort to control the spread of HIV/AIDS, most awareness campaigns call for fidelity in long term relationships and abstention in young people. Where this can not be done, use of condoms is greatly encouraged.

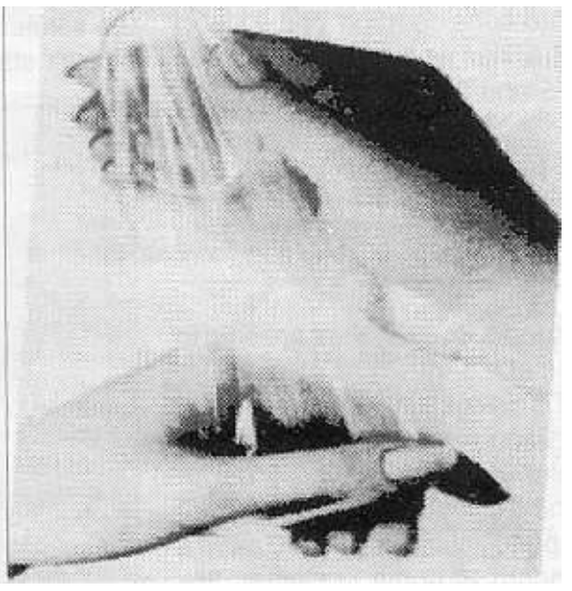
Femidom immediate answer

The early days of feminism did a lot for sex education. Emphasis was on informing and encouraging women to be proud of their sexuality. Women were greatly encouraged to have sex during menstruation, (even though menstrual fluid is still associated with impurity in some societies). Encouraging women to have sex during this particular time was an attempt to eradicate the idea that all body fluids from women are dirty, and therefore the women are also unclean at that time of their life. Emphasis was also made on the value and importance of the female genital area. With most women having been brought up with the belief that only female genitals cause STIs, it was important to inform everyone that female genitals are not in any way related to disease.

The points made above are true. However now there is need to emphasise that body fluids, from both men and women are and can be a mode of transmitting STIs including HIV. In order to minimise the risk of infection, each woman should be in a position to protect herself. This involves ensuring that secretions from a man's genitals do not enter the vagina, by using a barrier method that offers total protection to the female genitalia.

The first female condom was produced in the 1920s in Britain. Research during those days proved that the female condom was cumbersome and unacceptable to most people. The female condom has now been modified to suit the needs of its users.

There are some people who have criticised Femidom saying it is like having sex in a plastic bag. Such sentiments, especially coming from men, are a way of keeping total control in sexual encounters. It should also be noted that initial mass introduction of the male condom was also shunned, with most men saying they can not eat a sweet in its wrapper. Though criticised by many women's organisations as shifting the responsibility of STIs protection from men to women, Femidom is the only immediate alternative.



Femidom (From Women's Global Network for Reproductive Rights)

Femidom, which is a combination of the diaphragm and male condom has two flexible rings on both ends. The smaller ring is at the closed end and facilitates insertion. The open end remains outside the vagina, where it lies flat on the vulva.

Potential for acceptance

Research on the acceptability, effectiveness and safety of Femidom was done in 15 countries among which were Zimbabwe, Britain and the Netherlands. In Zimbabwe, more than 90 women from all parts of the country participated. Results from this research are still to be made public. Results from research in Britain show that the Femidom has the potential of being accepted. Out of 51 couples, 36 stopped using it after the first time. 29 have used it more than 10 times and have gained confidence in using it after every insertion.

Among women in Netherlands, 60% of those who used it reported that they were always cautious of the sheath. About 83% said their partners were also aware of it, while 66% of the women and most of the men did not mind it.

The ability for any woman to protect herself from HIV infection will be a challenge to the existing social structure. With everyone participating in this process, women's insights and their role in society will be valued. This might in turn lead to the gradual change in the existing social structures in most parts of the world.

Second World War "Comfort Women" Tell Their Ordeal

Photo: War Crimes on Asian Women

WOMEN from North Korea have released testimonies on their experiences as *"comfort women"* for Japanese soldiers, during the Second World War.

The detailed testimonies by 34 women portray their experiences as sexual slaves. Like all cases of sexual abuse and forced prostitution, the women unconditionally found themselves as *"comfort women"*.

The term *"comfort women"* (common term in some Asian countries) is used by the Japanese Imperial Army for women who provide sexual services to Japanese soldiers. The women are forced to stay in "comfort" houses or stations, which are brothels, for soldiers.

Psychological damage

In statements submitted to the United Nations, most of the women, now in their 70s, said they have remained physically maimed or psychologically scarred by the

horrible experience. Some have been ostracised by their husbands, children, friends and society at large. Only a few of the women have been accepted by their families, with some getting husbands who have helped them adapt into society.

According to the women's testimonies, most of them were lured away from their homes by promises of a job or abducted by Japanese and Korean soldiers. A book entitled *"War Crimes on Asian Women: military sexual slavery by Japan during World War II, the case of Filipino Women"* explicitly gives an account of the experience of Filipino *"comfort women"*.

In her testimony, Purita Canedo, from Manila in Philippines said she and 20 other girls from her neighbourhood were forcibly taken from their homes. They were taken to an Army Barrack, were they stayed in one room. Their duties included house work during the day and sex work at night.

Everyday they suffered sexual and physical abuse from the Japanese soldiers. She says, *"The soldiers were so cruel that we always wished for death. If the Japanese did not want the way we washed the dishes and kitchen ware, they would smash them on our heads."*

Juanita Jamot was taken from her home in Divisoria, when she was 18 years old. She was raped by soldiers who stormed into her late husband's home. She was taken to an area were she and 15 other women had to be *"comfort women"*. Each day she was raped by ten or more soldiers. She reports that at times she was so weak that she lost count of the number of soldiers who raped her.

In her testimony she also says, *"Each time I think about what happened during World War II, I always cry and feel dirty and ashamed of myself."*

Violation of human rights

Although the ages at which the women left their homes vary, (some left when they were as young as 12 years old) their experiences are similar. They were sexually abused and were denied the right to live like decent human beings.

The book says, *"The Asian "comfort women" were kept in small rooms in comfort houses which were near military headquarters and were forced to provide sex to Japanese soldiers. The soldiers wait in line outside the room for 30 to 40 times on weekdays and 60 to a 100 times on weekends. This is gross violation of the women's human rights and humanity as a person"*.

South Korean women were in 1991, the first to reveal the horrors of forced prostitution. It is estimated that 200 000 women and girls were used as prostitutes during the North Korean invasion by Japan. Women from the Philippines, Indonesia and other Asian countries also gave their accounts of abuse.

Almost all the North Korean women interviewed were unable to bear children. At one time or another they contracted a Sexually Transmitted Infection (STI). Some of the infections were so severe that they had to have the uterus removed. They also watched fellow Koreans tortured and murdered when they protested or tried to escape from the army barracks.

Government action

The 34 Korean women who gave their testimonies are among 131 other sexual slaves now living in North Korea. The women were identified during a one year fact-finding investigation on Japanese war crimes.

The United Nations have been requested by North and South Korea to investigate Japan's war crimes against women. The report demands that Japan reveal names of offenders. In addition Japan has been told to adopt a war crimes resolution in parliament. They are also expected to apologize for their atrocities during the war period, at the U.N. General Assembly. Although there is documentation on World War II, Japan has also been asked to give an accurate account in its textbooks on what happened during the war. The Japanese government is also expected to provide material compensation to the *"comfort women"* for the inhuman manner in which they were treated.

Although Japan has admitted that many women had been forced into sexual slavery, most Asian countries have not said what measurers they will take against the Japanese government. Some governments do not want to pressure Japan, as they fear that such an action will affect their relations. To date the Japanese government has made a public apology to the women.

General News

Source: Women's Health Newsletter Issue 19. 1993

TCRE and Contraception

TCRE is a relatively new method of treating heavy bleeding. Pregnancy after the procedure, which involves removal of the lining of the womb by resection or laser, is to be avoided because of serious complications. These include rupture of the uterus and severe intrauterine growth retardation in the developing fetus. Because of these risks, sterilisation is often performed at the same time. An immediate insertion of an IUD with a course of antibiotics to avoid any infection, is an alternative. Women taking HRT will require progestogen with the oestrogen, as small pockets of endometrium may still remain.

British Journal of Family Planning 1993, 18, p.134.

Black Community At Risk

Consumer Protection Act regulations on cosmetics are so weak they allow the sale of dangerous hair straightening chemicals caustic enough to burn skin and cause blindness, according to a senior government adviser. Professor Anthony Dayan described one hair treatment, designed for children, as "drain cleaner" after a survey by trading standards officers in the London borough of Southwark showed it was more caustic than 23 similar products analyzed.

Estimates show that more than half of black people under 60 are thought to use hair "relaxing" products, all of which are imported from the USA where hairdressers are licensed and "professional strength" chemicals are barred from home use.

Many brands sampled contained illegally high levels of caustic substances and were recommended for professional use. The most caustic appears to be harmless by name but lethal in content—Kiddie Kit Creme Hair Relaxer. Professor Dayan concluded, *"the potential of these products if not properly handled is very dangerous indeed."*

Guardian 27.4.93

Screening For Ovarian Cancer

Ovarian cancer has a low incidence (15 per 100,000) but a high mortality rate. Because of its asymptomatic nature, ovarian cancer is usually diagnosed at an advanced stage. According to clinicians, most early ovarian cancers are detected incidentally on routine pelvic examinations, and five year survival rates of over 90% can be achieved if the disease is caught in an early, localised state. This, along with small improvements in treatment of early detected ovarian cancer, has led to a renewed debate among doctors about the use of screening for ovarian cancer.

However, the low incidence of the disease has raised questions about the usefulness of screening in the general population. The only two screening tests for ovarian cancer that have been studied in any detail are pelvic ultrasound and a special blood test. Both proved limited in their ability to spot curable cancers and studies showed there is a long way to go before effective screening for ovarian cancer is established. Currently, lack of knowledge and limited technological accuracy suggests screening the general population is of little use. According to an article in the *British Medical Journal*, those women at high risk (women with a family history of ovarian cancer) should be encouraged to participate in large clinical

trials to assess the efficacy of newer screening techniques and, most importantly, to see if screening lowers the death rate from the disease. It's thought that in the future, genetic studies may be able to identify those women at risk who could benefit from careful screening or prophylactic removal of the ovaries.

British Medical Journal Vol. 306 17.4.93.

Talc And Ovarian Cancer Risk

A study was carried out in July 1992 aimed at determining whether common talc contributes to the risk of ovarian cancer. Talc was suspected because its chemical make-up is similar to that of asbestos.

A group of 235 women with diagnosed ovarian cancer was compared to a control group of 239 healthy women. All were asked about talc exposure through dusting of underwear, sanitary towels and diaphragms (for storage); exposure due to male partners' use of talc; and exposure through the use of talcum powder directly on the genitals.

No reliable information could be obtained on talc exposure on nappies during childhood.

Results revealed women who applied talc daily to their perineal area for more than 10 years were at sixty percent greater risk for ovarian cancer than non-talc users. Thirty years exposure raised the risk to eighty percent.

Talc products used before 1970 gave greater risk because of their increased use of asbestiform content, which seems to have decreased since 1976. However, researchers say further experimentation on animals may be necessary because it is not clear if the risk only affects talcs contaminated with asbestos.

Source: WomenWise Winter 1992.

Smears and Inflammatory Changes

Inflammatory changes are often noted on reports following cervical smear tests. It has been a common assumption that these changes were a possible indication of infection. Researchers decided to evaluate whether inflammatory changes could reliably indicate a vaginal infection was present. A study looking at 411 smear test results took place in Newfoundland, Canada. Of the 132 women with inflammatory changes on cervical smear, 64 (48%) had positive swab results. Of the 248 without inflammatory changes, 117 (47%) had positive results. The conclusion of the study therefore, is that cervical inflammatory changes cannot be used to reliably predict the presence of infection.

Source: British Medical Journal Vol. 306 1.5.93.

Screening To Prevent CIN Via HPV

A recent article in an American woman's journal has highlighted the prevalence of human papilloma virus (HPV), the family of viruses that can cause genital warts. There are many types of HPV and several have been implicated in precancerous and cancerous changes of the cervix. By 1990, HPV had become the second most common STD in the USA, closely following chlamydia. Many women hear about HPV for the first time after the virus is picked up on routine smear test results. If warts are also found, these can be successfully treated and removed. The article warns that HPV can be passed even when there are no symptoms. Men can wear condoms, but a condom does not prevent the viral particles on the scrotum from touching a partner's genitalia. Condoms and other barrier methods of birth control, such as diaphragm and cervical cap, can provide some protection against exposure of the cervix to HPV, but it's not 100 percent. Once HPV infects one genital area, it can move to another. Lesbians are not

immune from HPV, although we are not aware of medical literature on woman-to-woman transmission. There have been reports of HPV-related cervical changes showing up on cervical smears of women who have been sexually active with women only, according to the article. It concludes that exposure to HPV may not be preventable, but it is treatable. More importantly, cervical cancer is preventable with regular screening.

More research is necessary to assist prevention and treatment of HPV. For more information, Women's Health publishes a leaflet on genital warts; 40p plus SAE.

Source: Sojourner Vol. 18, No.7. March 1993.

Women and Heart Disease

Coronary heart disease has traditionally been regarded as a disease of middle aged men. But it is also the leading cause of death and an important cause of disability, with up to 80,000 female deaths and 100,000 male deaths in Britain every year. Despite this, several US research studies have tended to be very gender biased towards middle aged, white men. This means that women with symptoms are less likely than men to be referred for investigations and treatment or are diagnosed and treated later in the course of their illness, according to an article in the *British Medical Journal*. This leads to a worse prognosis, including higher mortality and slower recovery. The article suggests a similar bias operates in Britain and calls for more studies in women, the elderly and "ethnic minorities". In the USA the Office of Research on Women's Health was set up by the National Institute of Health to address the inequality of women in health research and care. It is a 10 year $500m research initiative that began in 1991. Considering British women have one of the highest rates of coronary heart disease worldwide, isn't it time to set up something similar here?

Source: British Medical Journal Vol. 306 1.5.93.

Sexuality Among Older Women

Family Planning Associations (FPAs)in Denmark, Portugal and Greece have joined forces on a project to foster positive attitudes towards sexuality in later life. This is to combat the often negative or disapproving views towards sexuality in older people held by health professionals and the younger generations. They hope to produce information and education materials for use by other FPAs and older people's associations. The project is being organised in Greece and would like help in collecting materials such as books, videos etc. **Contact:** Dr E.A. Mestheneos, General Secretary, Greek FPA, 121 Solonos Street, Athens 106 78, Greece.

Source: IPPF Open File June 1993

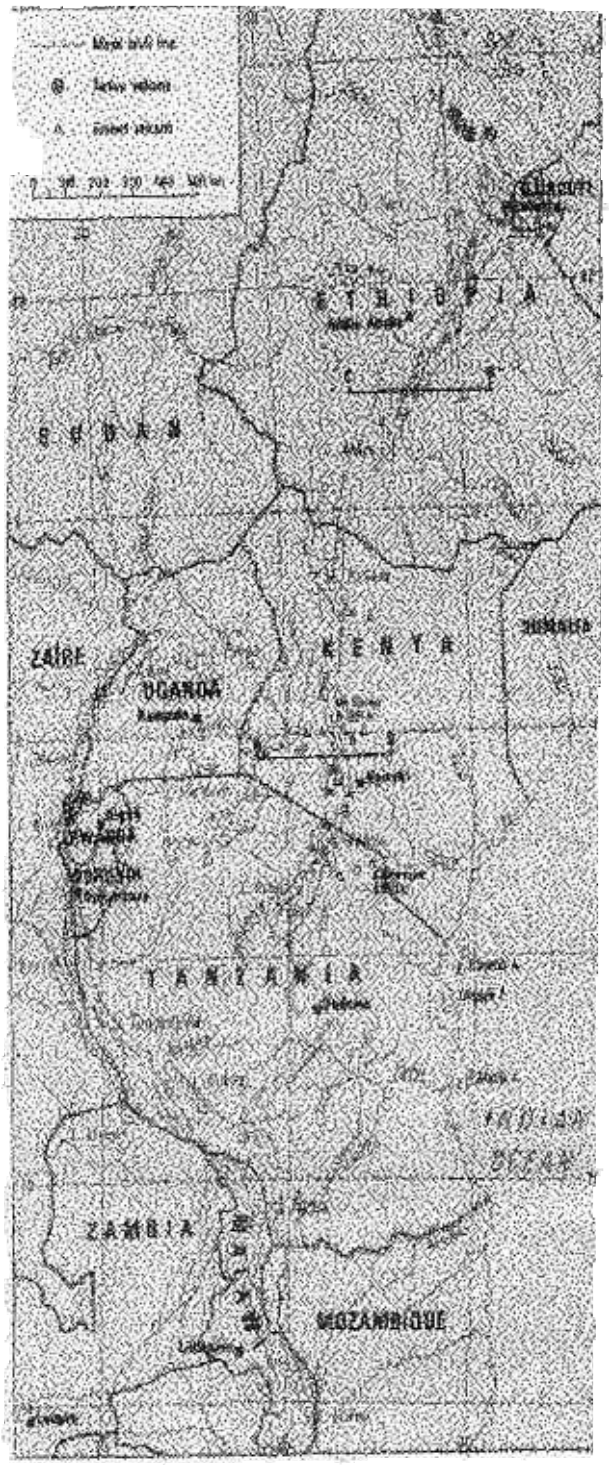
Isis - WICCE Settles In Kampala

Settling in a new home is hardly easy for anyone. More so for an office that has to move from one continent to another, with completely new staff.

Isis - WICCE's new home is now Kampala, the capital of Uganda. Since the organisation was started in 1974, it has been based in Geneva, Switzerland. Uganda is one of the smallest countries in Africa. The country is affectionately known as**The Pearl of Africa**. It has a population of about 16.5 million. About 51% of the population comprises women and children.

The internationally acclaimed tradition of caring found in Africa, has been very apparent to Isis - WICCE staff. This has made our new home considerably easy to settle in and made life for the two staff members very comfortable. Our great appreciation goes to the Uganda Local Advisory Committee for all their assistance and encouragement and the Geneva Task Force, and our Uganda office Lawyers for their continued support and guidance.

We would also like to thank you our members and readers for being supportive during this transition period. The move has greatly interrupted the smooth running of the office, including the production of Women's World, and the essential preparations for the Exchange Programme. We sincerely apologise for any inconveniences that might have been caused during this transition period. We assure you of a regular production of your valuable magazine, Women's World. The next issue will be in your mail box by November 1994. Again the theme will be Women and Health.



Map of East Africa showing Uganda and other surrounding countries

Drugs On The Streets

IN VERNACULAR languages, they shout for customers to buy drugs from them. Some say they have drugs to cure such ailments as epilepsy, diabetes and AIDS.

These street drug vendors are a common sight in Kampala, capital of Uganda. In most cases, they sell their drugs around busy places such as Taxi Parks, food, and clothes markets. The market places are mostly visited by women who are either selling their wares or buying house-hold goods and clothes at very low prices.

The vendors are mostly young school drop-outs who are trying to make an "honest" living. Most of them have no idea about the names and doses of the drugs they sell. The drugs range from antibiotics to corticostersis cream and hair straightening products. Under normal circumstances and in some developing countries like Zimbabwe and South Africa, it is only qualified personnel who are allowed to dispense prescription drugs.

No need for doses...

One drug vendor approached by *Women's World,* said he sells drugs because that is the only way to earn a living. He said, *"For the past five years I have been selling drugs in Kampala. I have been making just about enough money to send my brothers and sisters to school."* Asked about how he measures his doses, he said he does not. He said if any one comes asking for a drug, he just gives. All he wants is money.

In a television programme produced for Uganda Television, a woman was seen demanding injectable quinine for her child who had malaria. In some cases, if the patient is not given what she wants, she leaves the clinic and goes to buy her own prescription.

Women's World also noticed that most of the drug buyers are women. This was confirmed by an employee of the Uganda Red Cross, Rose Kinuka. She said, *"Most of the people who buy drugs from street vendors are women. This is easy to understand because in most homes, it is the women who shoulder the burden of looking after the sick. In some homes it is even the young girls who look after those who are ill".*

High risk of infection

A report produced by the Uganda Red Cross, said most families have their own syringes and needles. They diagnose themselves, with the help of a quack doctor, friends or someone who once had the same signs and symptoms. They inject themselves, and often an abscess develops at the

Play by local drama group on use of drugs in Uganda (Photo: Uganda Red Cross)

unsterilised injection site. In most cases, the shared needles and syringes are not sterilised. It is common to have a man and his wife or wives sharing one needle, while the children share another. In such cases, the risk of HIV infection is very high.

The report also says drug storage places are not secure or hygienic. Most families store their drugs under pillows, mattress or in the roofs of their houses. Only a few have hanging baskets and secure cupboards. Rose also pointed out that drugs are not only sold at street corners without proper monitoring. *"It is common practice to see some kiosks and shops selling drugs. Anyone can walk into any shop and ask for any drug. If you can afford to buy only half the course, there is no one to stop you from doing that,"* she lamented.

Proper drug use campaign

Rose is convinced that it is difficult to monitor the use of drugs in the country as there is no drugs control policy yet. It is even more difficult to monitor the situation because some of the vendors get bulk supplies of drugs from registered chemists and pharmacies. There is only one person in each district, to monitor drugs supply and distribution who does not even have transport. There are 39 districts in Uganda.

Skin lightening creams are also commonly sold on the open market. Creams like hydrocortisone and betnovet are easily available. For those who cannot afford these creams, they use bleaches such as Jik, which they mix with vaseline. *"It is mostly women who buy these creams. They believe that the lighter you are, the prettier you look. But this is a shame because most women have done irreparable damage to their faces,"* said Rose, sounding very concerned.

Having realised that there is a lot of drug abuse, the Uganda Red Cross has launched a drugs awareness campaign. *"Although the government is going to pass a bill on the use and sale of drugs, we realise that it will take long to implement. We have decided to go ahead and educate the masses, women in particular, about the use of drugs,"* said Rose.

The Uganda Red Cross programme will teach women the rights of a consumer when purchasing drugs, drug side effects, storage and expiration of drugs, among other things. The programme will initially be in three districts for a period of two years.

Training Workshop for drug use monitors in Uganda (Photo: Uganda Red Cross)

ABOUT ISIS - WICCE's EXCHANGE PROGRAMME

By Fenella Porter:- Exchange Programme Co-ordinator

ISIS - Women's International Cross Cultural Exchange, is widely known for its exhilarating and at the same time, edifying Exchange Programmes.

The main reason for having the Exchange is to facilitate and encourage women from different cultures, to share their experiences and knowledge on different issues.

Each Exchange is based on a theme, which directs the activities of the organisation. Themes for each Exchange are suggested by members of Isis - WICCE. Since its inception, Isis - WICCE has held seven Exchange Programmes.

Exchange Themes

Themes from previous years are *New Technology Conference in 1983. Women and Communication* was the theme for the *1984* Exchange. In *1987*, the theme was *Women and Appropriate Technology* and *Women Living Under Muslim Law* was the theme for *1988. Documentation and Communication* was done in *1990* and *Poverty and Prostitution* was in *1991.* Because most women feel that health is a critical topic, the next theme will be *Women and Health: an integrated approach.*

The question why *an integrated approach* might arise. This theme is set to explore the link between women's health and such issues as education, economic development, social status and the role of women in any setting.

Also of paramount importance is to find appropriate definitions of health for women.

The organisations that are accepted for this Exchange, are not necessarily actively engaged in running health programmes alongside education and economic development programmes. These are organisations who are working on health issues, in a more holistic manner, rather than strictly medical definitions. For women, health problems take many forms. They are not always accepted as legitimate by the medical organisations. Often it is ill health that can not be cured medically.

Thus, it is not only availability of medical treatment and having access to it, that the Exchange will concentrate on. We will also be looking at alternative health systems and looking at opportunities of creating what women would term a healthy life style.

Participants

There will be about 15 participants chosen from sending groups, and an equal number of receiving groups. Sending groups are those organisations that have been accepted as active participants. The receiving groups on the other hand, are those organisations that offer practical experience to the Exchange participants.

Participants are selected internationally, so that there is a balance in regional representation. Although participants may all be thinking about health from a wider social perspective, the cultural and political context in which women's health is experienced will be very different for each participant. The aim of the Exchange Programme is to facilitate communication between the women, and the sharing of experiences, across cultural and geographical differences. The exchange of information between women all over the world and a better understanding of each other is something that the Exchange facilitates.

A new angle that the Exchange will explore is to use women from regions such as Asia, Africa and the Caribbean as well as marginalised women from industrialised countries, as resource persons. This, we hope, will assist to break images of *"industrialised knowledge and experience" vis a vis "developing countries' ignorance and inexperience".*

Although women from such regions as Europe, North America and Australia are not given priority as participants, they are encouraged to act as receiving groups. Quite often women from the above mentioned regions are also used as *"resource persons".*

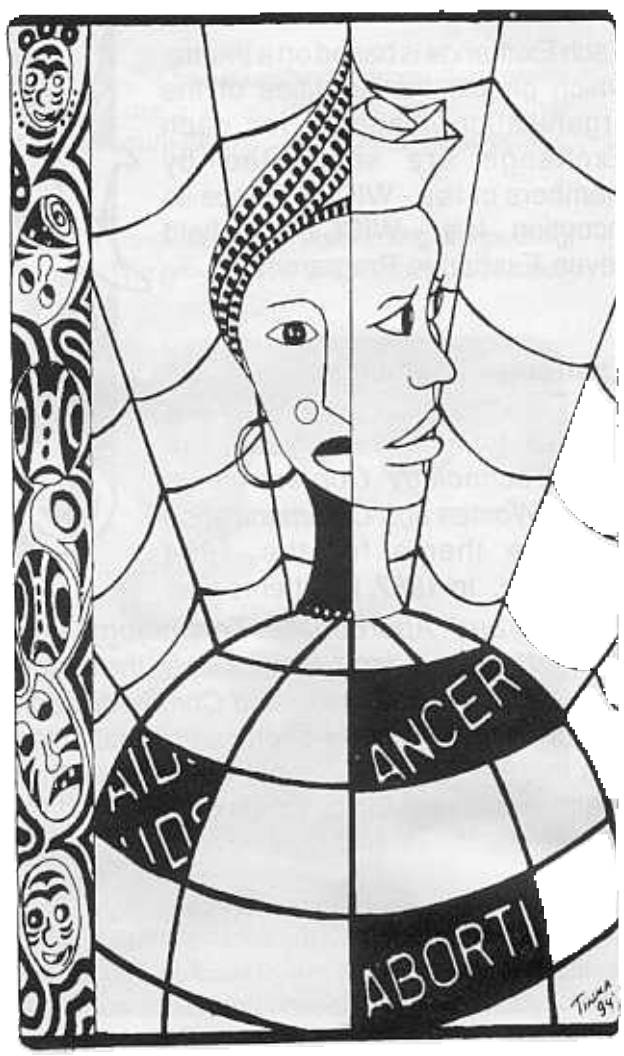
The Exchange starts with a two week orientation period. During this period, participants get together to discuss informally, the conditions that exist in their own countries, the specific issues that they regard as priority issues, the problems that they are facing and the strategies that they are using to overcome these problems. This is done through seminars, workshops, group discussions, and personal experience presentations. A team of resource people assist to guide these sessions.

Documenting the Exchange

Following the orientation period, participants are then sent to work with a receiving group for two months. They spend time in a different culture, experiencing at first hand the differences (and similarities) between different settings.

The final part of the Exchange is the synthesis period. This again is a two week period. Participants come together and discuss what they have learned during the Exchange period. They also discuss ideas for future action. Reports on their experiences during this period are documented as a means of continuing a communication forum for the participants and other women's organisations. This is done either in the form of a magazine, video or audio tape, to name just a few.

Making the most of the Exchange means continuing the struggle with renewed strength and solidarity.



Uganda Hosts The 7th International Women and Health Meeting

MAKERERE University, in Kampala, Uganda, was a hive of activity during the period September 12 to 17 1993. The 7th International Women's Health Meeting, (IWHM) took place at this once famous African University.

Over 420 women from more than 52 countries attended this important tri-annual Meeting. The theme of the Meeting, *United We Stand To Take Action On Women's Health*, gave all the participants a podium to air their concerns on women's health issues. This was also a chance for women from Africa to express and define the meaning of feminism in Africa.

The first IWHM was held in Rome in 1977, where only a handful of the participants were from Africa. The last two meetings have been held in developing countries, Costa Rica in 1987 and the Philippines in 1990.

Some of the participants at the 7th IWHM (Photo: SafeMotherhood Initiative Uganda)

Unlike the previous Meetings, the 7th IWHM had a majority of participants from Africa. Uganda alone, had about 120 participants. Most of them being health workers and government officials working in different ministries on women and development. Among other participants were women from Japan, Jamaica, India, The Philippines, The Netherlands, Canada and USA.

Participants from Africa took the opportunity to explain to the Meeting their understanding of the meaning of feminism. Unlike some participants from industrialised countries, women from Africa did not think that this was a feminist Meeting. Rather, it was a time for all participants to share their experiences on women's health issues.

The co-ordinator of the organising committee, Dr Josephine Kasolo, clad in her traditional Uganda attire said, *"We all have different ways of looking at the issue of feminism. One thing that is clear to us is that this is not a feminist Meeting,"* to which most women from Africa applauded.

Said Dr Kasolo, *"A women's health meeting is not a feminist meeting. It is a time for all of us to share our ideas and*

experiences. We know what feminism in the industrialised countries means. Now we have to educate you on what it means to us. But we have to keep in mind that we all have to support each other, in our struggle to emancipate women."

She went on to explain that women in Africa have their own special roles in society. They include being mothers, care givers, *"heads"* of households (even where there are men), advisors in some clans as well as being role models. These roles, she said, greatly influence the status of women. In most cases, women unwittingly oppress themselves because they do not realise how powerful some of these roles are.

A participant from Zambia gave an example of the role of an aunty, who is an extremely important person in any family. She said, *"It is us as the aunties who give our nieces the wrong meaning of the role of a woman, especially in marriage. We encourage her to be submissive. Not to have a say in her reproductive role. We chide and scorn her when she can not have children. We push her to serve her husband sexually even when she does not want. Basically we put her in a situation where she does not have control over her own body."*

Thembi Mahlangu, a participant from Zimbabwe cited cases in which the women's lib organisations in Zimbabwe had originally failed because they had adopted western feminist theories. There was a lot of resistance from both men and women, who were to benefit from the women's lib movement.

Says Thembi emphatically, *"Anybody from Africa will tell you that women play very important roles in any family. Look at the film Shaka Zulu from South Africa. Shaka's mother and his aunty had very important roles. We do not need a western type of feminism to be recognised as women. What we should fight for is educating our sisters on how to use their roles for the benefit of everyone."*

Other issues discussed at the Kampala meeting included HIV/AIDS infection, reproductive health, the role of the media in relation to gender issues and women and mental health.

It is believed that Africa has the highest number of women infected with HIV/AIDS. Figures from the World Health Organisation, (WHO), show that at least three and half million women in Africa are HIV infected. WHO also estimates that by the year 2000, 5 million women will be infected.

Reports by participants from Southern, Western and Eastern Africa showed that there were many AIDS awareness campaigns going on. Most women and AIDS organisations have now moved from home-based care programmes to community based care programmes. The latter looks at caring for Persons With AIDS, (PWAs) from a community point of view rather than having this done by a nuclear family. This approach has also assisted in making communities aware of the heinous effects of rape and child sexual abuse and genital mutilation in some societies. Genital mutilation was reported to be still common in such countries as the Sudan, Ethiopia and Nigeria.

The Meeting also emphasised that all issues of rape and child abuse should be reported in the media as issues of concern. Most media organisations tend not take this issue seriously, with little coverage being given. In most countries, rape and child abuse cases are used as fillers by newspapers. This has given the impression that all such cases are of little importance and do not need to be addressed.

Passing resolutions at this Meeting was not very easy. The main obstacle being the diversity of interests demonstrated by each region during the different plenary sessions. However, the need to construct an acceptable approach for each region, to strengthen the women's movement, was clearly stated by all participants. To maintain networking and strengthen the movement in each region, focal persons were appointed. Among other things, it will be their duty to sustain the links that were established at the Meeting.

Women from Africa have very often been marginalised at major conferences and meetings. This concern was made during a vibrant debate on the next venue of the IWHM. They emphasised the need to be fully involved in international conferences. The great success of the 7th IWHM, was the encouragement and hope that it gave to the health movement in Africa. The 8th IWHM will be held in Brazil, another developing country, in 1996.

INADEQUACY OF THE HEALTH SERVICES: A reaction to the inadequacy of the nursing services in Uganda.

Presented by SELINA RWASHANA at the 7th IWHM

A night walk down the corridors of any ward in a hospital in Uganda, will reveal that the ward is home, both for the patient on the hospital bed, and a close relative. Usually the relative is a woman. She spends many nights on a mattress on the floor beside the patient. This situation has evolved out of the inadequacy in our health service as a whole, and in particular, the nursing side.

Uganda has a population of seventeen million people. In May 1992 the total number of nurses in the country was 5 631. Thus each midwife attends to 15 000 expectant mothers while a nurse attends between 8 000 and 10 000 patients.

Given the above statistics it makes it very difficult for the nursing service to operate effectively and efficiently. As a result a cadreship of nursing service providers has developed in order to compliment the work of the nurse. This person has now become a permanent fixture at the patient's bed side in our hospitals. Because of this situation and the important role that cadre have assumed, we have to keep them in the hospital. These people are what we now call Resident Hospital Relative. The Resident Hospital Relative who is usually a woman is a close relative to the patient - wife, partner, mother, sister, auntie, or grandmother.

In this paper I will endeavour to highlight on the evolution, role and potential for change, that this cadre can play in the nursing service here. Although up to now their role has been ignored, I feel that it is important to look at that role and try to acknowledge it and develop it.

I think we have, in all hospitals of Uganda, a concentration of women who will spend varying periods of time in hospitals. These periods range from a few days to many months. Having recognised their role, efforts should be made to tap on their ability to become home based care providers. In this way, they can be educated to become agents for change back in their different communities.

A brief look at the evolution of this cadre of nursing service providers shows that it was a direct result of inadequacies in the traditional health service. Following the country's independence and the subsequent political turmoil that we went through, the nurse like any other professional got her share of problems. Many of the nurses who had undergone training in Britain ran out of the country. The few who remained and those being turned out by our nursing schools opted for better paying jobs. This meant government hospitals lost a considerable number of nurses who joined private practice in clinics, midwifery homes and drugs shops.

This meant that the hospitals were left with a few nursing personnel. And those few nurses who were left lost morale due to the ever increasing cost of living. So we now had a situation where the few nursing staff in a hospital were not only inadequate but also poorly motivated. So the evolution of the Resident Hospital Relative became handy in meeting this inadequacy.

These Resident Hospital Relatives have now become part of the hospital establishment. Their role is so important that in most

hospitals they are issued with special permits allowing them to be in hospital at all times. Some hospitals such as Rubaga Hospital (Missionary Hospital in Kampala) has gone as far as constructing a structure for their use called *Ekijanjabi* (House for the helper)

Among other things these people assist in the bathing of a patient, toilet procedure, timely taking of drugs and preparation of food for patients. Their role in drugs administration is very important, in times of shortages. There are times when the hospital can not provide certain drugs. The relative thus they purchase these from private laboratories and pharmacies. They also act as a link between the hospital staff and the patient's other relatives.

Their potential as agents for change is beginning to be realised now. For example in some Paediatric wards (Rubaga Hospital for example) when a malnourished child is admitted the mother who has played a big role passively or actively in the child's state is sent for Nutritional Education. After the training, she is more aware of what a nutritious diet is. Not only does she keep this information to herself, but passes it on to other parents in the community.

With the onset of the AIDS epidemic the mother of the child is sent for counselling about the underlying illness of the child and the implications for the rest of the family. In this way she will be able to understood her child's situation. This will also enable her to monitor the child when they return to their community, without necessarily having to consult a health worker.

It is very important that these cadre go through some form of formal health education training, while they wait on their relatives in the hospitals. There are certain health issues that we take for granted and believe that all women understand. We as African women have numerous problems that plague us. These range from malnutrition, malaria, gynaecological problems, STDs and AIDS and many more.

There are solutions to these problems. Just a little education on prevention on some of these issues can give us life long solutions. The messages will be even more readily received as ignorance leads to many hospital admissions. Ignorance that can easily be changed into knowledge. In Uganda this can be achieved by appreciating, acknowledging and equipping the Resident Hospital Relative.

Maternity: Between Function and Perception

Excerpts From The Presentation at 7th IWHM by Martha I. Rosenberg
Buenos Aires, Argentina

There is no doubt that to talk of maternity nowadays could be seen as another way to deal with the problem of controlling the world's population growth.

In our context, maternity can be understood as the function that renews human generations in order for them to reproduce the existing economic and social structures. Therefore we must be aware of the fact that, since it is a function with consequences for social life in all its dimensions, it will be ruled by different population policies - whether they respond to veterinary or human criteria.

I am not interested in dealing with the subject matter from a point of view of the *"functioning"* social system, but from the perspective of women. This "functioning" considers women as a "natural" instrument of human reproduction and not as subjects of an autonomous activity. That is to say maternity is recognised in spite of not having - at least not until very recently - a market value. The activity finds in itself its own aim and primary value.

I admit that this perspective is biased: human reproduction is not only a matter of women, but of both sexes, of the whole society. However, the female capacity for gestating, and the social designation of bringing up children, places women in the position of being the primary historical focus for the variation of reproduction patterns. Population policies, although functional to structural adjustment, manipulate women. Although women are the object and the agent of population policies, they have no access to the decision making levels.

The biased nature of maternity can be found at different levels:

- it does not cover the totality of the human biological reproduction, (ie that which requires the union of female and male gametes); it is neither purely biological nor purely cultural;

- the category of mother does not include the whole experience of being a woman.

Maternity, is one aspect of reproduction. There is, therefore, no need to assume it to be the totality. There is no need to deprive the other gender of its part, nor to oppose it as if it were an enemy, nor to subordinate it as an inferior being. However, femininity must be recognised as the feature that makes it possible to have a different relationship with the world, and with masculinity. The two sexes are different in their bodies. These differences are historically construed as subordination. But the two sexes are identical with regard to an imaginary neutral human, they are able to give an account of their differences. Two different sexes equal a real humanity. There can be no humanity without the two sexes; identical, but different.

Women are the focus of population control policies (the domain of the powerful classes from Malthus until now). Their points of view regarding maternity must be included in the formulation of these policies. This is an essential expression of their responsibility in the civilizing power that regulates their

gestating capacity. The introduction of their specific interests (with the full, global, variety of situations included) would guarantee justice.

It is a barbarism of society that treats this matter with categories that resemble the categorisation of livestock, and transforms the "*function*" assigned to itself or its membership. Society is merely the support of its biological reproductive capacity. The feminist movement suggests that women get away from this impersonal automatism. They must guarantee that their own perceptions regarding maternity, their needs and wishes, their image of the world and of themselves, are built into the singular history of social links that gives body to each one.

For over two centuries now, we have undergone - together with the promise of *Equality, Liberty and Fraternity* - the difficult and painful process of women's taming. Their unlimited sexual appetites, their appetites for knowledge and power must be dominated[2]. In the eighteenth century, European societies (and their colonies), assigned responsibility for the education of women to the convent and to the middle class family mother. This was convenient for industrial development.

Mothering was always accompanied by the established authority of the doctor as an ideological reference point. Bringing up children is thus "doctorized". The institution of a medical knowledge, supported by professional interests and the prestige of science, hides the business of patriarchal control over female activity. Simultaneously, opposition is created between female eroticism (which the psychiatric discipline takes care of) and maternity (assumed by gynaecology to be the field of "natural" reproduction processes)[3].

The field of any particular science, such as medicine or demography, is bound to be of concern to political plans. Technocratic methods of population control[4] imply a policy of manipulation of human life. The success of their work depends on the maintenance of poverty in Developing countries, to maintain the levels of consumption and technological efficiency in Industrialised countries. However, this technological efficiency should actually benefit more people. The scientific research is, after all, carried out in centres financed by all of society, and with the abuse of all the natural resources of the whole planet.

Population problems must be redefined in terms that are able to assure the survival of the existing populations that are being threatened by the dictates of the neoliberal economy, military and political oppression, patriarchal social relations, migrations determined by the unequal relationship between North and South and structural adjustment[5]. This definition of the population problem suppresses the myths that are so prevalent. The elevated birth rates in Developing countries is one of the effects of environmental deterioration and poverty, not its main cause as the myth would have us believe[6].

This is the context in which we are meeting today. The speech by the population establishment, religious speeches and medical-psychological speeches hardly pay any attention to what women say about their

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[2] *See Silvia Veggetti-Finzi, Female Identity between Sexuality and Maternity, in* Beyond Equality and Difference, *published by Gisela Bock and Susan James, Routledge, London and New York, 1992. Also, Jacques Donzelot,* La Policia de las Familias, *Pretextos, Valencia, 1990.*

[3] *Veggetto-Finzi, see ref no 3*

[4] *I consider "technocratic" to mean the implementation of pharmaceutical or surgical technology, as well as the use of community or family development prototypes, produced regardless of the will of the people concerned.*

[5] *Nancy Hartmann,* Old Maps and New Terrain: the Politics of Women, Population and the Environment In the 90's. *Paper presented in the Conference on Reinforcin Reproductive Rights, WGNRR, Madras, Ma 1993.*

[6] *See* Population Danger, Sex, Lies an Misconceptions, *IDAC/REDEH/IBAS E Rosiska Darcy de Oliveira, Thais Corra Fatima Vianna de Mello, Rio de Janeiro, Ma 1993.*

experience and needs regarding maternity. Instead they take advantage of their power to use for their own political-economical, ideological or corporate aims.

No one can speak on our behalf. Women's movements, feminist practices and speeches in the last decade have enabled and legitimised the problem of maternity for women as a collective subject. Spaces are opening up to acknowledge repressed aspects of the experience of maternity that have not, until now, been publicly recognised. They have rather been expressed as social and/or body symptoms by women and children, as an expression of their uneasiness and lack of legitimacy.

There is much to demonstrate the inherent conflict contained in the assumption of maternal functions. This includes among other things incidence of spontaneous or provoked abortions; the high maternal mortality rates; elevated child mortality rates; nursing troubles and resorting to assisted fertilization.

This situation of conflict is an unspecified one, shared with the male world. On the one hand it is the price that has to be paid for the submission of the biological legality to the cultural legality. This also indicates the specific submission of women to patriarchal domination through the adaptation and control of their productivity. This cannot be done without awakening their resistance, and their claims to see the fulfilment of the promises given by new ideas.

Let women speak about their maternity, meditate about it, free it from the burden that makes it impenetrable to reflection.

Let them also speak about the negative aspects of maternity - putting aside the demonic character attributed to it, or of the triumphal tone which it sometimes assumes. These are steps towards the construction of a female ideal of maternity that is not determined by the patriarchal control over their reproductive capacity and sexuality. This is an ideal that incorporates the existence of a female subjectivity. The problem of how to build a citizenship that does not ignore nor neutralize sexual difference (or other differences) is unavoidable for women. Only at the price of giving up our specific rights can we participate in the construction of a purely democratic political system. Deprived of the existing limitations and exclusions of race, sex, religion, and economic position.

Preparations:- 1995 World Conference and NGO Forum on Women

Never has anyone heard of more intense preparations being made for any international conference. More than 2 000 women's NGOs throughout the world are making preparations for the NGO Forum on Women.

WOMEN'S Non Governmental Organisations, (NGOs) throughout the world, are actively making thorough preparations for the Fourth World Conference on Women (WCW).

The conference, which will be in Beijing, China during September 4 to 15 1995, will be concurrently held with the NGO Forum on Women.

The first WCW was held during the International Women's Year, in Mexico City. It was at this conference that the United Nations General Assembly declared 1976 to 1985, the United Nations Decade for Women. Nairobi, Kenya, hosted the third WCW. The Nairobi Forward Looking Strategies for the Advancement of Women to the year 2000 was adopted at this conference.

The main objective of the 1995 WCW is to review and appraise the Nairobi declarations. Most women's NGOs have spent the last two years analysing the situation and status of women in their countries.

Forum '95, as the NGO Forum on Women is popularly known, is being organised by an NGO Forum Facilitating Committee, made up of 60 members.

Since March 1993, a number of pre-conference regional consultation meetings have been held. It is envisiged that by 1995, each region will have held at least two preparatory meetings. The preparatory meetings are reviewing the status of women's human rights and priority issues.

Women's human rights are usually not part of the agenda when policy makers discuss human rights issues. Govenments, international organisations and national human rights organisations have often concentrated on political and civil issues when discussing human rights.

Each regional meeting is expected to involve and ensure participation of

From: WILDAF News

women at grassroot level and those organisations working at that level. This will ensure that all women's perspectives, expectations and concerns are recognised at international level. They will also serve as a means for determining priority areas to be followed by governments in the different regions.

Most women's NGOs are concerned that although some governments ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), there have not been any significant changes for women. Some governments have registered reservations on CEDAW, and have not given women any meaningful protection under the respective conventions.

Two regional preparatory meetings have so far been held in Africa. Another regional meeting to be held in Dakar, Senegal is scheduled for September 1994.

The NGO Forum of Latin America and Caribbean women's organisations will be held in Argentina in September 1994. In June 1994, a working group on Regional Place of Action for Women and Development in Western Asia, will meet in Cairo, Egypt, while the Pacific Regional Preparatory conference will take place in Indonesia.

More than 20 000 participants are expected to attend the meeting which will be held at the Beijing Workers' Stadium.

Preparation Calendar for Beijing 1995

Continent	Meeting	Venue/Date
Africa	Regional expert group meeting on African Plan of Action	Tunisia May 1994
Africa	Regional preparatory conference	Senegal September or October 1994
Africa	International and development population	Cairo,
Asia	Asian and Pacific regional preparatory conference	Indonesia Pacific June 1994

COMING EVENTS...

Social Change, Women's Studies and Feminist Research, August 13 - 17 1994, Ottawa, Canada.

This conference will be looking at Women's/ Feminist Studies; content, educational theory, research, institutional allocation and its commitment to change the situation of women wherever they are. One possible out come of this conference might be the creation of an international women's studies. For further information contact:- International Conference on Social Change, Women's Studies and Feminist Research, University of Ottawa, Canada.

Sixth International Congress on Women's Health Issues, June 28 - July 1 1994, Gaborone, Botswana.

The theme of the congress is family health with women as health care providers and recipients. Abstracts are invited for possible presentation at the conference. For more information contact:

Sheila Dinotse Tloe
Sixth International Congress on Health Issues
PB 00452
Gaborone
Botswana

Third Women's Global Leadership Institute Women, Violence and Human Rights, June 12 - 25 1994

The workshop aims at looking for possibilities of co-operation and drawing plans which will influence the international community for its approach towards these issues. The center is looking for women from all over the world, who have taken leadership in various fields to make violence against women an issue. For details, please contact:

Susana Fried
Institute Co-ordinator
Center for Global Women's Leadership
27 Clifton Avenue
Douglass College
New Brunswick
NJ 08903
USA

Third International Women Playwrights Conference, July 1 - 10 1994, Adelaide, Australia

The International Women Playwrights Conference is a tri-annual event. The conference will bring together budding women writers and those who are already established in the field. More information on this event is available from:

ICMS PTY LTD
P O Box 8102
Hindley Street
Adelaide SA 5000
Australia

Sixth International Feminist Book Fair July 27 - 31 1994, Melbourne, Australia

For the first time, the International Feminist Book Fair will be held in the southern hemisphere. This will also be the 10th anniversary of the International Feminist Book Fair. Over the years, the IFBF has attracted women writers and publishers from all over the world. This is a valuable opportunity for publishers and writers to strengthen networking and to make new contacts. More information on the IFBF is available from:-

GPO Box 2681x
Melbourne
Australia 3001

YOUR REFERENCE

Women's Health Organisations and Resources

Centro De Estuios De La Mujer
Ave. Santa Fe 5380 7"E"
1425
Buenos Aires
ARGENTINA

Multicultural Women's Health Center
114 South St
6160 Freemantle
Perth
AUSTRALIA

Women in Industrial Contraception & Health
Women in Industry
83 Johnson St
Fitzroy
3065 Vic Fitzroy
AUSTRALIA

National Women's Association Of Bhutan
Norzin Lan
Thimphu
BHUTAN

Cameroon Medical Women Association
P O Box 5408
Yaounde
CAMEROON

Isis International
Casilla 2067
Correo Central
Santiago
CHILE

Fiji Women's Rights Movement
P O Box 14194
FIJI

Friends of Women's Health Center
502/296 Moo Ban Yoo Charoen
Asoke Dindaeang Rd
10310 Bangkok
THAILAND

Center for Development and Population Activities
1717 Massachusetts Av, N.W.
Suite 202
20036 Washington D.C.
USA

Catholics for a Free Choice
1436 U St. N.W.
Suite 301
20009 Washington D.C.
USA

Domestic Abuse Prevention and Training
c/o Alexandra Health Clinic
P O Box 175 Bergulei
Johannesburg
SOUTH AFRICA

Society for Women and AIDS in Africa
P O Box 65504
Dar es Salaam
TANZANIA

Tanzania Media Women's Association
P O Box 6143
Dar es Salaam
TANZANIA

Women's Health Research Net in Nigeria
Dept of Private Law
Ahmadu Bello University
Zaria
NIGERIA

Community Health and Development Programme
Rosary Hospital
P O Box 106 Police Lines
Gujarat
PAKISTAN

Women and Health Foundation
P O box 4263
1009 AG Amsterdam
THE NETHERLANDS

Women's Action Group
Box 135
Harare
ZIMBABWE

More reference addresses will be published in the next issue of Women's World.

RESOURCES

The following is a list of some of the books and reports we came across while researching articles on women's health. Although this is not an extensive list, we hope you will find it useful.

Women's Global Network for Reproductive Rights, Newsletter 44,July to September 1993

Health Action, Appropriate Health Resources and Technologies Action Group Ltd, Issue 6, September - November 1993

Women's New Digest, No. 31, Nov. 1993

Speak Out/Taurai/Khulumani, Issue No.25 1994

Women and Health in Japan, No. 11, Winter 1993 - 94

Women Wise, A Quarterly Publication of the Concord Feminist Health Center, Vol. 16 No. 3, Fall 1993

Africa Women & Health Magazine, Vol 1 No.2, Jan. - March 1993

WHO Press Release, 10 April 1994

Women's Health Newsletter No. 20

Out Look, Volume 11, No. 3, Sept 1993
Panos World AIDS, ISSN: 0954 6510, No.29, Sept 1993

AIDS Action, Issue 23, Dec. 1993 - Feb 1994

Conscience, Vol xiv, No. 4, Winter 1993/94

Women's Health Journal, Latin American and Caribbean Women's Helath Network, Isis International, 4/93

Women's Health Project, Newsletter No. 6 July 1993

CAFRA News, Vol 7, No. 4, Oct. - Dec 1993
Let's Discuss Women and Health Issues, a trainer's guide for awareness raising, problem identification and analysis and project formulation with grassroots groups, NGOs and development staff, Philip Langley (ed) with contributions from Philip Langley, Apollonoa Kerenge, Anthony Nchari & Precious Emeleu

Vaccination Against Pregnancy Miracle or Menace? Judith Richer

The Population Council, The development of Microbicides: A new method of HIV Prevention for women, by Christopher J Elias and Lori Heise

Reproductive Health Matter, Making abortion safe and legal: the ethics and dynamics of change, Vol. 2 Nov. 1993

Isis - Women's International Cross Cultural Exchange

Isis - Women's International Cross Cultural Exchange (Isis-WICCE) is a woman's international resource centre. It was started in Geneva, Switzerland, in 1974. *Isis - WICCE's* objectives are to improve women's economic, social and political situations. This is done through the exchange of information internationally and the promotion of ideas, actions and solidarity networks, which assist in the eradication of injustice based on sex discrimination.

Each year the Exchange Programme and other activities of the organisation are focused on a specific theme. In 1984 our theme was Media and Communication; 1985 it was Women and Health; 1986 and 1987: Women and Appropriate Technology; 1988 Women Living Under Muslim Laws; Documentation and Communication was the theme for 1989 and 1990; and Poverty, Prostitution and Trafficking in Women was the theme for 1991.

We have an extensive database of 15000 contacts in 145 countries. We also have a collection of more than 100 000 items of documentation. The information covers a variety of topics from health, education, food, nutrition, and appropriate technology to media, violence against women, employment, sexuality, peace and the theories of feminism. We publish two bi-annual magazines, *Women's World* (English) and *Monde des Femmes* (French). Other services on offer are:-

The Exchange Programme - provides an opportunity for women activists working in specific areas, especially from developing countries, to meet and share ideas, skills, experiences and develop a broader perspective on the programme's specific theme. This is done during a two week orientation period. This is followed by an exchange period of two and half months. Each participant is hosted by a women's organisation in a different country . She has an opportunity to work, learn and share skills and experiences with the women in the host group and country.

Information Services - in answer to written and telephone requests, people from all over the world use our documentation centre as a primary source of research.

Training and technical assistance - are offered in the areas of communication and information management.

Women's information update - is in English, French and Spanish. It gives listings and anthologies on specific subjects, book reviews, news, information about groups, and conferences. All this information coming into our documentation centre is available to individual women and women's groups worldwide.

International Feminist Network (IFN) - IFN mobilises international support for campaigns organised by women. Subjects covered are varied, among which are issues of justice, peace, sex discrimination, and violence.

Subscribe to Women's World and Learn More About Other Women!

Women's World is a bi-annual feminist publication, which gives a global vision on the themes of the Exchange Programmes. This includes theoretical articles, case studies, information about other women's groups, and available resources.

Subscription entitles you to receiving Women's World, Women's Information Update as well as access to Isis-WICCE's information services and data bank.

Subscription is open to any women's groups and to individuals. Subscription rates per year including postage are:-
US$50 - Supporting subscription
US$40 - Institutions
US$20 - Individuals

Publications Exchange is also considered, as well as free copies of publications to women's groups with scarce resources.

Please send your subscription fees payable to Isis - WICCE, to:-
Women's World
Box 4934
Kampala
Uganda
East Africa

Other Publications Available

Isis International Bulletin (1974 - 1983) - US$10
Classic collections are still available on issues such as women and food, migration, media, national liberation movements, peace, motherhood and new technology.

Women in Development:- A Resource Guide for Organisation and Action. Isis 1983, US$25 plus postage

Women's World dossiers, back numbers; US$20 plus postage
no.2 (1984) Women Transform Media
no.4 (1984) Giving and Taking (communication)*
no.6 (1985) Well Being/Being Well *
no.8 (1985) Health to Women
no.10 (1986) Looking at Appropriate Technology
no.12 (1986) Appropriate Technology for Our Earth (with Spanish supplement)
nos. 13, 14, 15, 16 various topics
no.17 (1988) Debt Crisis*
no.18 (1988) AIDS
no.19, 20 (1989) Refugees
NB * only photocopies available on request for US$15 plus postage
* claims for missing numbers cannot be accepted six months after the publication of each issue

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