

**CONFERENCE ON THE ROLE OF  
TRADITIONAL/RELIGIOUS  
LEADERS ON REDUCTION OF  
MATERNAL MORTALITY AND  
SURVIVAL OF WOMEN**

**SOKOTO 2008**

### **Introduction:**

One of the major development and health challenges facing developing countries, particularly those in Africa, is the unacceptably high levels of maternal deaths arising from complications related to pregnancy and child birth. An estimated half a million women die every year in child birth or due to pregnancy related causes. As a result, more than one million children are left motherless and vulnerable. Also, for every woman who dies, an estimated 20 or more other women experience serious complications such as obstetric fistula. In Nigeria, an estimated 30,000 women die yearly from complications related to pregnancy and child birth, a majority of them in North West and North East regions of the country. This does not have to be the case: these lives could be saved if all women had access to Reproductive Health (RH) services, care during pregnancy and skilled medical attendance and emergency obstetric care to handle complications. Increasing the survival of mothers is a crucial international development challenge. Both the Programme of Action of the International Conference on Population and Development, the Millennium Development Goals (MDGs) and Maputo Declaration and Action Plan call for concerted action to reduce maternal mortality, promote maternal health and empower women with knowledge so that they are more useful to themselves, their families and communities. Furthermore, several countries have a “Roadmap” for reduction of maternal mortality.

To reduce maternal mortality and promote maternal health traditional and religious leaders have a critical role to play. Though changes have been happening, still, most segments of communities have remarkable levels of trust in religious and traditional leaders-generally higher than their trust in other societal institutions. Traditional and religious leaders are listened to and respected. They shape opinions and influence decisions even at family levels. They play vital roles in the lives of people. Therefore, traditional and religious leaders can make substantial contributions to facilitate reduction in maternal mortality and promote well being of families and communities provided they are sufficiently informed, effectively mobilized and positively challenged.

The proposed sub-regional meeting will enable traditional and religious leaders to gain a better understanding and knowledge of causes and consequences of maternal mortality, as well as provide the forum for their exchange of views and experiences from their countries towards reducing maternal mortality and increasing well being of the women. The slogan of “No Woman Should Die Giving Life” should become a reality and the driving force of these leaders.

### **Objectives of the Meeting**

- To increase knowledge and understanding of causes and consequences of maternal mortality as a key development challenge
- To strengthen the capacity of traditional and religious leaders to assist people and communities to reduce maternal mortality and to have better quality of life
- To develop a sub-regional Plan of Action that identifies concrete actions to be undertaken by the traditional/religious leaders to strengthen their partnerships and capacity to act to improve maternal mortality

- To strengthen traditional and religious leaders networks to operate in support of the ICPD PoA
- To share experiences, achievements, best practices and lessons learned

### **Expected Outputs**

- Better understanding of causes and consequences of maternal mortality among Traditional and Religious Leaders
- Better prepared Traditional and Religious Leaders as advocates for and facilitators of reduction of maternal mortality
- Increased awareness on issues of Reproductive Health, Gender and Population and Development
- Sub-regional Plan of Action that identifies actions to be taken to facilitate reduction of maternal mortality
- Better understanding of UNFPA's mandate and support for ICPD PoA and MDGs

### **The sub-themes that will guide presentations and discussions of the meeting are:**

#### **Sub-Themes:**

- Levels and causes of High Maternal Mortality and Morbidity in the sub-region
- Utilization of Health Services for antenatal, delivery and post natal care: Role of Traditional and Religious Leaders
- Men as partners in maternal health
- Maternal Mortality with focus on Fistula (VVF): Levels, Causes, Consequences, & Preventive Measures
- Rights of Women and their Role in the Family: Christian, Muslim and Traditional perspectives
- Gender Based Violence (GBV) and other harmful traditional practices against women
- Female and Girl-Child Education and its impact on maternal mortality reduction

#### **Meeting Proceedings:**

- Technical Presentations on the sub-themes
- Concrete examples from Countries on what people and different groups are doing to facilitate the fight against Maternal Mortality: Role of Churches, Mosques, CSOs, NGOs
- Discussions by Traditional and Religious leaders and adoption of a strategic PoA
- Presentation of Videos and Documentaries on the sub-themes: Maternal Health, VVF, Cancer and GBV

**Participating countries:** Benin Republic, Burkina Faso, Central African Republic, Chad, Cote d'Ivoire, Equatorial Guinea, Gambia, Ghana, Guinea, Kenya, Liberia, Mali, Mauritania, Rwanda, Senegal, Sierra Leone, Swaziland, Tanzania, Togo and Uganda.

## **Overview of Maternal Mortality and Morbidity, Levels, Trend and Consequences Presented by WHO/UNFPA**

Maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Mothers are the cornerstone of families; their health and wellbeing is fundamental to the health of the newborn babies and children. The health of mothers is inseparable from the health of newborns<sup>1</sup>. Newborns whose mothers die of any cause are three to 10 times more likely to die within two years than those whose mothers survive.

### **A typical scenario of a pregnant, poor and powerless mother in labour:<sup>1</sup>**

Rahema is lying on matting on the mud floor of her hut. The contractions are coming thick and fast now. The pain is intense, but she draws comfort from the memory that, the previous three times, the agony of childbirth had given way to the peaceful, exhausted bliss of holding her babies in her arms. Her husband's mother is on hand to help – she has, after all, given birth many times herself and seen many more children born. Water has been brought from the pump and sits in two large bowls ready to be used – one to wash the baby and the other to wash everything and everyone else; pieces of old cloth have been gathered over the months before so as to soak up any blood and bodily fluid. A kerosene lamp has been borrowed from a neighbour to cast any light needed on this dark West African night.

The delivery itself seems to go well: a girl, Mama says, now to be heard crying. Rahema lies back and gives herself up to the pleasure of there no longer being any sharp pain, only exhaustion and discomfort, and to the satisfaction of having brought another life into the world. It is a while before Mama realizes that blood is still pumping out of Rahema, forming a widening pool on the mat and the floor. She uses the rags to try to staunch the flow; to no avail. There is no sign of the placenta being delivered, as would normally happen within minutes of delivery. It is half an hour before Mama realizes that the blood flow is not going to stop and that there is serious danger. Alarmed, she runs to a neighbour for help; the husband is woken and sent on his bicycle to try to contact the Nurse at the government clinic 12 kilometres away.

By the time the Nurse arrives, two hours have passed and it is too late for Rahema, whose life has drained away with her blood. There is nothing the Nurse can do for the woman. Instead he tends to the newborn baby, while cursing under his breath the fees he has to charge for attending a birth at the clinic that means so many women in this subsistence farming community opt to go it alone. He knows he could so easily have saved her – an injection of oxytocin, perhaps, or a manual delivery of the placenta – but knows just as clearly that this desperate experience will be repeated on many other nights and days over the months and years to come.

Just one story – but one that is repeated in one form or another on average 1,500 times every day around the world, and with particular terrible regularity in sub-Saharan Africa and South Asia. In other cases the complication might be not postpartum bleeding but an obstructed labour that demands, but does not receive, a caesarean section. In many such instances the baby will die along with the mother; in others, the mother will survive but would have lost her child.

### **Global Situation**

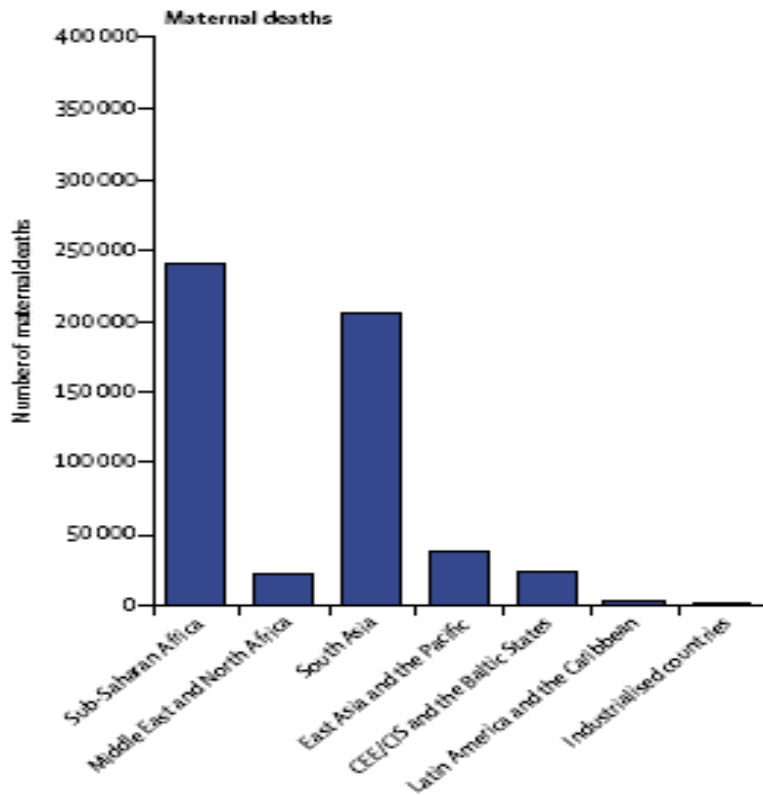
More than twenty years following the launch of the Safe Motherhood Initiative in Nairobi Kenya in 1987 and subsequent adoption by countries, the maternal mortality levels in Africa have sadly remained high with minimal decline in a few countries. Deeply concerned about the persistently high maternal mortality and morbidity, 189 countries at the Millennium Summit in 2000, set the Millennium Development Goals (MDGs)<sup>2</sup>. The fifth of the eight MDGs is focused on improving maternal health. Reduction of maternal mortality ratio, by three quarters of the 1990 levels by 2015 is one of the two targets for measuring progress in improving maternal health. The second indicator is the proportion of births attended by skilled birth attendants.

Of the estimated total of 536,000 maternal deaths world wide in 2005, developing countries accounted for 99% or 533,000 of these deaths. Slightly more than half of the maternal deaths 270,000 occurred in sub-Saharan Africa region alone, followed by south Asia (188,000)<sup>3</sup>. Thus, sub-Saharan Africa and South Asia accounted for 86% of global maternal deaths. Developing regions had an average maternal mortality ratio of 450 deaths per 100,000 live births in stark contrast to developed regions at 9 deaths per 100,000 live births. Among the developing countries, sub-Saharan Africa had the highest MMR at 900 in 2005, followed by South Asia, 490, Oceania 430, South-Eastern Asia 300, Western Asia 160, Northern Africa 160, Latin America and the Caribbean 130, and Eastern Asia 50. Figure 1 shows the regional variation in maternal deaths in 2005.

These regional estimates mask the wide variations among countries. A total of 14 countries had MMR of at least 1000 of which all excluding Afghanistan were in sub-Saharan African region<sup>3</sup>. These countries in descending order are Sierra Leone (2100), Niger (1800), Afghanistan (1800), Chad (1500), Somalia (1400), Angola (1400), Rwanda (1300), Liberia (1200), Guinea Bissau (1100), Burundi (1100), Malawi (1100), and Cameroon (1000). By contrast, Ireland had an MMR of 1. Globally, India has the highest number of maternal deaths -117,000, followed by Nigeria -59,000.

The African regions constitute only 12 percent of the world's population and 17 percent of all births in the world but contributed to over 51% of the maternal deaths. The adult lifetime risk of maternal death (the probability that a 15-year-old female will die eventually from a maternal cause) is highest in Africa (at 1 in 26) followed by Oceania (1 in 62) and Asia (1 in 120), while the developed regions had the smallest life time risk (1 in 7300). Of all the 171 countries and territories for which estimates were available in 2005, Niger had the highest estimated lifetime risk of 1 in 7, in stark contrast to Ireland, which had the lowest lifetime risk of 1 in 48,000.

**Figure 1: Regional Variation in Maternal Deaths**



*Developed with Data from WHO, UNICEF and WHO maternal mortality estimates for 2000<sup>4</sup>*

The comparison between the burden of maternal mortality in developed and developing countries has long been cited as the “largest discrepancy of all public health statistics” and is substantially greater than that for child or neonatal mortality.<sup>5</sup>

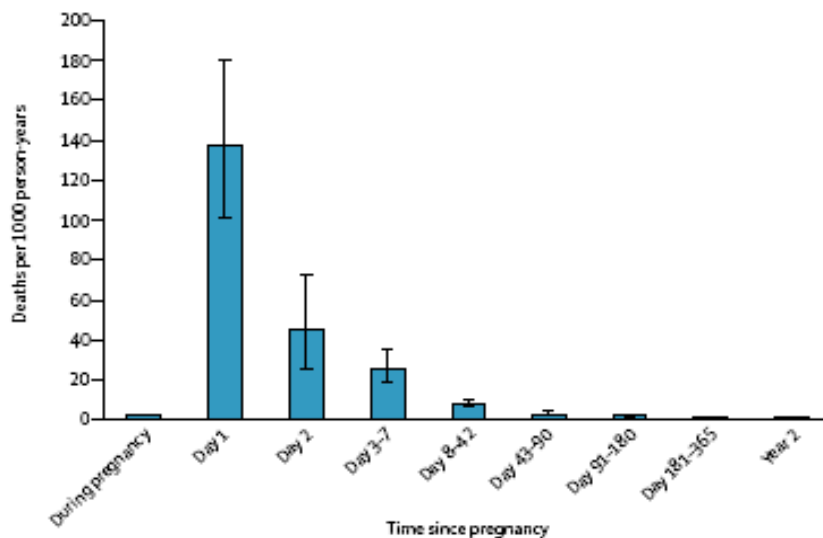
### **Trends in maternal mortality**

A recent analysis of changes in maternal deaths between 1990 and 2005 indicates slow and uneven progress towards the achievement of the first target of MDG 5 (to reduce maternal mortality ratio by three quarters, between 1990 and 2015)<sup>6</sup> Global maternal mortality estimates for 1990 and 2005 are 428 and 400 maternal deaths per 100,000 live births respectively and are far from the MDG target of 141 per 100,000 live births by 2015. Overall the global decline in maternal mortality ratio was 5.4% and the annual decline was less than 1%. It is estimated that an annual decline of 5.5% in global maternal mortality ratios is required between 1990 and 2015 to achieve the MDG target. While important gains have been made in some world regions such as Eastern Asia, where the highest annual decline of 4.2% was seen, and Northern Africa (3.0%), South-Eastern Asia (2.6%) and Latin America and the Caribbean (2.0%). However, maternal mortality ratio declined annually on an average of only 0.1% in sub-Saharan Africa between 1990 and 2005.<sup>3</sup> Countries in sub-Saharan Africa make up majority of the 68 countries that are currently off track to achieving the MDGs<sup>7</sup>.

### Timing of Maternal Deaths

Most maternal deaths seem to occur between the third trimester and the first week after the end of pregnancy. Mortality can be extremely high on the first and second days after birth<sup>8,9</sup>. For example, new data from Matlab Bangladesh show that maternal mortality rates were more than 100 and 30 times higher on the first and second day after birth respectively.<sup>10</sup> These findings provide strong support for prioritization of strategies that focus on skilled attendant at birth and emergency obstetric care. Mortality rates can be especially high after an abortion or stillbirth. In Bangladesh for example, pregnancies ending as abortions or stillbirths accounted for more than half of maternal deaths within the first week after the end of pregnancy, and 50% within the first six weeks. These data have implications for the timing of postpartum care and the duration that women should routinely have access to skilled care after birth. Figure 2 shows the timing of maternal deaths

**Figure 2: Timing of Maternal Deaths**



Source: Hurt LS, Ronsmans C<sup>10</sup>. Black lines show 95% CI

### Inequalities in the distribution of risks of maternal deaths

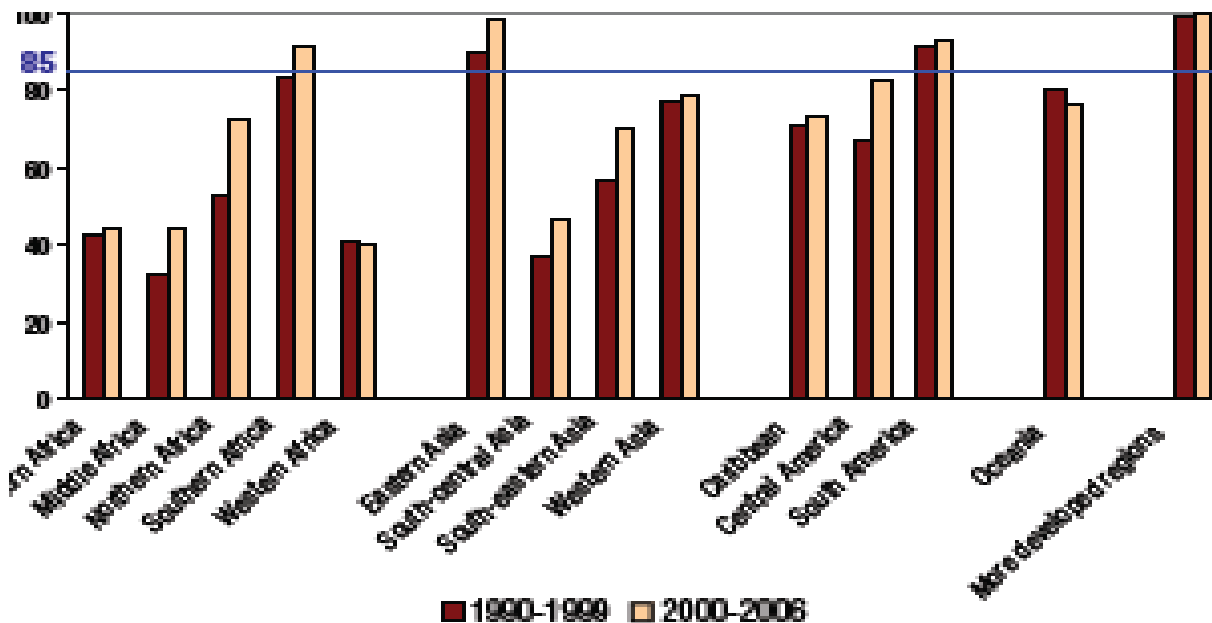
The main difference in maternal mortality between the world regions cannot simply be explained by variations in economic growth.<sup>11</sup> For example, Vietnam and Sri Lanka have achieved much lower levels of maternal mortality than Yemen and Cote d'Ivoire, despite being matched on gross national income per head figure<sup>4,12</sup>. National figures mask substantial internal geographical, economic and social variations which are not limited to developing countries. Differences in maternal mortality between urban and rural areas within poor countries are also substantial and may be explained in part by differences in physical access to obstetric care between urban and rural areas. The link between poverty and maternal health has been clear for more than a century and is supported by extensive evidence from rich countries.<sup>13,14</sup>

The second indicator for tracking MDG 5 is the proportion of births with skilled attendants. Just over half of the world's mothers deliver with a skilled attendant leaving

more than 60 million women giving birth without skilled care every year mostly at home. Three regions (south east and east Asia, north Africa and Latin America) have progressed, but the last decade has seen no progress in sub-Saharan Africa, where the risks of maternal and neonatal deaths are highest.<sup>15</sup> Postnatal care coverage is even lower than skilled attendance, despite the fact that at least half of maternal deaths and 4 million neonatal deaths occur in the first days after birth<sup>1</sup>.

Figure 3 shows the estimates of births attended by skilled attendants for regions and sub-regions comparing the two periods 1990 to 1999 and 2000 to 2006 against the target of 85 % by 2010 recommended at ICPD + 5. In every sub-region, the use of skilled health workers has increased, except in Western Africa where it remained stagnant. Highest increases were seen in Northern and Middle Africa, Central America and all of Asia except Western Asia.

**Figure 3: Skilled attendant at birth**



Source: Factsheet: Proportion of births attended by a skilled health worker 2008 updates: Department of RHR WHO 2008<sup>16</sup>

The coverage of antenatal care varies too. In Peru, 87% of pregnant women had at least four antenatal care visits, whereas in Ethiopia the coverage was only 12%. There are many reasons why women do not receive the care they need before, during and after childbirth. In some remote areas, there may be no availability of professional care or, if available, the care may not be of good quality. In other cases, the women may lack access to health facilities, because there is no transportation or because they cannot afford to pay the costs of the transport or the health services' user-fees. Also cultural beliefs or a woman's low status in society can prevent a pregnant woman from getting the care she needs.

Assessment of reasons for not giving birth in a health facility from the 2004 DHS for Chad among women provide some insights. For instance 29.7% claimed the facility was too far, 20.4% said it was too late to get there, for another 19.6% it was that they felt better at home while 11.7% said they were not sick and only 9.7% gave cost as a reason.<sup>18</sup> To improve maternal health, barriers to accessing health services must be identified and tackled at community level, and gaps in the capacity, coverage and quality of maternity care and the effectiveness of the health system must be addressed.

### **Causes of Maternal Deaths**

Women die from a wide range of direct or indirect causes in pregnancy, childbirth or the postpartum period. Globally, about 80% of maternal deaths are due to direct causes. The four major killers are: severe bleeding (mostly postpartum haemorrhage), infections (mostly sepsis), hypertensive disorders in pregnancy (usually eclampsia), and obstructed labour. Complications after unsafe abortion cause 13% of maternal deaths. Among the indirect causes (20%) of maternal death are diseases that complicate pregnancy or are aggravated by pregnancy, such as malaria, anemia, HIV/AIDS, and cardiovascular diseases.

In sub-Saharan Africa, the combined maternal mortality ratio for severe bleeding, hypertensive diseases, and infections is staggering at almost 500 deaths per 100,000 live births, compared with fewer than 300 per 100,000 in south Asia, just over 100 in Latin America and the Caribbean and four per 100,000 in developed nations. Of an estimated 166,000 deaths from haemorrhage globally each year, and estimated half occur in sub-Saharan Africa and more than a third in south Asia. Haemorrhage has long been known to be “one of the major cause of maternal mortality which women were dying needlessly for want of common skills that every midwife and practitioner should possess” Whether or not a woman dies from bleeding during or after childbirth depends largely on access to timely and competent obstetric care.<sup>19,20</sup>

More than one quarter of pregnancies worldwide, about 52 million annually, end in abortion. Many of these procedures are clandestine, performed under unsafe conditions. Estimates of maternal mortality ratios from induced abortion by WHO, puts the figures at 37 deaths per 100,000 live births in sub-Saharan Africa, 12 per 100,000 in south Asia, and 23 per 100,000 in Latin America and the Caribbean<sup>21</sup>. However, much higher estimates have been reported globally and in individual studies, especially in countries where abortion is illegal or restricted. For example, in a study in 12 hospitals in Benin, Cote d'Ivoire, and Senegal, almost all deaths in early pregnancy were due to induced abortions and a third of all maternal deaths were due to unsafe abortions. Abortions was rarely given as a cause of death in studies in Afghanistan, Egypt or Senegal, conversely, induced abortion was the leading cause of maternal death in rural areas in Tanzania and Bangladesh in the 1980s, with maternal mortality ratios as high as 80 and 100 deaths per 100,000 live births respectively.<sup>22</sup>

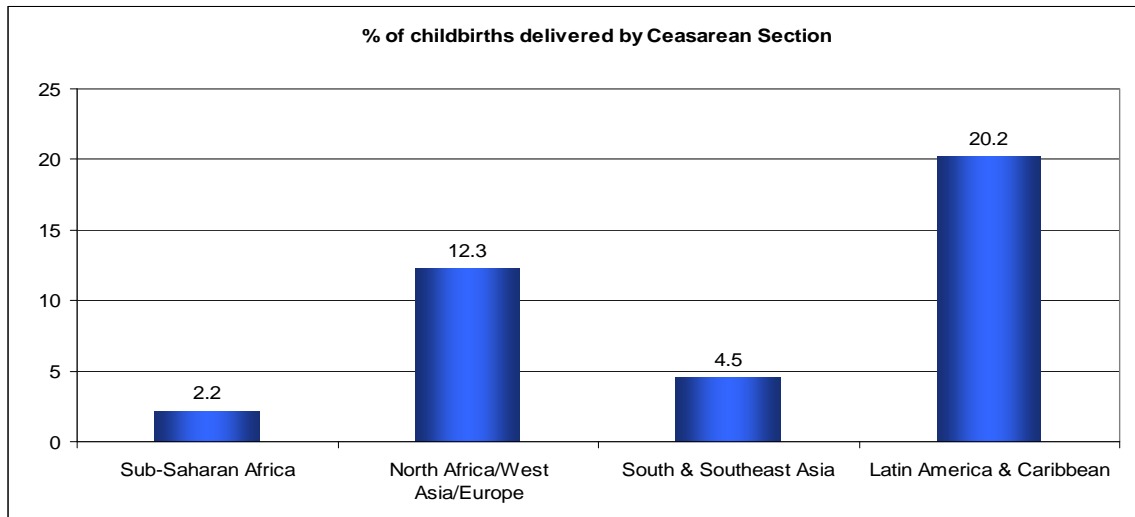
HIV/AIDS has become a leading cause of pregnancy-related deaths and there is growing evidence of its importance as a cause of death in population with a high prevalence of HIV, such as Malawi, Zimbabwe and South Africa where the AIDS epidemic is thought

to have reversed previous gains in maternal mortality.<sup>23</sup> In the Rakai district of Uganda, the maternal mortality ratio was five times higher in HIV infected than in HIV uninfected women.

Most maternal deaths are avoidable as the medical solutions to prevent or manage the fatal causes are well known. Skilled care at birth backed by emergency obstetric can make the difference between life and death. For instance, if unattended, severe bleeding in the third stage of labour can kill even a healthy woman within two hours. An injection of the drug oxytocin given immediately after childbirth reduces the risk of bleeding very effectively.

Sepsis, the second most frequent cause of maternal death, can be widely reduced if aseptic techniques are respected. The third-cause, pre-eclampsia, is a common hypertensive disorder in pregnancy, which can be monitored. Although pre-eclampsia cannot be completely cured before the delivery, the administration of drugs like magnesium sulfate can lower a woman's risk of developing convulsions (eclampsia), which can be fatal. Another frequent cause of maternal death, obstructed labour, can be prevented or managed by skilled birth attendants. Obstructed labour occurs when the fetus' head is too big compared to the mother's pelvis or if the baby is abnormally positioned. A simple tool to identify problems in labour early is the partograph, a graph of progress of labour and the maternal and fetal condition.

**Figure4: Caesarean-Sections by Regions**



Skilled practitioners can use the partograph to recognize and deal with slow progress before labour becomes obstructed, and, if necessary, refer the woman to caesarean section. The rates of caesarean sections point to the inequities in access to these lives saving interventions and stress the need for skilled attendant and access to emergency obstetric care. Figure 4 shows the difference in caesarian section rates by regions of the world. A rate of 5% of all birth is one of the indicators for measuring met needs for emergency obstetric care.

While we know that Traditional birth attendants (TBAs) are the main providers of care during delivery for millions of women, especially in settings where maternal mortality rates are high, it is evident from the kinds of interventions required to save lives, that they can not be substitutes for skilled attendants at birth. The roles for TBA will need to be redefined, e.g. in Burundi the involvement of TBAs to promote the use of skilled attendance has increased facility deliveries in one district.<sup>24</sup> Malaysia has successfully used TBA training as a step towards skilled care.<sup>25</sup>

Although the highest risk of death for mother and child is during birth and the 24 hours after birth, saving the maximum number of lives requires a continuum of care from pre-pregnancy, through birth and into the postnatal period and on to child health services and promotion of effective links between communities and health facilities. The effect in each period is dependent on the foundation set in the preceding period, for instance, intrapartum care is more likely to save lives if this follows effective antenatal care.

### **Other Factors associated with maternal mortality**

Survival rates depend upon the distance and time a woman must travel to get skilled emergency medical care. The “three delays” raise mortality rates, Delay in seeking care because women may have to get permission from family males, or may not recognize the emergency, or may fear hospital practices. Delay in arriving at an emergency care facility: transportation may be unavailable or unaffordable or take too long. Delay in receiving care from providers: richer patients or males may be seen first; facilities may lack staff, equipment or supplies; or care may be unaffordable. It is estimated that the first and second delay may be associated factors in 20 and 40 percent of maternal mortalities respectively. This implies the need to find innovative ways of working with communities to reduce these two delays.

Mortality is relatively high at young maternal ages, is lowest at age 20-29 years, and then increases as maternal age increases. Young maternal age below 18 years has been associated with various adverse pregnancy outcomes, such as obstructed labour and pre-eclampsia, and young women’s pelvises may not yet be large enough to accommodate childbearing.<sup>26</sup> Older women are far more clearly at increased risk of maternal deaths. As women get older, they are at higher risk of haemorrhage, pregnancy-induced hypertension and uterine prolapsed.<sup>27</sup> Age effects are particularly pronounced where maternal mortality is high; where mortality is lower, age effects are not as great. Evidence from Sweden and the United States, for example, indicates that older women are not at markedly increased obstetric risk.

Higher order births-fourth birth and higher are associated with substantially increased risks of negative outcomes compared with birth order two and three. Uterine prolapse for example is much more common among high-parity women as is post partum haemorrhage. First births, however, also appear to be more risky than second and third births. Women having a first birth are more likely to suffer from pre-eclampsia and eclampsia than women having second or later births.

A study of hospital data from Latin America has shown that short interpregnancy intervals particularly of less than six months were associated with increased risk of adverse maternal outcome.<sup>28</sup>

It is estimated that one in three deaths related to pregnancy and childbirth could be avoided if all women had access to contraceptive services. That means some 175,000 women each year could be saved, and many more could avoid severe or long-lasting injuries. Expanding access to client-centred information and services, where a range of effective contraceptive methods is offered and responsive counselling provided, reduces the number of unplanned pregnancies. The unwanted pregnancies are disproportionately higher among young, unmarried girls who often lack access to contraception, is a key reason why so many seek out abortions. The use of modern contraceptive methods, including voluntary sterilization, has generally increased rapidly over the past 30 years, especially in countries with strong family planning programmes. However, progress has stalled in many low-income countries. The use of modern contraceptive methods has changed little in the past decade in sub-Saharan Africa, and is still low (less than 10 per cent in many countries). In its effort to draw global attention to FP, UNFPA is focusing on Family Planning and the theme for the 2008 World Population Day is Family Planning, “Its a right, Lets make it real”.

### **Maternal Morbidity and their consequences**

Maternal mortality ratios are indicative of the overall state of maternal health for a particular population. For every woman who dies, some twenty others face serious or long-lasting consequences. Women who survive severe, life-threatening complications often require lengthy recovery times and may face long-term physical, psychological, social and economic consequences. The chronic ill-health of a mother puts surviving children, who depend on their mothers for food, care and emotional support, at great risk.

### **Obstetric Fistula**

Obstetric Fistula is one of the most devastating complications and disabilities of childbearing. It is caused by prolonged labour without prompt medical intervention. The affected women is left with chronic incontinence to urine and feaces (continuous leaking) and other prolonged medical disabilities and effects such as damaged pelvic structure, chronic infection, depression and impaired productivity. Obstetric Fistula also leads to social consequences such as marital problems, household dissolution, social isolation, shortened life spans and possible contemplation of suicide. In addition, the cost of medical care and lost productivity arising from immobility can drive women and their families into poverty.

### **Uterine Prolapse**

Sometimes called, a ‘fallen womb’, uterine prolapse is a debilitating condition in which the supporting pelvic structure of muscles, tissue, and ligaments gives way, and the uterus drops into or even out of the vagina. This can limit a woman’s mobility, making it

impossible for her to perform routine household chores or have sex. The condition is often accompanied by chronic back pains and urinary incontinence. Many women who suffer from it are abandoned by their husbands and end up as social outcasts in their own communities. Uterine prolapse can be triggered by difficult, prolonged labour, frequent pregnancies, inadequate obstetric care, and carrying heavy weights. In Nepal, where fertility is high and women carry heavy loads on their backs, one out of ten women is estimated to suffer from the condition.

### **Perinatal Depression**

Depression is one of the most prevalent complications of pregnancy and childbirth: About 10 to 15 per cent of women in developed countries, and an even higher percentage in developing countries, experience serious depression during pregnancy or after childbirth. Perinatal depression is a severe disorder which needs appropriate treatment and care. It differs from postpartum blues, which are experienced by nearly half of women following childbirth, but which spontaneously disappear, usually in a few days. Perinatal depression is associated with maternal physical morbidity, substance abuse and suicide. Gender-based violence can be a cause of depression and can also increase a woman's risk of it. The consequences of maternal depression on the child can be severe as well, including premature delivery, low birth weight, malnutrition, poor growth and stunted emotional, cognitive and behavioral development.

### **Way Forward**

Evidence from several countries suggests that a 75 percent decline in maternal mortality can be achieved within a shorter period than it took the developed countries to achieve it. Malaysia and Sri Lanka have seen declined in the maternal mortality ratio of more than 50% between 1960 and 1980s. More recent evidence from Honduras and Egypt indicate that they were able to reduce the MMR by over 50% in less than 7years.<sup>29,30</sup> Bangladesh has also recorded some substantial decline in the Matlab district.

The achievement of these countries tells an important and encouraging story. First they show that substantial falls in maternal mortality are feasible. Second the successes give rise to some optimism about achieving the MDG-5 target of a 75% reduction. These substantial achievements are thought to be due to a combination of factors including improving access to family planning information and services, increased coverage with skilled attendants at birth and emergency obstetric care, together with strong political commitment and appropriate financial investments. As the countdown to 2015 begins, there is need for all to join hands in ensuring that no woman dies giving life.

### **The role of men and other influential stakeholders**

Reproductive health programmes have gained increased awareness of the role of men in maternal and new born health as partners, fathers and community members. Their role is defined by interplay of cultural, social and economic factor, which do not in general prepare men to participate in the crucial aspect of pregnancy, childbirth and postnatal care. Men are key decision-makers in maternal and newborn care-seeking behaviour.

They need to understand the needs, risks, and danger signs of pregnancy, childbirth and postpartum period to support women. This role should be actively promoted for their involvement and support.

Community leaders, family members, TBAs and other influential stakeholders can also be positive agents for supporting women and newborn health needs and decision making. Depending on the context, elderly family members such as mother in-laws, have a strong, culturally sanctioned power for decision-making and care, for example, the diet of pregnant women, work load, and household responsibilities and the use of emergency services.

Traditional rulers and religious leaders have a key role to play particularly in community education for individuals and families to know that while pregnancy is not a sickness, there is need to seek care and to be prepared for the complications. The establishment of community funds to support poor households to access care if emergencies arise contributes to pregnancy outcomes; an example is the establishment of mechanisms for transporting women to appropriate facilities during emergencies, which will go a long way to ensure that the first and second delays are reduced.

One other area particularly for the religious leaders will be community based maternal mortality audits to find out if there were any actions that could have been taken either at the household or community level to have prevented the death of the woman. This is particularly important since religious leaders are aware when births or deaths occur within their communities.

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## **HIV/AIDS AND MATERNAL MORTALITY**

By

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### **Introduction**

Infection with the Human Immunodeficiency Virus (HIV) and the resultant Acquired Immunodeficiency Syndrome (AIDS) have become a global pandemic. It is however more prevalent and has a more devastating impact in Sub-Saharan Africa. This presentation highlights the route of transmission of HIV, the scope of the HIV pandemic with special reference to Sub-Saharan Africa, the impact of HIV/AIDS, issues of HIV infections in women, HIV and reproduction, Mother to child transmission of HIV and the relationship between HIV/AIDS and maternal mortality. The reasons why women in Sub-Saharan Africa are more vulnerable to HIV infection and maternal mortality is also highlighted and ways of reducing the HIV prevalence and maternal mortality are suggested. Finally, the role of traditional / religious leaders in the reduction of the spread and impact of HIV/AIDS and maternal mortality have been articulated.

### **Routes of transmission of HIV**

Sexual contact is the main route of transmission of HIV and it accounts for over 80% of all HIV infections. Transmission can occur in both heterosexual and homosexual relationships, and either the man or the female partner can infect one another. Transmission from infected mother to her new born child accounts for about 10% of total infections. Other means of transmission include blood transfusion, injection drug use, and use of unsterilized sharp equipments. It is important to note that HIV is not transmitted through casual contacts including sharing of living rooms/bed, cutleries etc.

### **Scope of HIV Pandemic with Special Reference to Sub-Saharan Africa**

HIV has been reported in virtually every country. It is however more prevalent and its impact found to be more devastating in Sub-Saharan Africa. The 2007 UNAIDS/WHO AIDS epidemic update (Table 1) showed that -

- At the end of 2007 there were 33.2 million persons living with HIV/AIDS, with the majority of 22.5million (68%) in Sub-Saharan Africa.
- 1.8 million (68%) of newly acquired HIV infections occurred in Sub-Saharan Africa.
- In sub-Saharan Africa, the national HIV prevalence averaged 5%, but varied from 0.7% - 25.9%. (Table 2)
- Young women aged 15-24 in sub-Saharan Africa are three times more likely to become HIV positive than young men of the same age
- Unlike other regions where about half of the population of HIV are women, in Sub-Saharan Africa, the majority of people (61%) living with HIV are women.

**Table 1**

**REGIONAL HIV AND AIDS STATISTICS - 2007**

AIDS Epidemic update – December 2007, UNAIDS and WHO 2007

REGION	Positive Adults & Children	Adult Prevalence	Deaths due to HIV/AIDS
Sub-Saharan Africa	22.5 million	5.0%	1.6million
Middle East and North Africa	380,000	0.3%	25,000
South and South-East Asia	4.0million	0.3%	270,000
East Asia	800,000	0.1%	32,000
Oceania	75,000	0.4%	1,200
Latin America	1.6million	0.5%	58,000
Caribbean	230,000	1.0%	11,000
East Europe and Central Asia	1.6million	0.9%	55,000
Western and Central Europe	760,000	0.3%	12,000
North America	1.3million	0.6%	21,000
<b>TOTAL</b>	<b>33.2</b>	<b>0.8</b>	<b>2.1million</b>

**Table 2**

**HIV PREVALENCE IN SOME AFRICAN COUNTRIES**

(Adults aged 15-49 years)

(Recent Population - based HIV surveys) - UNAIDS 2007

S/N	Country	HIV Prevalence (Year)
1.	Benin Republic	1.2% (2006)
2.	Botswana	25.2% (2004)
3.	Burkina Faso	1.8% (2003)
4.	Burundi	3.6% (2002)
5.	Cameroon	5.5% (2004)
6.	Central African Republic	6.2% (2006)

7.	Chad	3.3% (2005)
8.	Cote d'Ivoire	4.7% (2005)
9.	Equatorial Guinea	3.2% (2004)
10.	Ethiopia	1.4% (2005)
11.	Ghana	2.2% (2003)
12.	Guinea	1.5% (2005)
13.	Kenya	6.7% (2003)
14.	Lesotho	23.5% (2004)
15.	Malawi	12.7% (2004)
16.	Mali	1.3% (2006)
17.	Niger	0.7% (2006)
18.	Rwanda	3.0% (2005)
19.	Senegal	0.7% (2005)
20.	Sierra Leone	1.5% (2005)
21.	South Africa	16.2% (2005)
22.	Swaziland	25.9% (2006-7)
23.	Uganda	7.1% (2004-5)
24.	Tanzania	7.0% (2004)
25.	Zambia	15.6% (2001-2)
26.	Zimbabwe	18.1% (2005-6)

### **Impact of HIV Infections**

The impact of HIV/AIDS at individual, family, community and society levels in Sub-Saharan Africa is overwhelming with adverse demographic and socio-economic consequences. The death toll is high with 76% of the 2.1million HIV deaths in 2007 occurring in Sub-Saharan Africa and the life expectancy in most African countries is falling (53 years in 1991, 51 years in 2003). The health system is overloaded with HIV/AIDS cases and the numbers of orphans have increased significantly (over 900,000 in 2001). Most of the deaths and the sick are young people within the productive age group thereby affecting the labour force in the productive sector - agriculture, manufacturing and other industries, as well as security agents, professionals – lawyers, doctors, pharmacists, etc.

### **HIV Infection in Women**

Young women aged 15-24 in sub-Saharan Africa are three times more likely to be HIV positive than men of same age. Unlike in developed countries where about half of the population of HIV are women, in sub-Saharan Africa majority of the people (61%) living with HIV are women.

If not properly cared for, an HIV infected woman will die from AIDS if antiretroviral treatment is not given and her children will become orphans in the event of her death. She may also infect her partner (if not already infected).

HIV may also reduce the chance of a woman becoming pregnant from protracted illness and makes her prone to pelvic inflammatory disease that may lead to tubal damage.

### **Pregnancy and Mother-To-Child Transmission of HIV**

Mother - to - child transmission of HIV is a major concern in an HIV positive pregnant woman. If no intervention is undertaken, about 25 to 40 percent of babies born to such mothers will contract the infection during the period of pregnancy, labour/delivery or through breastfeeding. Over 90% of childhood HIV infections are contracted through this route and majority occur in sub-Saharan Africa. HIV sero-discordant couples can be managed to prevent a newborn baby and indeed the uninfected partners from getting infected.

### **HIV/AIDS and Maternal Mortality**

The extent of the contribution of HIV to maternal mortality is difficult to fully quantify as the status of many pregnant women is unknown. A recent systemic review indicates that in Sub-Saharan Africa, HIV/AIDS contributes significantly (over 6%) to maternal mortality. HIV impacts on direct (obstetrical) causes of maternal mortality by associated increase in pregnancy complications such as anaemia, post-partum haemorrhage and puerperal sepsis. HIV is also a major indirect cause of maternal mortality by an increased susceptibility to opportunistic infections such as tuberculosis, anaemia and pneumocystis carinii pneumonia.

### **Reasons Why Women in Sub-Saharan Africa are more Vulnerable to HIV Infection and Maternal Mortality**

The following are some reasons for vulnerability to HIV and Maternal deaths -

- Biological vulnerability especially for young girls who are forced into early marriage.
- Poverty - Many young girls and married women are of low socio - economic status. Hence they are powerless to enforce abstinence or to insist on condom use. Most women can not afford cost of hospital care without support from their husband
- Increasing incidence of sexual violence.
- Non availability /accessibility of female-controlled HIV prevention methods e.g microbicides and female condoms.
- Harmful traditional practices (e.g early marriage, discrimination against the female child, female genital cutting)
- Religious beliefs may act as barriers to utilization of available reproductive health services e.g family planning, non-blood transfusion
- Illiteracy / ignorance - Lack of access to formal and reproductive health / HIV and AIDS education

## **Ways to Reduce HIV Infection and HIV related Maternal Mortality**

The spread of HIV and HIV related maternal mortality can be reduced through the following means -

- Abstinence from pre-marital / out-of-marriage sex.
- Restriction of sexual relationship to one partner
- Used of condoms when necessary
- Use of only screened blood for transfusion
- Use of Prevention of Mother - to - child transmission (PMTCT) of HIV services by pregnant women
- Application of universal precaution at places of work and homes
- Avoidance of stigmatization
- Access to and use of antiretroviral drugs

## **Role of Traditional / Religious Leaders in Reduction Of HIV/AIDS and Maternal Mortality**

The Traditional / Religious leaders may contribute to the reduction in HIV prevalence and HIV related maternal mortality by -

- Promoting community acceptance of HIV positive persons, thereby reducing stigma.
- Mobilization of male support for HIV and reproductive health services
- Elimination of harmful cultural practices such as female genital cutting, widowhood practices etc
- Non-discrimination against the girl child / women in education, nutrition, employment, economic empowerment, etc
- Support dissemination of information on and utilization of effective family planning services
- Support utilization of modern health care services including obstetrics and Prevention of Mother - to - child transmission (PMTCT) services
- Community support systems to response positively in assisting women who require emergency obstetric services

## **Conclusion**

The HIV/AIDS epidemic intersects with the problem of maternal mortality in most developing nations. An integrated approach is needed to arrest this trend. Efforts at reducing maternal mortality must include strategies to prevent, diagnosis and offer appropriate treatment for pregnant women. The Religious and Traditional rulers have a definite role in mobilizing community participation and support.

# POVERTY AND MATERNAL MORTALITY

Presented by  
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## **Introduction**

The World Health Organization defines Health as ‘a state of complete physical, mental and social well being of the individual, the family and the community’ not merely the absence of disease or illness<sup>1</sup>. This definition recognizes health not from the perspective of absence of disease or illness but from a wider perspective. It also indicates that personal health is not simply a matter of individual decision and action but that it is dependent on several factors, many of which may be beyond the control of the individual alone. This emphasis has led to discussions about the social determinants of health and the analysis of the social conditions that determine the health of the individual as a member of the family, the community and the larger society. One very important component of these social determinates of health is **POVERTY**.<sup>2,3</sup>

This paper examines the meaning of poverty and its linkages with the health of a very important segment of the community – **Our Women**. It looks at the effect of poverty on maternal illnesses – (Maternal Morbidity) and the death of women from illness related to pregnancy and child birth (Maternal Mortality). It is hoped that the paper, in discussing the linkages between poverty and morbidity and mortality would galvanize prompt actions by religious and traditional leaders in promoting pro-poor interventions in their communities and by so doing, contribute to a significant reduction of the rate of maternal morbidity and mortality.

## **Poverty**

Poverty can be defined as “a condition, where an individual lack the means to satisfy the basic needs necessary for survival”<sup>4</sup>. It can also be looked at as “a state of marginalization and deprivation in the conditions needed to make life meaningful for individuals”<sup>5</sup>. The conditions that pose as root causes to poverty could be economical, political and social, with economic and political dimensions having primary dominance. Poverty is therefore multidimensional and manifests in different forms:

**Absolute poverty**, is usually defined in economic or monetary terms by a fixed standard such as the international one dollar (1\$) a day poverty line and is used to compare the extent of poverty across different communities.

**Food poverty** refers to a condition of members of the society whose expenditure on food are insufficient to meet the FAO/WHO recommended daily allowance of 2,250 calories per adult.

**Overall poverty** defines those individuals whose expenditure for both food and non-food items do not meet the recommended minimum and/or standards.

Other inter-related factors are

**Quality of life**, which is understood as having living conditions below acceptable standards and inadequate access to basic social services as defined by each Country's poverty profile.

**Capacity**, understood as the empowerment of individuals, institutions and communities to respond to their real needs for the improvement of quality of life.

Globally, in 2001, it was estimated that 1.1 billion people had consumption levels below the \$1 a day poverty line. The evidence provided by UNDP<sup>6</sup> and several other sources<sup>7,8</sup>, indicates that the incidence, depth and severity of poverty have been growing in African countries over the years. In Nigeria, estimated to have the third largest population of the poor in the world, the depth and severity of poverty have more than doubled between 1980 and 1996. According to the National Policy on Poverty Eradication of the Federal Government of Nigeria, the depth and severity of poverty were 0.16 and 0.080 respectively in 1980, while in 1996, the same index figures had increased to 0.358 and 0.207, indicating a worsening situation. The document also shows that poverty has been higher over the years in rural than urban areas. In 1980, the levels of poverty in urban and rural areas were 17.2% and 28.2% respectively; while by 1996 the figures for the two areas had also increased to 58.2% and 69.8% respectively.

A report from Kenya indicated a similar pattern to Nigeria. In 1994 there were about 11.5 million poor people out of 24.5 million inhabitants, while by 1997 the number of the poor had increased to 13.3 million out of 27.0 million total population. Also, the poor were found to be more in rural than urban areas. In 1994, 46.75% of the poor were from rural areas compared to 28.95% in urban areas, while in 1997 these had grown to 52.9% from rural compared to 49.2% urban.

### **Maternal health**

Maternal mortality or death, which is the focus of this conference, is an important indicator of maternal health, the well-being of women, as well as the performance of any country's health system.

The current response to maternal mortality in developing countries is weak and differs from what occurs in developed countries. In a country such as Sweden, only one maternal death may occur in any one year, while in succession of four years, no single maternal death would occur. Whenever a maternal death occurs in Sweden, it is regarded as a National tragedy for which an inquiry would be instituted. The life time risk of a woman dying during pregnancy and childbirth is 1 in 18 for Nigeria specifically, 1 in 61 for developing countries in general, whereas, it is 1 in 29,800 for Sweden (a developed country)<sup>9</sup>. Indeed, maternal mortality is one of the greatest sources of disparity between

low-income and high-income countries. Equally, maternal mortality ratios in any given country vary considerably between various geographical locations in the country and also between rural and urban populations. In Nigeria, it is considerably higher in rural than urban areas and worse in the Northeast and the Northwest geopolitical zones than in the Southwest and Southeast zones.

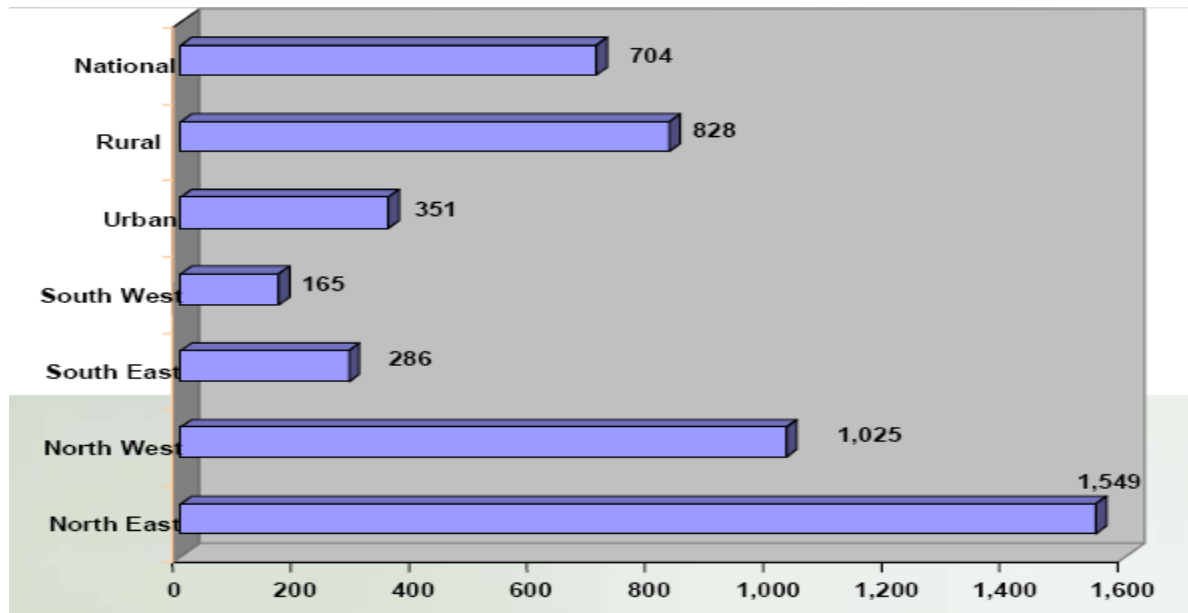


Fig 1. Comparison of Maternal Mortality Ratios Nationally and by Zones in Nigeria, per 100,000 Total Births. Source: SOGON 2004 Report of Status of Emergency Obstetrics Services in Nigeria

Similar trends therefore exist for both poverty and maternal mortality in low- and high-income countries, as well as for rural and urban populations with the poor at a disadvantage.

## **Poverty – as a cause and consequence of Maternal Morbidity and Mortality**

*a) Poverty as a cause of Maternal Morbidity.* Poor countries and poor people suffer from a multiplicity of deprivations which translate into levels of ill health that far exceed the population average. Poverty has been shown to greatly amplify every other risk factor that causes maternal mortality, hence the focus.

A large percentage of pregnant women in poor communities have been shown to lack the financial resources to pay for health services, food, clean water, good sanitation, and the other key inputs to producing good health. It is not just the lack of income that causes high levels of maternal ill health among poor people, contributory also is the fact that the health facilities serving the poor are often dilapidated, inaccessible, inadequately stocked with basic medicines and run by poorly trained staff. Furthermore, the poor are also disadvantaged by a lack of knowledge about prevention and when to seek health care.

They also tend to live in communities that have weak institutions and have social norms that are not conducive to good health. The specific linkages between the aforementioned and maternal mortality will thus be discussed in greater detail.

Poverty as a cause of maternal mortality would be discussed under six (6) factors

### 1. Access

The lead paper “Overview of Maternal Morbidity and Mortality”, has enumerated the three (3) delays that lead to maternal death. It is important to note that such delays have been eliminated or substantially reduced in many high-income countries, hence their lower rate of maternal mortality. In contrast these delays remain the defining feature of maternity care within the context of low-income countries, inclusive of those represented at this conference.

Specifically, Type I and Type 2 delays could be attributed to a woman’s lack of access and control of resources in the household, limited access to education, lack of decision making power and inaccessibility to regular transport facilities, especially in the rural areas where more than 80% of the women live. Type III delay is due to many factors including non – affordability of antenatal care costs, delivery costs and post-natal care costs; delays within health facilities, delays in seeing staff in health facilities, delays due to supplies and delays in necessary referrals.

It could be concluded therefore that all the three delays in one way or another have linkages with poverty in its many dimensions. This can be demonstrated with an extract from the UNDP Human Development Report 2005 which looked at births attended by skilled health personnel amongst other health indicators.

Country	HDI Ranking	Survey Year	Births attended by skilled health personnel (%)	
			Poorest 20%	Richest 20%
Nigeria	157	2004	12	70
Ghana	136	2004	18	86
South Africa	121	2004	68	98

*Table 1: Inequalities in Maternal and Child Health UNDP 2006 Human Development Report*

## Poverty linkages with Maternal health: skilled attendants at birth

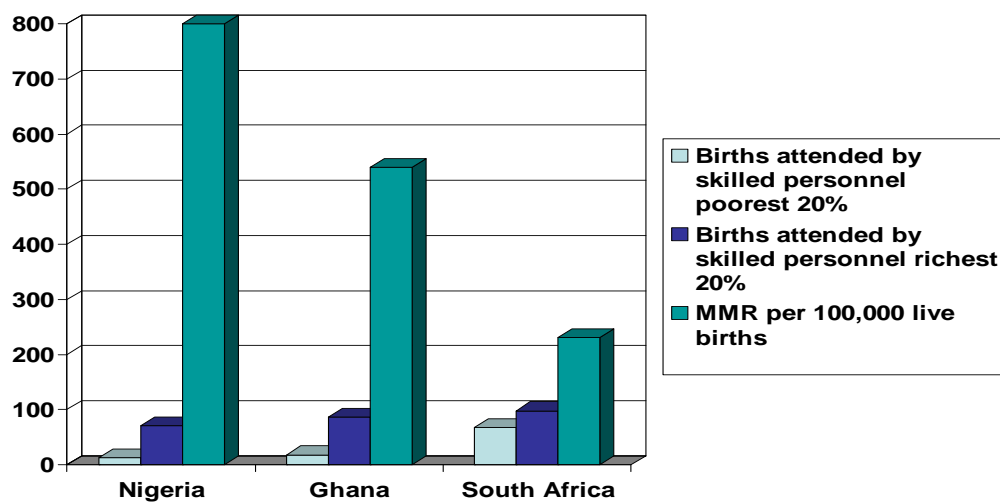


Figure 2 – Poverty linkages with Maternal Health, UNDP 2006, WHO 2006

Table 1 and Figure 2 show a consistently dismal health pattern for the poor. In contrast, the attendance of skilled labour available to the richest 20% is linked to their ability to afford services, availability of transportation means to timely access maternal health services and the impact of literacy and empowerment status of women in this category on household decisions to allow them seek care from ANC to post natal stages of pregnancy. The reverse is the case for the poorest 20%.

### 2. User fees

Poverty poses very high financial, physical and cultural barriers that prevent access to effective health care by much of the population, especially the rural poor. Only three out of every five Nigerians receive medical care when in need<sup>13</sup> with the cost of the services being the main reported barrier to accessing health care. Although some services are free in theory, users generally have to pay formal fees for medicines, tests and surgical procedures, as well as many unofficial user charges. Almost all patients make substantial out-of-pocket (OOP) payments for health services in both public and private facilities. The total private OOP expenditure in Nigeria in 2004 was above US\$20 per capita.<sup>14</sup> According to the 2003 Nigerian Demographic and Health Survey, 30% of Nigerian women cited the problem of getting money for treatment as responsible for their poor reproductive health seeking behavior. The situation where the ability to pay determines the distribution of health services and goods does not augur well to poor populations. There are numerous ways governments and communities can reduce the amount that households need to pay as out of pocket fees to access health services. These include exemptions and waiver mechanisms to ease the burden on the poor and disadvantaged. These schemes could be financed through taxation systems or through social insurance mechanisms for workers. Communities may offer a community-financing scheme whereby those enrolled pay minimal membership fees and in turn have access to services, while not paying the full cost at the point of use. In Nigeria, for instance, insurance scheme cover only a very small percentage of the population (Federal Government and

some other formal sector employees). However, in June 2008, the National Health Insurance Scheme (NHIS) has launched a community-based social health insurance programme for rural dwellers, while concluding processes of providing free maternal and child services.

As a consequence of Poverty, the burden of health expenditure in accessing maternal health services as at when required has proved to be very high for households, and exposes them to the risks of maternal mortality.

### **3. Nutrition**

A diet that provides sufficient calories and micronutrients is essential for a pregnancy to be successfully carried to term. Poor nutrition resulting from inadequate food intake before and during pregnancy contributes in a variety of ways to poor maternal health, obstetric problems, and poor pregnancy outcomes. The effects of malnutrition can manifest in **Stunted growth** during childhood which exposes women to the risk of obstructed labour; **Anemia**, though due to several causes, could be as a result of inadequate food intake, and losses due to parasitic infestations and malaria, of iron, folic acid, and vitamin A. Women with severe anemia are more vulnerable to infections during pregnancy and childbirth, are at increased risk of death due to obstetric hemorrhage, and are poor operative risks in the event that caesarean delivery is needed; **Severe vitamin A deficiency** may make women more vulnerable to obstetric complications and to associated maternal mortality; **Iodine deficiency** increases the risk of stillbirths and spontaneous abortion and may contribute to maternal death through severe hypothyroidism; **Lack of dietary calcium** appears to increase the risk of a woman developing pre-eclampsia and eclampsia during pregnancy; **Calcium supplementation** seemingly has little impact in preventing pre-eclampsia in areas where dietary intake is sufficient but may be an important option where diets are deficient in calcium.

Efforts to improve nutritional status of women can only take place at the community level and in the household by ensuring that pregnant women are provided with adequate portions of balanced nutritious diets. Community education efforts need to raise awareness that preparation for successful pregnancy and childbirth begins well before adulthood, with adequate nutrition for girls.

### **4. Family Planning, HIV/AIDS and STIs**

Reproductive health programmes also address unmet needs for family planning targeted at the poor and rich alike by providing the much-needed information and services that promote sexual health and trigger responsible behaviour among adolescents and young people. Making voluntary family planning information, services and commodities available and accessible to the poor, and the subsequent child spacing contributes to people's ability to better their lives. Furthermore, family planning information helps postpone first sexual intercourse and prevents HIV/AIDS, prevents STIs and provides access to condoms, which would go a long way to address the vulnerability associated with adolescents and youth.

## **5. Cancer of reproductive organs**

An emerging area is that of poor women having less access to screening for cancers of reproductive organs. Out of the 200,000 annual deaths recorded from cervical cancer, 80% occur in developing countries, while 600,000 new cases of breast cancer are detected each year with 40% in developing countries. In 2000 alone, breast cancer resulted in 373,000 deaths worldwide.<sup>15</sup>

## **6. Education and employment**

Socio-economic variables such as education and employment are strongly related to uptake of maternal health services, and choice of 'safe' services in developing country settings (Stephenson 1998). Women from poor communities are often not educated, of low standing and are poorly paid. These factors in themselves compromise maternal health service use and subsequent maternal health. Aspects of women's autonomy such as freedom of movement, decision-making power, control over finances and support from natal kin can also be constrained in a poor setting. The status of women in poor families is low and this is likely to influence maternal health care use. Care seeking behaviour have been strongly associated with such factors in urban settings in previous studies (Bloom et al 1998, Ramasubban and Singh 1999).

Preventive interventions however earnestly pursued, have little chance of success without addressing the gender, social and cultural roots of sexual behaviour and the exclusion from information and service that women and the poor experience. Women make up two-third of the world's poor, and their reproductive health is strongly impacted by social and cultural norms. A society which encourages boys to bully or coerce girls and to engage in sex with multiple partners, while requiring girls to be submissive and ignorant of sexuality, is not one which is conducive to good reproductive health. Among newly HIV-infected 15-24 year olds in developing countries, females outnumber males by a two to one ratio.<sup>i</sup> The importance of gender issues in the promotion of reproductive health and poverty alleviation cannot be over-stressed. The single factor most consistently associated with lowering maternal mortality rates being girl-child education.

In the African context, the removal of discriminatory laws against women regarding property and inheritance would go a long way to reduce the reliance of women on their children as a source of security, thus lowering the number of children they will choose to have. It is for this reason that the UNFPA's ICPD Programme of Action emphasizes improving the situation of women, especially in areas of education and reproductive health, noting that this would result in demographic gains.

Income characteristics	Not Knowing where to go for health care	Permission to go for treatment	Money avail for health care	Travel Distance to health facility	Transport required to health center	Not wanting to go alone	Concern there may not be a female provider	Any of the specified problem	Number of women
Not employed	16.1	11.9	31.2	24.6	24.7	17.5	19.9	48.4	3,177
Working for cash	11.5	8.5	26.4	22.2	21.1	11.2	15.2	42.3	3,744
Working not for cash (voluntary)	13.8	7.9	49.1	35.1	34.6	14.9	14.2	60.4	673

Table 2: Percentage of women who reported they had big problems in accessing health care for themselves when they are sick by type of employment, (Source: National Population Commission. Nigeria Democratic and Health Survey 2003: 2004:140)

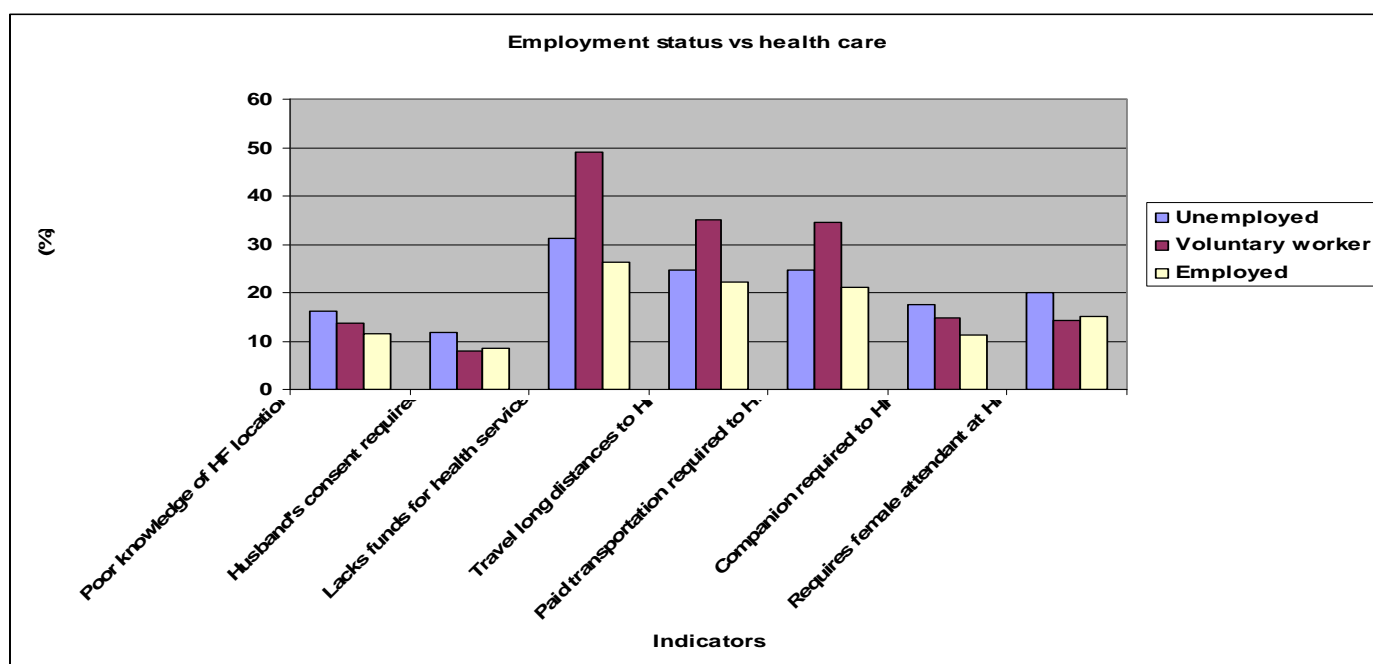


Figure 3: Illustration of linkages between Employment status and access to health care

**b) Poverty as a consequence of Maternal Mortality.** Maternal ill health and death are often reasons why households end up in poverty, or sink further into it if they are already poor. The illness of a woman, who supports the family through her productive labour and household chores as well as the consequent loss of her income and presence as the nurturer and *de facto* household head, can undermine a poor household's ability to cope financially. Example is Out-of-pocket payments for health services for an ill woman — especially for hospital services — which can make the difference between a household being poor or not.

At the macroeconomic (national) level, maternal morbidity and mortality puts a strain on national budgets and slows down development of any nation. Severe macroeconomic consequences are related to loss of income, savings and workers' productivity. At the

microeconomic (household) level, maternal illness places an undue burden on the poor who are forced to sell land or livestock assets to meet the cost of treatment and also compensate for loss of income from the woman. In case studies compiled by the World Bank, ill-health including maternal morbidity emerged as the most common reason why families have fallen into poverty.<sup>10</sup> Far too often, parents debilitated by illness are forced to take their children out of school to send them to work, perpetuating the inter-generational cycle of poverty.

There is therefore a heavy toll of maternal mortality on poverty, which can be illustrated thus - the mother who dies in childbirth leave behind children deprived of maternal care, who, as a result, are 3 to 10 times more likely to die within two years of their mothers death.<sup>11</sup> Almost half (3.4 million out of 8 million) of infant deaths per year are due to poor maternal health and inadequate delivery care.<sup>12</sup> The economic impact of poor maternal health on families and society as a whole is most times too multi-faceted to be measurable in its entirety.

The logical conclusion is that just as poverty is a contributory factor to maternal morbidity and mortality, the latter in turn plays an important role in perpetuating poverty. Poor people are caught therefore in a vicious cycle: their poverty breeds ill health; and ill health in turn conspires to keep them poor.

The linkage between Poverty and Maternal health cannot be overemphasized, as poor women are:

- a. less likely to afford nutritious food that aid health development of the girl child and progression of pregnancy
- b. not likely to afford the cost of transportation to health facilities from ANC to post natal stages
- c. less likely to afford the out-of-pocket costs charged by health facilities during ANC, delivery and post natal check-ups
- d. less likely to afford the cost of emergency treatment for complications that may arise during pregnancy or delivery.

An observation of the Internal Center for Health Society on the social determinants of health summarizes the interplay between contributory factors;

**“Combining economics, sociology and psychology with neurobiology and Medicine, it looks as if much depends on understanding the interaction between material disadvantage and its social meaning. It is not simply that poor material circumstances are harmful to health; the social meaning of being poor, unemployed, socially excluded, or otherwise stigmatized also matters. As social beings, we need not only good material conditions but, from early childhood onwards, we need more sociable societies, we need to feel useful, and we need to exercise a significant degree of control over meaningful work. Without these we become more prone to depression, drug use, anxiety, hostility, and feeling of hopelessness, which all rebound on physical health.”**

**Source: WHO: *The Social Determinant of Health: The Solid Facts*, 2003:9**

## **Roles of Traditional and Religious Leaders in reducing maternal mortality and improving the survival of women**

From the analysis and discussions above, factors affecting maternal health are not limited to medical or health related issues, they include social, cultural, economic and religious issues, for which poverty is our focus of discussion.

The Traditional and Religious leaders who are the custodians of culture and faith respectively command significant influences on the lives of their people in this regard. Some of the ways they can support on-going global and national efforts to reduce maternal mortality include the following:

### **Advocacy to Political Leaders/Policy Makers:**

The traditional and religious leaders as leaders of their communities have influence on the political leaders and policy makers in their country. They need to utilize this influence to increase political commitment and increase funding for maternal Health. They also could advocate for policies and programs that would increase access to maternal Health Services.

As an example collectively, the Jammatah Nasir Islam and the council of Emirs and chiefs in Northern Nigeria may as a group advocate to all the Governors and Council Chairmen in the region to institute a comprehensive free maternal Health Services. If this is done by the highly respected group the political leaders would definitely yield to their pressure. In addition, the traditional and religious leaders should advocate for economic and other programmes that would eradicate poverty such as agriculture, availability of infrastructure and improved employment creation opportunities.

### **Dissemination of appropriate and adequate information to the community**

The traditional and religious leaders are well respected by their followers hence their words and actions are highly respected and accepted. The leaders should use this opportunity to inform their followers (at functions such as Id Maulid Celebrations/Sallah, Christmas, New Year, Friday sermon Sunday service and others) on correct information on maternal health. Such correct information would enable their followers to understand the rationale behind various interventions aimed at addressing maternal health. This may also assist them to take remedial corrective action. Such information coming from them may also address some enormous cultural and religious inhibits that cause poverty and maternal morbidity and mortality.

### **Addressing cultural and religious barriers**

The traditional and religious leaders as custodians of culture and beliefs should identify such issues or factors that inhibit their subject from achieving their full potential economically hence keeping them in poverty and making them to have high maternal morbidity and mortality. Examples include addressing issues of girl child education, early marriage, Almajir education system, institutionalization of begging in the society, non-empowerment of women to engage in productive economic activities etc. Most of these issues occur because of ignorance and marginalization. It is time for the leaders to address these issues so as to improve the quality of life of their subjects.

### **Pro-poor activities in the community**

The traditional and religious leaders could mobilize their followers to provide safety net for the poor among their subjects. These could be done in a number of ways. An example may be to utilize the zakat collection for creating jobs for the poor or use it as a fund to care for the health of the poor. The church may also use part of their collection for this purpose. In addition, specific funds could be created under the leadership of the leaders to provide community base health insurance. Such funds may be used for subsidies, exemption and deferral for health services provision for the poor. An example of this in Nigeria is the Shonga community health fund in Kwara State, Nigeria, where the Emir of Shonga is the Chairman of the Board of Trustee that manages the community health insurance fund.

### **Village or community committees**

The Traditional and Religious leaders would be able to improve the health of their followers by participating directly as leaders of the committee that oversee the health facilities in their domain. In doing this, they would be able to ensure availability of health workers at their duty posts, ensure quality service provision by these workers, ensure availability of supplies and above all encourage their subject to use the services. The traditional and religious leaders could do these management participation through their chiefs or leaders of their religious faith but they should ensure that their representatives are adequately supervised.

### **Fostering partnerships within the communities**

The traditional and religious leaders as leaders of all may mobilize other sectors to support health services provision. Such sectors include the transport sector. The transport union should be sensitized and mobilized to support the transportation of poor pregnant women to health facilities as part of their social responsibility. The mechanisms for compensating the transporter are usually arranged. There is an example of this partnership in Jigawa- Nigeria. The Road Transport Union, the health sector and the community institute a partnership where the union use their vehicles to transport any pregnant women to health facility without a charge to the women. At the facility they will show a red card to indicate that they brought a patient requiring urgent attention. The driver is compensated later via the union. This has been shown to reduce maternal morbidity and mortality.

A case is being made that the traditional and religious leaders as custodian of culture and faith of their people have several roles in alleviating and eradicating poverty. In doing this they would be able to improve the health of and reduce the death of women in their communities. Their efforts in reducing poverty and improving maternal health in their communities will be an important contribution to socio- economic development and transformation of their various communities.

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# **AN OVERVIEW OF THE UTILIZATION OF HEALTH SERVICES FOR ANTENATAL, DELIVERY AND POSTNATAL CARE IN SELECTED AFRICAN COUNTRIES**

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## **INTRODUCTION**

Utilization of antenatal, delivery and postnatal care services can be assessed by determining the percentage of the under- one population whose mothers had at least one antenatal visit during pregnancy, had labour attended to by a trained health personnel (midwife or doctor) and had records of postpartum counseling for family planning and immunizations such as OPV<sub>1</sub> and/or measles.

### **Utilization rate of antenatal care services in Nigeria**

Data from the Nigerian Demographic and Health Surveys indicate that among pregnant Nigerian women, only 64% receive antenatal care from a qualified health care provider. There are wide regional variations, with only about 28% of women in the Northwest Zone and 54% in the Northeast Zone receiving antenatal care from trained health providers. The rest either do not receive antenatal care at all or receive care from untrained traditional birth attendants, herbalists, or religious diviners.

### **Utilization rate of delivery services in Nigeria**

Only about 37% of deliveries in Nigeria take place in health institutions, while 57% of deliveries takes place at home (NDHS 2003).

### **Utilization rate of postnatal care services in Nigeria**

According to the Nigerian demographic and health survey, the contraceptive prevalence rate in Nigeria (proportion of women using effective method of contraception) is only 6%, and it is one of the lowest in the African continent.

### **Utilization rate of Obstetrics services in Uganda**

Kyomuhendo (2003) reported that in 2000, Uganda had a total fertility rate of 6.9, a contraceptive prevalence rate of 23% and had only 38% of births attended to by trained attendants.

### **Utilization of maternal health services in Namibia from 1993-1999**

In Namibia, there has been a progressive increase in the utilization of ante-natal, delivery and postnatal services. Utilization of antenatal care increased from 62% in 1993 to 65% in 1999 while the number of deliveries in a medical facility increased from 48% to 54% and post natal care also increased from 30% in 1996 to 54% in 1999.

The reason for this increase could be attributed to introduction of reproductive health and family planning programmes. The objectives of this programme are: to reduce maternal and infant deaths, increase contraceptive use among women of reproductive age, and promote and improve access to reproductive health services at all levels of health care delivery.

**Table 1: Utilization of maternal health services,**

Item	1993	1994	1995	1996	1997	1998	1999
Women delivery at the medical facility	48%	49%	51%	51%	51%	52%	54%
ANC	62%	67%	85%	73%	73%	62%	75%
PNC				30%	42%	40%	54%

*Source: Namibia Ministry of Health and Social Service*

#### **Utilization of maternal health services in Tanzania**

According to the 2004 Tanzania Demographic and Health Survey (TDHS), only 47% of deliveries occur in the health facilities. In a recent study, findings showed that utilization of antenatal care services was universal with (99.8%) of respondents reporting to have attended antenatal clinic at least once during their last pregnancy. However, less than half, (46.7%) of respondents reported to have delivered in a health facility in their most recent deliveries. Among women who delivered at home, 50.1% were assisted by untrained relatives or friends while 46.3% were assisted by Traditional Birth Attendants (TBA's) and 3.6% were assisted by skilled midwives. This is happening amidst the fact that Tanzania has a good network of health facilities with about 72% of the population residing within 5km and 90% reside within 10 km of a health facility. Also maternal health care services are provided free of charge in almost all public facilities.

#### **Utilization of maternal health services in Ethiopia**

The coverage of maternity care services is very low in Ethiopia. It is estimated that only about 27 percent, 6 percent, and 3 percent of women received professionally assisted antenatal, delivery, and postnatal care services, respectively. Such levels of service coverage are considered low even by sub-Saharan standards. (Mekonnen and Mekonnen (2002)).

Figures 1, 2 and 3 below indicate the summary of utilization of various maternal health services in selected African countries

Figure 1:

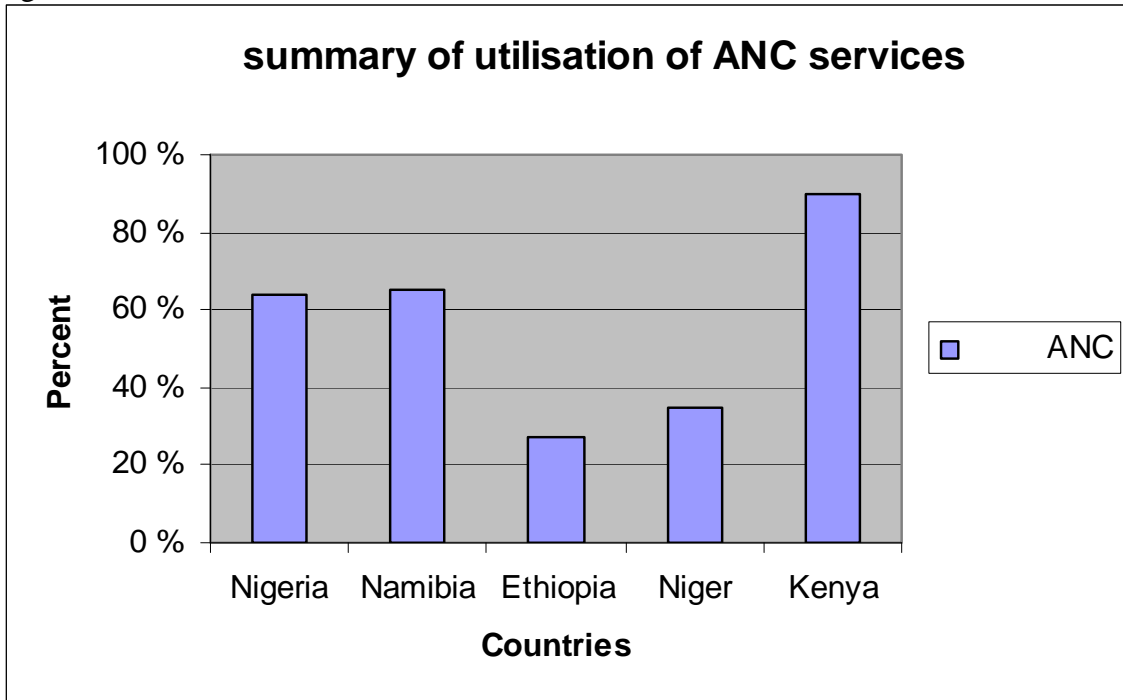


Figure 2:

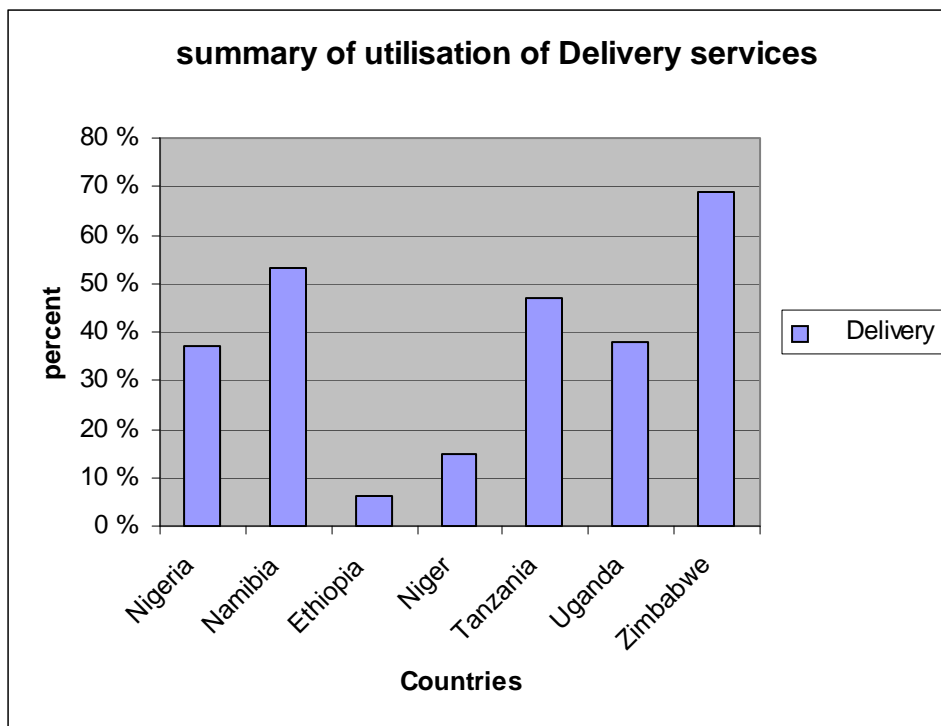
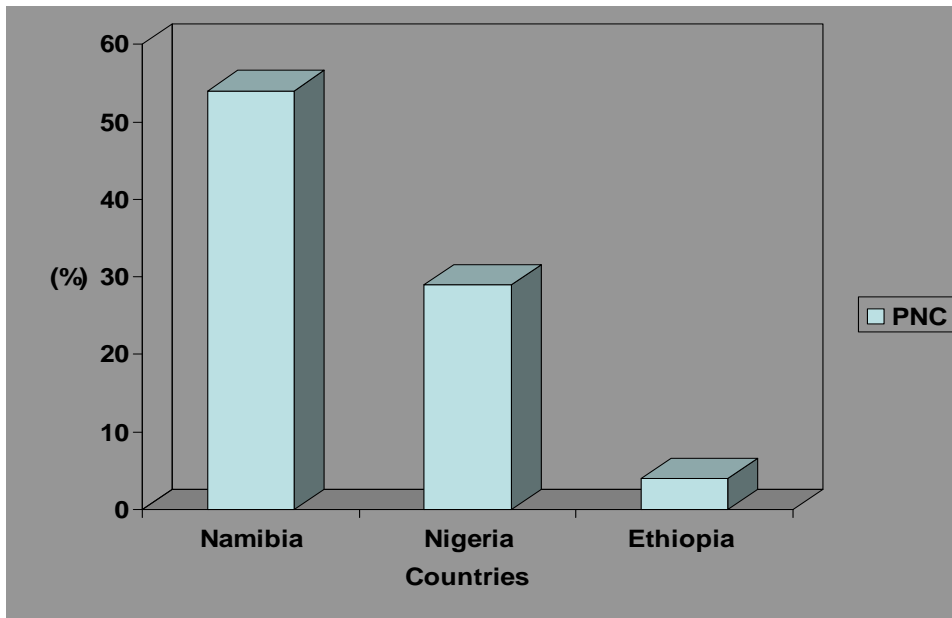


Figure 3:

### Summary of Utilization of Post Natal Care (PNC) services



### Determinants of Utilization of Obstetrics services

It is necessary to understand the range of factors associated with the decision to seek care during pregnancy and delivery, and to understand the role that the community has in influencing this decision. Studies of health care use have highlighted a range of potential influences on a woman's propensity to seek care.

### Demographic factors

Demographic factors that have been shown to increase the likelihood of health service use are low parities (Magadi, Madise, and Rodrigues (2000), Bhatia and Cleland (1995), Kavitha and Audinarayana (1997)) younger maternal age (Bhatia and Cleland (1995)) women's employment in skilled work outside the home (Addai (1998), Estrin (1999)), and high levels of husbands' education (Nuwaha and Amooti-kaguna (1999)). Socioeconomic factors, however, have been shown to be of greater importance in determining health service use than demographic factors (Obermeyer and Potter (1991)).

### Education

The most consistently found determinant of use of reproductive health services has been a woman's level of education (Magadi, Madise, and Rodrigues (2000), Bhatia and Cleland (1995), Addai (1998), Nuwaha and Amooti-kaguna (1999)). Obermeyer believes that increased education influences service use by increasing female decision making power, increasing awareness of health services, changing marriage patterns, and creating shifts in household dynamics (Obermeyer (1993)). Cost has often been shown to be a barrier to service use (Bloom, Lippeveld and Wypij (1999)) and also influences the source from which care is sought.

### **Socioeconomic indicators**

Socioeconomic indicators such as urban residence (Addai (1998)), household living conditions (Bloom, Lippeveld and Wypij (1999)), household income (Kavitha and Audinarayana (1997)), and occupational status (Nuwaha and Amooti-kaguna (1999)) have also proven to be strong predictors of a woman's likelihood of using reproductive health services. Both demographic and socioeconomic determinants of use of reproductive health care are mediated by cultural influences on health-seeking behavior that shape the way individuals perceive their own health and the health services available (Basu (1990), Rutenberg and Watkins (1997)).

### **Cultural influences**

Community beliefs and norms are reflected in an individual's health decisions; behavior is influenced by how a person thinks the community views his or her actions (Rutenberg and Watkins (1997)). For example, traditional beliefs about childbirth, coupled with misconceptions and fears of medical institutions, have led many women to maintain reliance on home births in India (Basu (1990)). Thus, although demographic and socioeconomic factors are key determinants of health service use, the individual's cultural environment provides a strong influence on the extent to which these factors can lead to the use of health services. The community also plays a vital role in determining a woman's choice of place of delivery. There are several pathways through which a community could influence an individual's health.

### **Community beliefs and norms**

Community beliefs and norms relating to health behaviors have a strong influence on the health care decisions made by individuals (Rutenberg and Watkins (1997)). An example is the outcome of a study among the Bariba of Benin, which described how women take pride in giving birth unassisted and are in turn "silently admired". The study noted that:

"Birth represents a rare opportunity for a woman to demonstrate the proverbial virtue of courage and bring honor to her and her husband's families by her stoic demeanor. The woman who manages to deliver without indication that she is in labour and without calling for assistance until the child is born is especially esteemed ..." (Sargent (1990)).

The conceptualization of childbirth as "the woman's battle" was also found to be prevalent in West Africa, where maternal mortality was explained as "she fell on the battlefield in the line of duty" (Diallo (1991)). However, the view that birthing wields immense power, attributed to the unique nature of childbearing, is especially noticeable in societies where women command much less power than men in the public domain.

*In Benin more recently, antenatal care was sought when symptoms of complications were experienced, but the women had to negotiate with their husbands for the money to pay for the visit, which often led to quarrels and anger over their financial dependency. Nor were they always given enough to pay for the medications they needed....*

*Extract from "A Call Beyond Duty Often Omitted Root Causes of Maternal Mortality in West Africa", UNDP 1991.*

## **Economic development**

Economic development is also positively related to health outcomes through its relationship with increased female decision making power, an increased likelihood of female labor force participation, and positive attitudes toward health service use (Grady, Klepinger and Billy (1993)).

## **Impact of Individual, Household and Community Level Influences**

In a study of six African countries (Cote d'Ivoire, Burkina Faso, Ghana, Kenya, Malawi, and Tanzania) *Stephenson et al* (2006) demonstrated the impact of individual-, household-, and community-level influences on the decision to deliver a child in a health facility.

### **1. Individual level influences**

Maternal age, parity, educational status, religion, and marital status were all influential in a woman's decision to deliver her last child in a health facility, although the pattern and magnitude of these relationships varied across the 6 countries, indicating geographic and cultural variations in the pathways through which these variables influence health behavior. The significance of urban residence in 4 countries highlights the benefits of greater service availability afforded to urban residents. **Two variables were consistently related to the decision to deliver a child in a health facility in all 6 countries: receiving prenatal care and delivering a previous child in a health facility.** The latter demonstrates a simple relationship: women who have delivered a child in a health facility are the most likely to continue to deliver future children in health facilities, irrespective of maternal age and parity. The significant effect of prenatal care points to the role that care during pregnancy has in informing women of the benefits of institutional deliveries and in connecting women to appropriate services. The result also highlights a selectivity effect: the characteristics that predispose women to seek pregnancy care also make them more likely to seek care during labor. There is obviously an influence of previous exposure to maternal health care services on a woman's decision to seek care during pregnancy, suggesting that other reproductive health services can be used as an opportunity to inform women of the benefits of institutional deliveries. The variables measuring previous exposure to maternal health services are also likely to reflect the availability of such services in the community.

### **2. Household level influences**

Greater household wealth may enable women to seek care during pregnancy, with the costs of seeking care acting as a significant barrier to women from poorer households.

#### **a. Levels of female education**

Higher levels of female education in the community may also point to greater awareness of the need for care during childbirth. Although the content of formal education may not include health information, higher levels of education may create a greater awareness of health services and the need for care.

In more traditional societies, higher levels of female education may also indicate greater female autonomy, as education is often restricted to male children, and earlier ages at marriage and childbearing may restrict female access to higher levels of education.

### **b. Husbands approval of Family Planning**

There is a positive association between the percentage of husbands in the community who approve of family planning and a woman's decision to deliver her child in a health facility. High levels of approval of family planning are associated with less conservative communities, which may also be less conservative in their attitudes toward women's roles. Hence, women living in communities with higher levels of female education and approval of family planning may also be living in climates of greater autonomy, allowing them greater decision making power and the opportunity to seek care during pregnancy and labor. The significance of education at the individual and community levels suggests the importance of both individual autonomy and the climate of autonomy that exists in the community. It also suggests that the influences on individual health behavior extend to beliefs and practices of others in the community.

## **3. Community level influences**

### **a. Presence of Maternal Health Services in the Community**

In Malawi, Tanzania, Ghana, Burkina Faso, and Cote d'Ivoire, the percentage of women in the community who had delivered a child in a health facility had a strong positive influence on a woman's decision to seek care. There are several possible pathways of influence. The high percentage of women in the community who had delivered their children in a hospital may simply reflect the presence of maternal health services in the community.

### **b. Peer Influence**

Studies have shown that women's decisions regarding health seeking are strongly influenced by the practices of others in the community (Stephenson and Matthews, 2004); in a community in which a high percentage of women are using health services for childbirth, the practice is therefore likely to be seen as a norm, influencing individual behavior.

### **c. High Fertility**

A high mean number of children per woman in a community have a negative influence on a woman's decision to deliver her child in a health facility. Communities with higher fertility may be more conservative in their attitudes toward service use and the expected roles of women, and may have a lower level of economic development, all of which influence a woman's ability to seek care during labour. High fertility may also reflect a lack of reproductive health services and a lack of awareness of such services, both of which have obvious implications for maternal health service use.

### **d. Women's perceptions of the Quality of Health Service Delivery**

In more recent studies from Botswana and Benin on the attitudes of women towards institutional and non-institutional deliveries, not only socio-cultural factors but also women's perceptions of the poor quality of health service delivery were found to be important. In Botswana, 47% of women respondents attended antenatal clinics at health facilities, but 82% preferred to give birth at home and virtually none attended post-natal clinics. Of the women who preferred to give birth at home, 41% said they did so for the

use of traditional medicines (muti) and abdominal massage, and also because they were reluctant to entrust the disposal of their placenta and other products of conception to strangers like nurses. Significantly, 23% also felt that home deliveries were both more convenient and safer.

Women in Tajikistan preferred to deliver at home because although medical settings were accessible and free of charge, women perceived these settings to be of very low quality and unsafe (Falkingham (2003)). Midwives' advice on where to deliver was ignored by Jamaican women, who perceived the midwives to be too authoritarian (Gertler, Rahman, Feifer and Ashley (1993)). Women in rural Guatemala were less likely to deliver in medical settings because of the lack of social support provided by health-care professionals compared with traditional midwives (Glei and Goldman (2000)).

#### **e. Women's Autonomy**

In India, for example, the extent of an Indian woman's autonomy, which is often determined by continued links with her parental family after marriage, affected use of skilled delivery care, because living with or near a member of her birth family increased her ability to leave the house and go where she wanted (Bloom, Wypij, Das and Gupta (2001)). However, among rural Chinese women, freedom of movement did not affect rates of delivery with the help of a skilled health worker (Li (2004)). Jamaican women did not want to be treated as ill during uncomplicated pregnancies, and so tended to delay initiation of antenatal care (Gertler, Rahman, Feifer and Ashley (1993)). Non-white South African women did not see the value of antenatal care, aside from it being necessary to allow access to care during delivery; therefore they began antenatal visits later in pregnancy (Burgard (2004)).

#### **4. Health Policies**

The wide range of health policies, financing arrangements and organizational structures also needed to be taken into account. Women who did not comply with policies to restrict numbers of children in China tended to avoid formal maternal health care to prevent being discriminated against by health-care providers (Li (2004)). Following the end of apartheid, health policies in South Africa have been especially concerned with increasing access to primary health care, including maternal health care (Burgard (2004)). Health care is free for pregnant women in Jamaica and South Africa (Gertler, Rahman, Feifer and Ashley (1993), McCaw-Binns, La Grenade and Ashley (2007), Burgard (2004)).

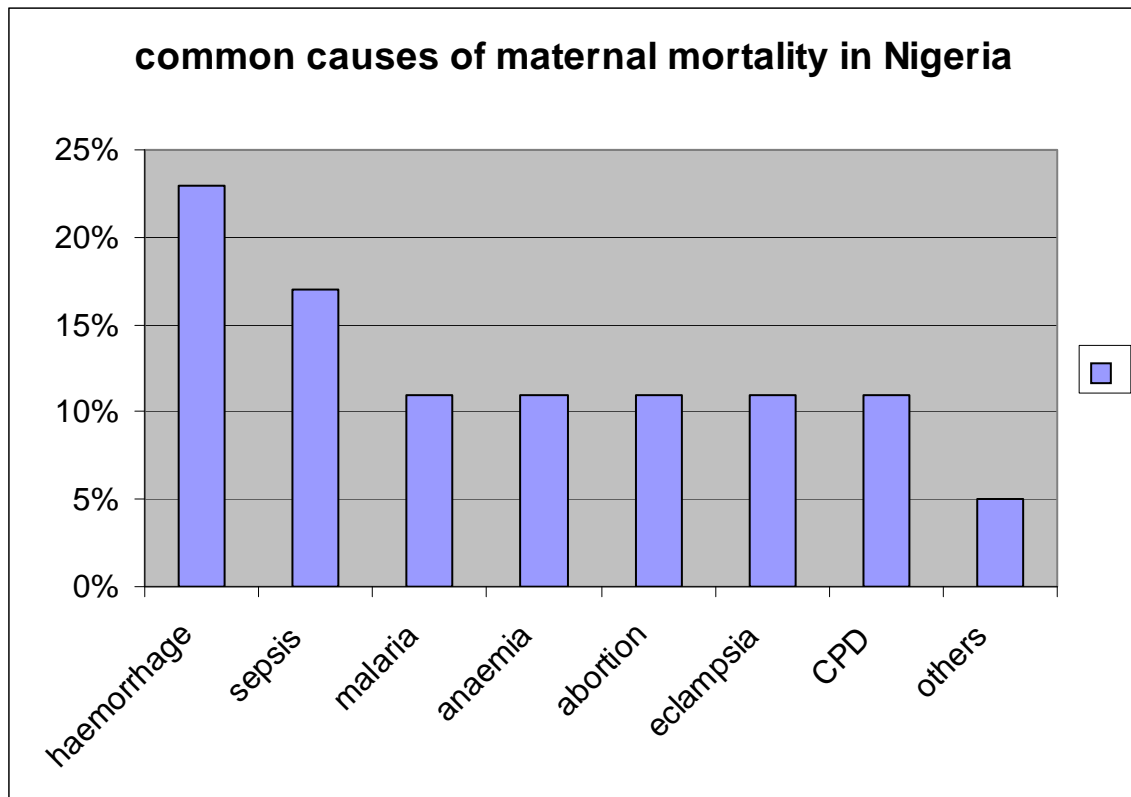
By contrast, the private and informal sectors are increasingly active in provision of maternal health care in India (C Bhatia, J Cleland (1995)). Introduction of fees for maternal health care in Morocco during reorganization of the health sector was thought to limit access for poor women (Hotchkiss, Krasovec, El-Idrissi, Eckert and Karim (2003)). Differences in use of skilled delivery care across economic groups were explained by informal charges in Tajikistan, where maternal health care was officially free of charge (Falkingham (2003)). Interventions aimed at poor areas did not benefit poor and underserved women in Brazil (Burgard (2004)). By contrast, multipurpose health workers

facilitated provision of antenatal care in remote parts of Karnataka in India, where rural residence and economic status did not affect this aspect of care (Navaneetham and Dharmalingam (2002)).

### **EFFECTS OF POOR UTILIZATION OF OBSTETRICS SERVICES**

The resultant effect of poor utilization of obstetric services is that when women suffer from pregnancy related complications such as malaria, anaemia in pregnancy, hemorrhage, prolonged/obstructed labour, ruptured uterus and eclampsia while in labour at home, there is often delay in bringing them to health facilities where they can be treated.

Figure 4: Bar chart showing common causes of maternal deaths in Nigeria due to delays at instituting appropriate interventions.



Thus, it is not the complication per se that causes these deaths but the delay in obtaining emergency treatment for the complications that cause death among Nigerian women. Such delays have been eliminated or substantially reduced in many developed countries, hence the lower rates of mortality among pregnant women.

In a needs assessment of the available emergency obstetrics services undertaken by Society of Gynaecology and Obstetric of Nigeria (SOGON) in the six geopolitical zones

of Nigeria using the frame work described by Deborah Maina and her colleagues to allocate the types of delay in clinical management, three types of delays were described.

- Type I delay is when the women fail to seek health care in time in the events of an obstetrics emergency.
- Type II delay is when the woman experiences difficulty with transportation.
- Type III delay is when there is delay in management after the woman has arrived in hospital.

Using this framework the prevalence of the different types of delay was determined for each maternal death and computed for each hospital and participating state. The leading causes of maternal mortality in the states were eclampsia, sepsis, postpartum hemorrhage, antepartum hemorrhage, unsafe abortion, obstructed labour and heart failure. The results of the needs assessment revealed that type III delay made significant contribution to maternal deaths in all the states. Type I delay is largely due to poverty among women who cannot afford the high cost of treatment in secondary and tertiary care centers. There are also adverse cultural factors that are deleterious to women, for example, in northern Nigeria women have to wait to seek the permission of their husbands before going to hospital for treatment. Thus, even when the husband is away at the time of complications, the woman would still have to wait until he returns before she can seek treatment.

Throughout the country, women and (men) hold strong religious beliefs, which sometimes act as barriers to the utilization of available maternity services. Such beliefs, for example, are responsible for women sometimes refusing caesarean section or blood transfusion needed to save their lives, and accounts for their use of alternative sources of antenatal and delivery care rather than evidence-based orthodox sources.

### **Interventions to Improve Utilization of Maternity Care services and Reduce Maternal Mortality**

The Nigerian government has been fully involved in the Safe Motherhood Initiative (SMI) and its follow-up, the Making Pregnancy Safer Initiative (MPSI) strategies for reducing the prevailing high maternal mortality rates in the country. To achieve these goals, the government has worked in partnership with many professional, local and international organizations such as the WHO, World Bank, UNICEF, UNFPA, Ipas, Prevention of Maternal Mortality (PMM), Society of Gynaecology and Obstetrics of Nigeria (SOGON), and religious bodies. Government has also been involved in training large numbers of birth attendants, upgrading the skills of midwives in Life Saving Skills (LSS), and medical officers in Expanded Life Saving Skills Initiative (ELSSI), which are integral parts of capacity building in the MPSI. Included in these are the provision of adequate equipment for quality delivery services and emergency obstetric care; functioning of referral systems between PHC facilities (basic essential obstetric care facilities) and secondary health care facilities (comprehensive essential obstetric care facilities) within the same LGA.

## **THE ROLE OF DECISION MAKERS, TRADITIONAL RULERS AND RELIGIOUS LEADERS IN IMPROVING UTILIZATION OF MATERNAL HEALTH SERVICES- Examples from a UNFPA supported project**

The UNFPA reproductive health project in Kebbi State commenced in 2004. The activities commenced with needs assessment of 17 selected local government areas.

This was followed by sensitization and advocacy activities to educate the communities and decision makers about the project. The mode of sensitization included: sponsored radio and television programs which were targeted at both urban and rural dwellers on the importance of antenatal care for pregnant women and conduct of deliveries by trained health attendants such as midwives and doctors.

Advocacy visits were also paid to local Government Chairman, traditional rulers, members of the State House of Assembly, member of the State Executive Council and religious leaders. Notable traditional rulers and religious leaders who gave their full support which facilitated the success of the project in Kebbi State include: His Royal Highness the Emir of Argungu, Alhaji Ismaila Muhammad Mera, the district Heads of Ambursa Alh. Isa Haruna Rashid, the district Head of Gotomo, Alhaji Abubakar Makwashe, the Sarkin Malaman Gwandu, Alhaji Umaru Ika, a highly respected Islamic cleric and other village heads too numerous to mention.

### **COMMUNITY INITIATIVES FACILITATED BY UNFPA TO IMPROVE UTILIZATION OF OBSTETRICS SERVICES IN KEBBI STATE**

With the blessings of the Royal fathers and the support of the religious leaders the communities were mobilized through preaching in the mosques and various community meetings to setup contribution schemes, community loan funds and transport services in order to alleviate problems encountered during obstetrics emergencies.

Communities that have excelled in this area include Takalau and Ambursa where contribution box are placed at the mosques for people to make voluntary contributions specifically for the purpose of assisting pregnant women in need.

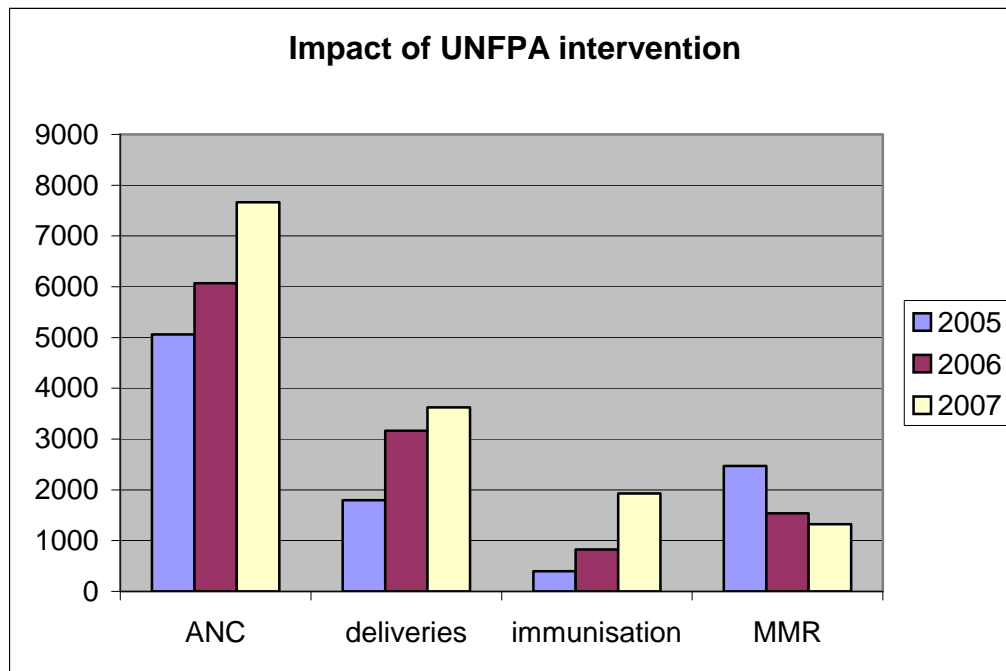
In Yauri Local government, the community also set up a “Safe Motherhood Insured Local Endowment Scheme (SMILES). This is operated in form of a contributory health Scheme in which a pregnant woman at booking for ANC starts contributing N500 per month till the time of delivery. Every woman in the scheme is eligible to ten times the amount of her contributions in the scheme at the time of delivery. This scheme has helped to improve utilization of antenatal and delivery services in the community.

Men were also urged to allow their wives attend ANC clinics and utilize the hospital health services for deliveries. They were also encouraged to make arrangements for their wives to seek medical assistance from the hospital at times of emergencies even when the husbands were not around in order to avoid the type I delay.

## IMPACT OF UNFPA INTERVENTION IN KEBBI STATE

The baseline indicators of utilization of obstetrics services and maternal deaths in Kebbi state, which included number of women attending ANC clinics, total number of deliveries in health facilities, and maternal mortality ratio in 2005, shortly after commencement of UNFPA assisted reproductive health services, was compared with those recorded as at December 2007, three years later. A summary of the data is illustrated below.

	2005	2006	2007
<b>ANC</b>	5063	6067	7662
<b>Deliveries</b>	1799	3164	3625
<b>Immunisation</b>	397	823	1929
<b>MMR</b>	2473	1535	1326



The ante natal clinic attendance increased by 51.3% between 2005 and 2007, while total deliveries during the same period increased by 101.1%. Maternal mortality rate decreased by 37.2% between 2005 and 2007.

### Conclusion

Poor utilization of antenatal, delivery and postnatal care services is still a major problem in Nigeria. However, the UNFPA Reproductive Health Project in Kebbi State has had a positive impact on the utilization of these services in the state. These achievements are

mainly attributable to (among other things) the greater involvement of and the role played by the traditional rulers and religious leaders.

### **Recommendation**

It is hoped that these can be improved upon in the coming years to achieve a zero maternal mortality and a significantly reduced maternal morbidity.

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**THE LEVELS AND CAUSES OF HIGH MATERNAL MORBIDITY AND  
MORTALITY IN THE REPUBLIC OF GAMBIA  
By the Gambian Delegation**

According to a study (a qualitative one) conducted in rural Gambia on access to emergency obstetric care, women do seek access to care for obstetric emergencies, but because of a variety of problems encountered, appropriate care is often delayed. Disorganized health care with lack of prompt response to emergencies is a major factor contributing to a continued high mortality rate.

This study is adopted for the purposes of this presentation. The following were discovered to be part of the causes of maternal morbidity and mortality in the Gambia.

**Delay in deciding to seek care**

The delay was estimated from the moment somebody, either the woman or her family realized that there was a complication until the decision to seeking care was made. In seven of the 32 (thirty two) cases studied, the process of seeking medical attention was delayed after becoming aware of the complication. The delay ranged from two hours to five days. The reasons mentioned for the delay were underestimation of the severity of the complication, cultural belief or previous unfavourable experience with the health system.

**Underestimation of the severity of complication**

Previous uncomplicated pregnancies may influence actions taken during the current pregnancy that can lead to delay in the decision-making process. Women or their relatives used previous pregnancies as a risk- predicting tool. A husband of a deceased woman narrated:

‘This was her ninth pregnancy. All previous pregnancies were delivered at home. She always gave birth without even calling for help from the traditional birth attendant. We thought she will deliver this time without problem’.

In another case a mother in-law narrated:

‘She swept the house and prepared breakfast. At midday she was lying in the room complaining of labour pains. We thought she will deliver without a problem as in her last pregnancy. It was after 2.00 pm she did not deliver then we decided to look for transport to take her to the health centre’.

**Cultural belief**

In Gambian society pregnancy and child birth are generally regarded entirely as women’s entity. Older women in their menopause are seen as experts on pregnancy and childbirth, particularly in rural areas of the country. These women are consulted if a complication is noticed during pregnancy, labour or during the puerperium. When consulted, they usually decide what should be done and their advice is taken. Words of elders are hardly

challenged in Gambian societies. In the case below an older woman advised a woman in labour to wait until after the next Muslim praying time (after three hours) before seeking medical attention. The rationale for the delay was that it is believed to evaluate progress in labour at specific times corresponding to the Muslim praying times:

‘Labour and child birth takes place at certain times... .. these times correspond with Muslim praying times. It was around midday and the next praying time was 2.00 pm so we thought she will deliver by then. It was after then when she did not deliver we decided to take her to the health centre’.

### **Experience with the health care system**

Other testimonies indicated that structural factors in maternal health care provision discouraged women from seeking care. Prenatal care is provided on specific days in each community during week days only. This gives the impression that maternal health services are only available on days when clinics are held. A mother in-law narrated:

‘On Thursday evening she complained of abdominal pains... .. throughout the weekend she was with severe abdominal pain but we had to wait until the following Monday as it is the day on which pregnant women are attended to. The clinic is closed on Saturdays and Sundays’.

Poor provider attitude, fear of punishment by health care providers based on previous experiences or just gossip can lead to delays in the decision making process. A midwife narrated:

‘She was vomiting throughout the night, the following morning the husband decided to take her to the health centre but she refused... .. she has not yet got an antenatal card. She feared the nurses because if she goes to complain about the vomiting she will be asked the card and without it they [nurses] will tell her all salty words. She may be insulted or may even not be given medicine’.

Information from care providers that is not clearly understood, can lead to delay in seeking medical care. A woman with twin pregnancy was advised to deliver at the hospital. However, the information provided led to the following situation:

‘She was told she had twin pregnancy by the nurse. She was told by the nurse to report to the hospital when in labour. When labour began we decided to go to the hospital. She was not told to report to the hospital before labour began’.

Barriers to seeking care may not appear as such to care providers when they make recommendations. The woman may not see them as an issue, as she is not given room to discuss these with the nurse.

Lack of money and refusal to receive medical attention were not identified as factors affecting health care seeking process. In twenty-two out of thirty-two women, no funds were available when the complications developed. In all these cases the woman was

taken to a medical facility without money and a relative was left behind to raise money in the community, to be able to pay at a later stage.

### **Delay in reaching an appropriate medical facility**

Once a decision to seek medical care has been made, other obstacles had to be overcome in reaching a medical facility. Twenty-seven of the thirty-two women were delayed in reaching an appropriate medical facility. The reasons for this delay can be grouped into three categories: lack of transport. Prolonged transportation and seeking care at more than one facility.

#### **-Lack of transportation**

Transportation difficulties, such as poor road conditions, lack of readily available transport and/or inadequate means of transportation were mentioned. The relatives often expressed shortage of transport as serious obstacles. Lack of motorized transport forced some families to opt for alternative means of transport such as using a cart (donkey, ox or horse) or in extreme instances, they walked. A husband explained:

‘She started pouring blood late in the evening just after evening prayers [5.00 pm]...we took her to the main road [tarred road] to look for transport. We were there [main road] up to twelve midnight but couldn’t get transport. All the vehicles that came were full. We went back home and woke up early morning the following day to catch the first transports’.

Transportation difficulties were experienced even after reaching the first medical facility, as some of the health facilities were without an ambulance. If a facility has an ambulance it usually serves multiple purposes and may not be available at certain times. A midwife narrated:

‘The patient came to the health centre at around 4.00 pm... .. she cannot be managed here because she may need an operation [caesarean section]. We planned to evacuate her to the hospital but our ambulance had a breakdown a week ago. We looked for transport in the village throughout the night but could not get one. The following morning we went to one of the other government departments to look for transport but their vehicle had already left for trek. It returned around 11.00 am and thereafter it came to the hospital to transport the patient to the hospital’.

Lack of fuel for the ambulance was also mentioned. In such occasions relatives or escorts make efforts to meet the fuel cost. A husband narrated:

‘I took my wife to the health centre... .. two hours later the nurse told me that she [my wife] will be transferred to the hospital but that the ambulance had no fuel. I was asked to buy fuel for the ambulance to take my wife. I bought twenty litres of diesel’.

Some communities in the Gambia have – with the assistance of the health authorities – tried to set up community based emergency transport systems, such as horse carts or bicycle ambulances, but it is difficult to make them sustainable.

### **Prolonged transportation**

Long distance, visiting different health facilities, poor road and vehicle conditions contributed to prolonged travelling time. Several testimonies highlighted this. A husband explained:

‘She was admitted in the hospital for two weeks and discharged on a Monday. On her return to our village [85 km away from the hospital] she fell down unconscious. We took her to the health centre in our village where she was transferred to another health centre [20 km]. She was again transferred to the hospital [60 km away]. She spent few hours at the hospital and died’.

### **Seeking care at more than one medical facility**

Seeking care at an inappropriate level of facility actually delays access to appropriate treatment. The inability to provide comprehensive obstetrical services forces peripheral health facilities to refer all women needing such services to the nearest hospital: 26 of the 32 women visited more than one medical facility during the care seeking process, 18 of the 26 women visited two health facilities while the other 8 women visited three different facilities. Thus, the women accessed a health care facility, but not appropriate health care. The husband of a deceased narrated:

‘We took her to the health centre in the village... ..she was examined by the nurse who later transferred her to another health centre [44 km away]. There she spent the night and the following morning she was again transferred to the hospital [36 km away]. On our way to the hospital we had to cross the river at two different crossing points. Immediately after we reached the hospital she died’.

### **Delay in receiving prompt and appropriate care after reaching the hospital**

Thirty-one women experienced delay in receiving prompt and adequate obstetric care at the hospital level. Lack of blood transfusions and basic medical supplies were mentioned in the testimonies. A mother in-law explained:

‘When we reached the hospital, they [the doctor and the nurses] told us to find two bottles of blood for her [our patient]. We went to the laboratory but the man at the lab said there was no blood. I donated one bottle and bought another in the lab. After giving her [patient] the blood we were asked to get another two bottles. We went back to the lab but the man at the lab insisted there was no blood. I paid him D300.00 [equivalent to US\$ 12.00] before getting the two bottles of blood’.

A husband of a deceased woman narrated:

‘She was pouring blood at home so we took her to the health centre. There we were told she urgently needed blood but blood bags were not available. She was then transferred to

the hospital [60 km away]. At the hospital blood bags were finished. She was in the hospital from mid-day up to the following day in the evening but had not received blood. Late at night she died’.

A laboratory officer narrated:

‘Here patients are escorted to the hospital by old women who are not fit to donate blood. In addition most men in this area are reluctant to donate blood and prefer to buy blood’.

Delay in providing prompt and adequate care by the medical team was also highlighted in the testimonies. A midwife narrated:

‘She was brought to the hospital on the 13<sup>th</sup> at around 9.00 am from another health centre. The doctor saw her and diagnosed hand-presentation. He [doctor] asked us [midwives] to observe her. No action was taken by the doctors up to the 15<sup>th</sup> late in the evening [48 hours later] when they took her to the theatre. He [doctor] first tried external cephalic version which failed before a caesarean section was performed. The patient was wheeled dead from the theatre’.

Poor management of staff availability, especially with regards to doctors, has been mentioned as a factor contributing to poor care. A midwife narrated:

‘There used to be four doctors in the maternity unit but in July all three went on leave together. Now only one doctor is available for the unit. He does ward rounds, performs operations and runs the out-patients clinic. Even when there were four doctors we usually have problems with them [doctors] because there is no duty rooster in place. After normal working hours when there is an emergency it is always difficult to see them’.

## **Discussion**

The Gambia was the first country to implement a sisterhood approach to measure maternal mortality rates. Former studies of maternal deaths in the Gambia indicated a decrease in numbers. However, factors related to health care delivery could contribute to further improvement, as substandard care has been demonstrated as a contributing factor to poor survival. We used multiple sources of information, such as health workers’ identification, community leaders’ knowledge, hospital files and postpartum follow up visits to identify maternal deaths that took place in the health care facilities.

Maternal death is often a consequence of a long and complex chain of delays, and only in few cases death can be attributed to a specific event. Any one delay could be fatal to a woman with obstetrical complications. Contrary to the common belief, that women do not seek care and die in the community, we identified a number of women who initially intended to deliver at home, but tried to get assistance once a complication occurred. The problems encountered in trying to do so, reveal major obstacles in access to appropriate care within an acceptable time.

### **Delay in deciding to seek medical care**

Delay in deciding to seek medical care on the part of the woman or her relative is usually regarded entirely as patient factor. First, the illness or complication must be recognized and classified as abnormal. Recognition of an illness may be influenced by factors such as the prevalence of the condition. In a study among pregnant women in Senegal, 13% regarded fever, pallor and dizziness as normal signs of pregnancy because these conditions were common among pregnant women in the area. In Tanzania, rural women seem to avoid going to the hospital because of fear of discrimination, geographical and financial barriers and different interpretation of danger signs. Raising awareness is a health education issue for health care workers and the community. One role of appropriate antenatal care is to address these issues and to offer care seeking solutions in advance. Access to skilled attendance at childbirth includes improved technical skills as well as skills in attitude, communication, information and early advice on referral. Brown defined culture as a 'complex whole' that refers to the learnt pattern of thoughts and behaviour characteristics of a social group. It involves religion, kinship, knowledge, belief, art, morals and child bearing practices. The tendency to act or not in the presence of a complication is also influenced by the interpretation supported by cultural beliefs. Several studies carried out in Africa and elsewhere have highlighted how culture influenced health care seeking process. Religious belief was mentioned to have influenced the care seeking process in this study. Jansen asserted that religion, medicine and magic are closely interwoven. If the barriers to care are too overwhelming, a culturally based reassurance that 'things most likely will go well' may cause a hesitation in recognising early signs of complications.

Health service related factors were mentioned to have constrained the decision-making process in this study. Bad experience with the health system will mostly lead to reluctance or non-utilization of health care services. Poor provider attitude towards patients has been identified as a major factor to low utilization of services in Kigoma and to low compliance to a referral hospital by high-risk pregnant women. The communication barriers between lay people's concepts and those of professional care providers may lead to serious misinterpretations. Women in the Gambia often resort to home delivery assisted by a traditional birth attendant or a relative as their first option. Sundari identified unfamiliar setting at the health facility, being attended to by strangers, lack of family support, attendant being male care provider, reduced autonomy, lack of sympathy and understanding on the part of the health care personnel and not seeing the need for care as some of the factors contributing to non-utilization of health services during labour and childbirth.

### **Delay in reaching an appropriate medical facility**

Lack of public transportation systems in rural areas requires that communities need to form partnership with the local commercial transport owners in addressing the transport problem. This strategy was adopted in North-Western Nigeria and had contributed to the reduction of maternal deaths and cost of transportation.

Major health centres are strategically located in the Gambia, but accessing them does not necessarily mean to receive appropriate care. Sometimes using these sites as the entry point to health services can delay further attempts of accessing adequate care. Efforts to transfer health centres into fully functional basic obstetric emergency units could reduce the delay caused by long transportation time.

Being unable to meet the costs for immediate health care was not seen as a main obstacle. Some health facilities supported by non-governmental organizations [NGOS] and local associations have implemented a system of cost sharing in order to provide quality health care.

### **Delay in receiving prompt and appropriate care after reaching the hospital**

A multiple-centre study from three West African countries, reported that most of the women classified as ‘near misses’ were referred from another facility, highlighting the need to differentiate between those who arrive in a critical condition and those who develop one. Inadequacy of health care may be due to one or a chain of the following events: shortage of medical supplies, lack of equipment, lack of trained personnel, and incompetence of the available staff. Health system failures have been identified as a major contributing factor to maternal deaths.

### **Conclusion**

The failure to get adequate treatment in time may be seen in a ‘right to access health care’ context. Women’s access to appropriate services is a concern in the Gambia. This study reveals that women do try to reach adequate health services when an emergency occurs, that there are many obstacles that delay this process. Improving accessibility and quality of EOC services in the area is necessary if maternal deaths are to be prevented.

**Note:** The study, from which this presentation is adopted, was partly financed by Norwegian government quota grant for students from developing countries for higher studies in Norway. The project was also funded by the Participatory Health Population and Nutrition Project (PHPNP) of the government of The Gambia.

## **Global Situation of Obstetric Fistula by UNFPA, Nigeria**

Obstetric fistula (OF) is a hole in the birth canal caused by prolonged labour without prompt medical intervention, usually a Caesarean section. The woman is left with chronic incontinence and, in most cases, a stillborn baby.

The smell of leaking urine or faeces, or both, is constant and humiliating, often driving loved ones away. Left untreated, fistula can lead to chronic medical problems, including ulcerations, kidney disease, and nerve damage in the legs.

Without treatment, fistula often leads to social, physical, emotional and economic decline. Although some women with fistula display amazing courage and resilience, many others succumb to illness and despair.

### **Global Situation**

- Once common throughout the world, fistula has been virtually eliminated in Europe and North America through improved obstetric care.
- An estimated two million women are living with fistula in developing countries, with an additional 50,000 to 100,000 new cases occurring each year. These figures are based only on the number of women seeking treatment, and are likely to be gross underestimates. In areas with high maternal mortality, fistula may occur at a rate of two to three cases per 1,000 pregnancies.
- About 15 per cent of all pregnancies will result in complications that require emergency medical intervention.
- Only 58 per cent of women in developing countries deliver with the assistance of a professional (a midwife or doctor). Only 40 per cent give birth in a hospital or health centre.
- The average cost of fistula treatment — including surgery, post-operative care and rehabilitation support — is US \$300, well beyond the reach of most women with the condition.
- The success rate of fistula repair for experienced surgeons can be as high as 90 per cent while after successful treatment, most women can resume full lives.
- Obstetric fistula is preventable and treatable.
- Prevention is the key to ending fistula.
- Meeting the existing demand for family planning services would reduce maternal deaths and injuries by 20 per cent or more.
- Women in sub-Saharan Africa suffer almost twice as much illness from sexual and reproductive health causes than women in the world as a whole.
- Chances of an African woman dying in pregnancy: **1 in 16**
- Chances of a woman in high-income countries dying as a result of a pregnancy: **1 in 2,800**.
- Number of new obstetric fistula cases resulting from childbirth occurring in the U.S. each year = 0
- The year the last U.S. hospital treating fistula patients closed its doors: 1895.

- In 2003, UNFPA launched a global Campaign to End Fistula. The Campaign is now under way in more than 35 countries in Africa, Asia and the Arab region.

### **Types of Obstetric Fistula**

There are basically three types of Obstetric Fistula depending on the location of the injury/hole;

1. **Vesico-vaginal fistula (VVF)** - this occurs when the hole is between the bladder and vagina causing urine to leak continuously.
2. **Recto-vaginal fistula (RVF)** – this occurs when the hole is between the rectum and vagina causing feaces to leak continuously.
3. **Combined fistula (VVF + RVF)** – in this case the two types occur together, therefore Urine and Feaces leak uncontrollably and concurrently.

### **Cause(s) of Obstetric fistula**

Prolonged Obstructed labour accounts for 80 – 95% of Obstetric Fistula. This usually occurs when the baby's head is too big; the birth canal is too small or the baby's presentation is abnormal.

Thus obstructed labor occurs when the fetus will not fit through the mother's pelvis (cephalo-pelvic disproportion), when the fetus is not positioned correctly for delivery (malpresentation), or when uterine contractions are ineffective in delivery. An obstructed labor is considered prolonged after 24 hours, and it can last one week or more unless the fetus is delivered surgically.

In prolonged labor the unrelenting pressure of the entrapped fetal head against the mother's pelvis can cut off the flow of blood to the soft tissues of the bladder, vagina, and rectum. If the mother survives, prolonged obstructed labor usually ends with the death of the fetus, followed by fetal decomposition to the point that it can slide out. The mother's injured pelvic tissue soon sloughs away, leaving a fistula/hole between adjacent organs. If the fistula is between the vagina and bladder (vesico-vaginal, or VVF), urine leaks from the vagina; if the fistula is between the vagina and rectum (rectovaginal, or RVF), feces leak. The great majority of fistulas are vesico-vaginal. Estimates of the extent of recto-vaginal fistulas are few but include 7% in a case series of patients in Ethiopia and 4% in a series of patients in Nigeria. An estimated 6% to 24% of obstetric fistula cases are combined VVF and RVF.

Rarer causes of fistula are from sexual abuse and rape, the complications of unsafe abortions and surgical trauma (following injury to the bladder at caesarean section or incisions to the genital area by Traditional Birth Attendants, TBAs). Gynaecological cancers and/or related radiotherapy treatment can also cause this condition, although this is rare in developing countries.



## **Predisposing factors**

### **a) Poverty lies behind most fistulas.**

While the immediate causes of obstetric fistula in developing countries are obstructed labor and lack of prompt access to emergency obstetric care, pervasive poverty is often a root cause. Usually fistula patients tend to live in remote areas and to be impoverished — factors typically associated with inadequate health care during pregnancy and delivery and thus with increased risk for obstetric complications. With less access to obstetric care, rural women are more likely to suffer fistulas than urban women. Among rural women those with lower social and economic status are more likely than others to suffer fistulas and other obstetric problems.

Recent country-level assessments confirm that most reported cases of obstetric fistula occur among rural, low-status women. The prevalence of untreated obstetric fistula appears closely associated with lack of skilled assistance during delivery and lack of access to emergency obstetric care, as well as the shortage of capacity for fistula repair.

Clearly the immediate causes of OF are obstructed labour and a lack of emergency obstetric care, nevertheless pervasive poverty is an important underlying cause. Women who suffer from OF tend to be impoverished, malnourished, lack basic education and live in remote or rural areas. Studies of fistula have found that over 99% of women undergoing repair were illiterate. In some sub-Saharan Africa countries the incidence of OF has been estimated to be about 124 cases per 100,000 deliveries in rural areas, compared with significantly lower number of cases in major cities. Like many other women in remote areas of poor countries, most women who develop untreated fistula give birth at home, without assistance from skilled birth attendants

### **b) Early childbearing increases risk.**

Although obstructed labor and obstetric fistulas can occur at any age during the childbearing years, adolescent women are at particular risk, especially where early marriage is common. In parts of sub-Saharan Africa, for example, many women become pregnant soon after menarche (the first menstrual period) occurs, before a woman's pelvis is fully developed for childbearing. In specific instances more than one-quarter of

241 fistula patients studied had become pregnant before age 15, while more than one-half had become pregnant before age 18. In many developing countries many adolescent women are undernourished, stunted, and underweight—factors that compound the risks of early pregnancy.

The traditional practice of early marriage contributes to a risk of obstructed labour and fistula. In parts of sub-Saharan Africa and South Asia, where OF is most common, women often marry as adolescents, sometimes as young as ten years of age, and many become pregnant immediately thereafter, before their pelvises are fully developed for childbearing. Fistula formation has also been found more likely to follow a first labour and often these girls and women may have been the victims of forced marriages.

In many traditional communities early marriage and childbearing, and large families, are the norm. There is little awareness of the need to delay the first pregnancy, or to space pregnancies well apart to enable the mother to recover and gain strength before a subsequent pregnancy. However, health services alone are unable to respond to these problems. Deeply embedded cultural and social values, and systems of beliefs, continue to form barriers which prevent young women from being able to manage their own lives and bodies. Changes in social and cultural attitudes, and enabling legislation to protect the rights of the health of adolescent girls, are also needed to help women delay their first pregnancy until they are physically able to deliver safely.

It has been estimated that up to 100,000 maternal deaths could be prevented each year if women who do not wish to become pregnant had access to, and used, effective contraception. The number of fistula that could be prevented by the availability of family planning must therefore be considerably higher.

### **c) The role and status of women**

The low status of women, particularly young women just after marriage, plays a fundamental part in fistula development. Some women are denied access to care, or actually harmed, due to cultural beliefs and traditional practices. Some women may live in seclusion and, for many, the responsibility to decide to seek health care in pregnancy, or even after prolonged labour, falls to the husband or other family members, including the mother-in-law. When these women fail in their perceived duty to bear live children and, still worse, develop the stigmatizing condition of OF, they are often rejected by their husband's family and have no means of subsistence. They are usually immediately divorced and left to fend for themselves.

### **d) Sexual violence as a cause of Obstetric Fistula.**

While the overwhelming majority of fistula cases stem from obstetric causes, others result from direct trauma caused by rape or other sexual abuse. At the one Fistula Hospital, for example, 91 of 7,200 cases over a six-year period, or about 1.2%, were caused by rape or other sexual abuse. Fistula caused by rape and other sexual abuse probably is far more common than this statistic suggests, because many victims do not

seek treatment, lacking access and often fearing stigmatization. In situations of war and civil unrest, when rape is usually far more common, often used as tactic to intimidate and control, the proportion of fistulas caused by sexual abuse can increase substantially. Aid workers in war-torn areas have estimated that one woman in every three is a rape victim and that the majority of new fistula cases are caused by rape

#### **e) Harmful traditional practices raise risks of fistula.**

In some areas harmful traditional practices, such as female genital cutting (FGC), also add, either directly or indirectly, to the risk for fistula and other gynecological and obstetric complications. FGC is usually carried out under unsanitary conditions, often removing large amounts of tissue and possibly causing the vaginal outlet and birth canal to become scarred and constricted. One well-documented practice during obstructed labor, “gishiri cutting,” occurs in northern Nigeria. A traditional birth attendant or local surgeon uses a sharp instrument—a knife, razor blade, or piece of broken glass, for example—to make a series of random cuts in the vagina in an attempt to remove the obstruction and make way for the baby. This practice can directly injure the bladder or urethra and may explain as many as 15% of fistula cases in northern Nigeria.

#### **f) Social consequences of Obstetric Fistula**

As if the misery of uncontrolled leaking of urine (and sometimes feces) isn't enough, these women and girls are ostracized and disdained by their families and communities. Without being cured, women with fistula commonly spend the remaining years of their lives in shame and isolation, literally waiting to die. They usually live in abject poverty, shunned or blamed by society and, unable to earn money, many fall deeper into poverty and further despair.

The wide range of adverse consequences, social as well as medical— which has been termed in some quarters as the “obstructed labor injury complex” — has crucial implications for care. The appreciation that one must treat the ‘whole person’ with the fistula—not just her injured bladder or rectum—is the single most important concept in fistula care. Often, society blames the woman for her condition, and some women even blame themselves. Many fistulas occur among women in traditional cultures, where women’s status and self-worth may depend almost entirely on marriage and childbearing. Many fistula patients are subsequently abandoned or divorced by their husbands, particularly when it becomes apparent that the fistula will not go away.

For example, 71% of patients were divorced or separated from their husbands in a recent study of 899 fistula cases at a hospital in Nigeria. While in India and Pakistan some 70% to 90% of patients studied in the 1980s had been abandoned or divorced.

Facing familial and social rejection and unable to make a living by themselves, many women with fistula live for years without any financial or social support and therefore slip into extreme poverty. Unfortunately some, unable to cope with the pain and suffering, resort to suicide. Other women living with untreated fistulas, however, show

remarkable resilience and strength. Despite the stigma, they find ways to support themselves and their children, and some set aside money for years to enable them access fistula repair.

### **Comprehensive approach to Obstetric fistula interventions**

The key strategies to address the Obstetric fistula challenge broadly follow the lines of;

- **Prevention**
  - Improve girls' nutrition to prevent stunted growth (which can leave the mother's pelvis small in relation to the baby's head) and to minimize the risk of complications during childbirth
  - Postpone pregnancy for young girls until they are physically mature (e.g by promoting girl child education)
  - Improve the status of women
  - Increase access to education and family planning services for women and men
  - Provide access to adequate medical care for all pregnant women and emergency obstetric care for all who develop complications
- **Treatment**
  - Repair physical damage through medical intervention
- **Reintegration and Rehabilitation**
  - Repair emotional damage counseling and psycho-social support

### **Prevention**

#### **Poverty, early marriage and human rights**

Early marriage is linked with poverty. In poor households, girls may be considered an economic liability and married off at a very young age, often without their consent. But early marriage tends to perpetuate the cycle of poverty. Conversely, girls who are educated are more likely to marry and start childbearing later and have smaller and healthier families.

In some cultures, families believe that early marriage can protect girls' reputations and secure their futures. But this can also mean a denial of their basic human rights, including the right to education, good health, economic opportunities, friendship with peers and free choice as to whether, to whom or when to marry.

"Girls are not free if they cannot go to school. Women are not free if they are expected to marry early and bear many sons."

- UNFPA Executive Director Thoraya A. Obaid

Poverty robs people of choices. It contributes to fistula by closing off options at critical points in a woman's life. Poor women often have little choice over who or when to marry.

They are less likely to have a say in their education or delivery care. If they do develop fistula, they have great difficulty finding the resources for treatment.

Extreme poverty prevails in many of the countries where fistula is most common, and undermines entire health systems. The HIV/AIDS epidemic has made matters worse. As a result, health centres and hospitals are often short-staffed, poorly equipped and unable to provide an adequate level of care. This poor quality of care is a reason some pregnant women avoid seeking medical attention: they associate hospitals with illness and death.

**Helping women gain greater power - and providing them with more options in life - are keys to improving reproductive health generally and reducing fistula.**

In countries where fistula is common, women may have little control over their own lives. They may also have little control over how resources are spent, in spite of their considerable paid or unpaid labour. And in the rural areas where fistula is most common, communities may be tightly bound by cultural practices and traditions, some of which make it difficult for women to protect their reproductive health.

In many cases, husbands, brothers or other family members make important decisions, including those having to do with childbirth. They may be poorly informed about the risks of childbirth and the need for medical care. Informing men about reproductive health issues through community-based advocacy activities can encourage and empower them to be better partners in this regard.

In some cultures, women cannot even leave the house without the permission of the husband, father or in-laws. Girls are less likely to complete their education than boys. Girls and women are also less likely than boys and men to get enough to eat. The resulting malnutrition or anaemia may stunt growth and contribute to poor pregnancy outcomes.

It's one thing to repair the horrific physical damage. It's harder but even more urgent to prevent the damage in the first place. That means confronting the social and economic ills that underlie girls' and women's vulnerability to fistula.

**Power dynamics affect reproductive health**

In places where women can freely make decisions about their reproductive lives and where they can pursue school or work, they overwhelmingly choose to delay the birth of their first child and to have fewer children. Both choices lead to fewer problems with childbirth, and to healthier mothers, children and families.

Education is a powerful lever to empower women in other ways as well. Educated women understand the need for appropriate care during pregnancy and childbirth. They have more power to assert and protect themselves. Improving women's education helps reduce fertility and child malnutrition and improve maternal and child survival.

**Delaying early pregnancies, spacing births and limiting total pregnancies are all ways to significantly reduce fistula as well as other maternal and infant injuries and deaths.**

Teenage pregnancies are risky, and the younger the girl, the higher the risk. Girls under 15 are five times more likely to die in childbirth than women in their twenties. Many of those who survive days of obstructed labour end up with fistula. Thus, delaying a girl's first pregnancy is a critical strategy for reducing fistula and maternal death as well as an important public health issue.

The dangers associated with early pregnancy are the reason the UNFPA led campaign also advocates for alternatives to child marriage. Young married girls are often pressured to get pregnant soon after marriage and may face a variety of barriers to accessing contraceptive services. In spite of laws against early marriage, 82 million girls in developing countries will be married before they turn 18. About half of all teenage girls will have their first child by the time they turn 18.

Too many pregnancies, or closely spaced births, are also detrimental to women's reproductive health and can result in complicated pregnancies, fistula, other injuries or death. Meeting the existing demand for family planning services would reduce maternal deaths and injuries by at least 20 per cent. However, in many of the countries where fistula is common, use of contraceptives is very low. It is estimated that at least 120 million women would use family planning methods if they had access to information and services about contraception or the support of their husbands and communities.

**Skilled attendance at birth, including swift surgical intervention if obstructed labour occurs, can prevent a fistula.**

Prolonged obstructed labour puts a woman at risk for fistula and other serious injuries, including death. Unless she receives prompt medical treatment - usually a Caesarean section - the lack of blood flow can cause soft tissues to die, leaving a fistula, or hole, in her bladder or bowel. Fistula has all but disappeared in countries where women experiencing complicated deliveries have access to timely emergency obstetric care.

The longer obstructed labour continues, the more likely it is to cause fistula or death. Delays - in the decision to seek medical attention, in reaching a health care facility, or in receiving emergency obstetric care at the facility - jeopardize both mothers and infants. A skilled attendant with obstetric training can help to recognize danger signs and treat certain complications. But women with obstructed labour need to get to an operating theatre quickly - so back up referral and transport to an appropriate facility also need to be organized ahead of time.

Longstanding customs may also limit a woman's access to obstetric care. In some cultures, women are expected to give birth at home, sometimes with no help, or with the help of traditional midwives. Husbands, male relatives or mothers-in-law may be the ones to decide what care a woman receives, and cost may play a large part in the decision.

*The sun should not rise or set twice on a woman in labour.*

— An African proverb.

About 15 per cent of all pregnancies result in complications and require emergency medical intervention. Caesarean sections to relieve obstructed labour are needed for between 5 and 15 per cent of all births. However, a recent assessment of health care in West Africa found that Caesarean sections represented fewer than 1 per cent of births in some countries.

### **Treatment**

At current levels only about 20% of the annual number of new cases (of Obstetric fistula) is being repaired each year. Therefore at the current treatment rates it would take about 140 years to clear existing backlog of obstetric fistula cases (provided the new cases can be prevented from occurring and death is not factored into the equation).

Creating more specialized fistula repair centers, expanding the capacity of existing hospitals to provide repairs, establishing hostels for fistula patients, and training surgical and nursing staff are important components in successful fistula repair.

More fistula hospitals and more trained medical staff are needed. Training more doctors in fistula surgery and encouraging them to maintain their skills should be a high priority. Team-based training that includes not only surgeons but also nursing and counseling staff can be particularly effective, because postoperative care is important to a patient's recovery. Supporting women and girls to be able to access the services at these centres should also be given due attention.

### **Reintegration and Rehabilitation**

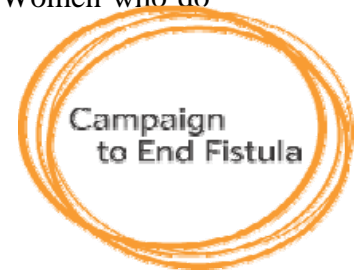
Women with fistula have endured enormous psychological and social trauma, often at a tender age. Empowering them to reclaim their place in society should be a major goal.

Surgical repair of their medical condition offers women with fistula the chance to return to a full life. In some cases, however, the disability has eroded their social and economic status, or worn away their self-esteem. Some fistula centres are able to provide basic education, training in income generating skills, and psychosocial support to help clients reintegrate into their communities.

Health education and counseling are key components of post-operative care. Women are advised on when it is safe to resume sexual activity and get pregnant. They are provided with or referred to family planning services. In areas with high HIV prevalence, prevention counseling is also encouraged. Following surgery, women are sometimes provided with a booklet or card describing their medical history and the need for a Caesarean section in the event of another pregnancy.

Some women who have gone through the suffering of fistula and the loss of a child never want to experience labour again. However, in many cultures, motherhood and childbearing are central to women's identity and social status, and many of the young women who are treated for fistula still have long lives ahead of them. Often, they desperately want to marry – or return to their husbands – and bear children. In most cases they can, so long as the pregnancy is closely monitored to prevent the possibility of complications. Usually a Caesarean section is recommended.

Post-operative medical counselling is critical. Abstaining from sex for several months after the fistula repair is advised. For women who do not want to go through another pregnancy, contraceptives should be made available. In areas with high HIV prevalence, information on how to avoid infection and condoms should be offered. Women who do want to get pregnant need to be advised on Caesarean sections.



### **Campaign to End Fistula**

UNFPA and its partners in the Campaign to End Fistula are committed to the internationally agreed-upon goal of improving maternal health by increasing access to skilled attendance at birth and emergency obstetric care.

UNFPA and its partners also work with community and religious leaders, traditional birth attendants, radio stations, influential public figures and policy makers to increase awareness of the needs of pregnant women and to mobilize support for them. UNFPA supports training of doctors, nurses and other health workers in life-saving obstetric care in about 76 countries.

Ensuring universal access to a full range of safe and reliable family planning methods by the year 2015 is part of UNFPA's mandate. UNFPA works toward this goal by supporting clinics and outreach services, training community health workers and other health providers, procuring contraceptive supplies and advocating for couples to have the information and services they need to freely plan their families.

Eradicating poverty, as called for by the Millennium Development Goals, is an overarching aim of many international organizations. UNFPA and its partners in the Campaign to End Fistula focus on tackling poverty primarily through interventions to improve women's reproductive health and rights. Reproductive health interventions also have far-reaching and inter-generational effects in terms of reducing poverty, and have been shown to be cost-effective entry points to ending the cycle of poverty.

UNFPA helps mobilize donor support to provide essential reproductive health services, equipment and supplies for countries that cannot afford to pay for them. The Fund also supports skills training and income-generating projects for women and adolescents, so they can break out of a cycle of poverty and have options beyond early marriage.

UNFPA and many of its partners in the Campaign to End Fistula also work to promote gender equality, which is one of the eight Millennium Development Goals agreed upon by world leaders in 2000. A benchmark for achieving this is equality in girls' and boys' enrolment in primary and secondary schools. UNFPA efforts to promote girls' education also tend to delay too-early marriage and pregnancy.

UNFPA is a powerful advocate for women in all the countries it serves. It also recognizes that changing deeply entrenched traditions requires sensitivity and patience. In many countries, UNFPA works with influential community and religious leaders, as well as traditional healers and midwives, who in turn, can be very effective in mobilizing support for women's right to reproductive health.

Expanding the role of fistula centres is a key strategy of the Campaign. As the Campaign is launched in each country, an important task is to identify and support health facilities that have the potential to serve as fistula centres for treatment, training and convalescent care. Already, the Campaign has encouraged communication and networking among fistula centres, which will facilitate training, research, advocacy, development of universal standards and fundraising.

The Campaign is educating individual women and men, communities, policy makers and health professionals about how fistula can be prevented and treated. Ending the 'culture of silence' that has surrounded fistula is a major strategy for improving lives and mobilizing resources. The Campaign has helped bring the issue to the attention of millions of people in the developed world.

Support for social reintegration is a component of several initiatives supported by UNFPA and its partners. For example, hundreds of women are benefiting from skills learned at an income-generating cooperative set up to help treated fistula patients. UNFPA works with NGOs to support the centre, which specializes in sewing and embroidery. Medical counseling is a key component of post-operative care. Women are advised on when it is safe to resume sexual activity and get pregnant. They are provided with or referred to family planning services. In areas with high HIV prevalence, counseling on prevention is encouraged. After surgery, women might also receive a booklet or card explaining their medical history and the necessity of Caesarean sections for future pregnancies.

## **Conclusion**

That obstetric fistula, a totally AVOIDABLE and PREVENTABLE human tragedy still challenges the developing world especially sub Saharan Africa is a situation that should no longer be condoned.

A broad coalition of stakeholders must urgently collaborate to implement various interventions across diverse sectors to engender the necessary development that will indeed put an end to "Obstetric Fistula".

**Country Experience on VVF Advocacy, Repairs, Rehabilitation & Re-integration**  
**By**  
**Jonathan A. Karshima, FWACS**

**INTRODUCTION:**

Obstetric Fistula which hence forth I will represent it with the acronym VVF is a devastating childbirth injury that occurs to women mainly as a result of severe social obstruction and neglect of the populace. It has remained a 'hidden' condition, and this is largely because it affects some of the most marginalized members of the population –the poor, young, often non literate girls and women of the poor and ignorant members of the society.

The continuous occurrence among us of VVF is a glaring indication of the enormous gap in maternal health care that exist between Nigeria and the developed world. VVF still exist because Nigeria fails or neglects to provide accessible, quality and culturally acceptable maternal health care, including family planning, skilled birth attendance, basic and emergency maternal care, and affordable treatment of fistula. For example estimated 54,000 women died in the year 2003 alone, because Nigeria failed to give them quality, socially acceptable and accessible maternal health services, (FMOH 2003)

It is however encouraging to note that VVF is beginning to gain attention at many levels of the society, including the international community.

**ADVOCACY: NIGERIA EXPERIENCE**

With a dehumanizing problem of such magnitude like VVF in our country, one of the key strategies to eradicating and controlling it is advocacy. Advocacy in general terms means speaking out in order to gain support over an issue. Initial efforts at controlling the problem of VVF in Nigeria were within medical circles. This recorded marginal success in raising public consciousness and catalysing public action to deal with the underlying determinants of VVF. Yet, this continued until early 1990s, the decade that I consider as the turning point in addressing the issue of VVF in this country. In 1990, the Society of Obstetricians and Gynaecologists of Nigeria (SOGON) held a national conference on Safe motherhood initiative as a follow up to the 1987 Kenyan international conference to address the rising profile of Maternal mortality and morbidity in the developing world, sponsored by UNFPA, World Bank, WHO and other development partners. The issue of VVF as living evidence of the plight of women in childbearing in this country came glaringly to the fore. National Council of Women Societies (NCWS) under the leadership of Hajiya Amina Sambo MON in 1991 took up the challenge and constituted a National Task Force on VVF to spearhead a national, multi-sectoral fight against VVF. This task force later transformed to the National Foundation for Vesico-Vaginal Fistula (NF-VVF). Because of the activities of this NGO, Kano and Katsina State Governments and the Federal Government of Nigeria started addressing the problem of VVF. Multilateral organizations like UNFPA, bilateral organizations and international organizations started giving support to VVF work. The experience that will be shared in this write up is that which resulted from the work of NF-VVF.

The NF-VVF, founded in 1991 transformed from National Task Force on VVF of the National Council of Women Societies to spearhead a national, multi-sectoral campaign in addressing the issue of VVF.

### **ADVOCACY: GOAL**

The goal of NF-VVF is to contribute to the promotion of quality of life of women and families through a multi-sectoral campaign against VVF.

### **ADVOCACY: JUSTIFICATION**

The magnitude of the problem provided the justification for the intended effort. The organization also observed a high level of neglect of the problem by the relevant stakeholders at the time the issue caught its attention. There was also absence of information for public consumption on VVF and also very little knowledge about the problem among stakeholders, including, in some instance health managers.

### **ADVOCACY: TARGET**

The campaign against VVF in Nigeria calls for a comprehensive, multi-dimensional, multi-sectoral, collaborative effort of all stakeholders. This was understood ab initio by NF-VVF and the target for the advocacy were policy makers and leaders at all levels. The first effort was to 'recruit' other organizations to join the advocacy and social mobilization. The first target was therefore Civil Society Organizations, particularly the women's organization so as to lead in the advocacy effort.

The government is the custodian of laws, policies and the national treasury. The government became the next target so as to formulate appropriate laws and policies that can support VVF work and also create the enabling financial and material environment.

The third target was partner agencies like international, bilateral and multi-lateral organization to support VVF work with technical and financial support.

The fourth and important target was the community and religious leaders and those significant others necessary to carry out community sensitization and provide critical support.

### **ADVOCACY: AIMS**

The aims of the advocacy work by NF-VVF were to mobilize resources and the build capacity of the few treatment centers to clear the backlog of the women suffering with VVF. Advocate for formulation of relevant policies that will promote the prevention and control of VVF. Raise awareness on the problem to such a level that community members are no longer ignorant of the problem. Enlighten the public and sensitize communities to supporting women suffering with VVF and the campaign against VVF. Finally, mobilize other stakeholders in a strategic manner to join the fight against VVF.

### **ADVOCACY: STRATEGY**

#### Situation Analysis:

To achieve the desired aims as stated above, five strategies were developed. The first was to have a good knowledge of the status problem in the country. Inadequate information and knowledge was a bane of the problem. The Foundation needed to have facts to guide the development of advocacy messages and kits. The first country wide VVF fact-finding mission was undertaken at the inception of the Foundation in 1991. The visits were very revealing and showed the following findings

- A wide spread ignorance about VVF

- Large number of women awaiting VVF repairs at the few treatment centres.
- Wide variation in VVF related activities. The teaching hospitals had the required facilities and specialist for VVF treatment but charged fees that were beyond the reach of a fistula client or her family.
- The state hospitals offered free or highly subsidized treatment but lacked the skilled personnel and materials.
- There were only two dedicated and active VVF treatment centres in Nigeria; one at Anua in Akwa Ibom State under Dr. Ann Ward and the other Kano and Katsina under Dr. Kees Waldjilk. The two centres handled over 80% of the VVF repairs at that time in Nigeria.
- No centre had a comprehensive rehabilitation and/nor prevention programmes.

Twelve years later (Year 2003) a rapid assessment of the VVF situation was undertaken. This time the work was in collaboration with the FMOH. The study showed the following:

- A decline in volume of VVF surgeries done in the teaching hospitals compared with the finding in 1991. The development resulted from an increase in hospital charges in the teaching hospitals in a bid to recover costs as directed by the FMOH.
- More State governments, especially in the north-western zone established VVF treatment centres operated by doctors trained by the NF-VVF
- A faith based organization; ECWA had also started a VVF treatment centre at the Evangel Hospital Jos.
- An apparent increase in the number of women suffering with VVF.

Public enlightenment and community sensitization:

The information obtained during the fact-finding visits provided the basis for intense public enlightenment and community sensitization by development, production and distribution of fact sheet on VVF. Pictorials on the causes and prevention of VVF were also developed, produced and distributed. Appropriate messages were through media such as radio jingles and a documentary on VVF were produced, aired and televised. Series of conferences and workshops were held on the challenge of VVF.

Visits were made to various government ministries, departments and agencies. Courtesy calls were made to the Governors of the states in the north western zone and the Ministers of Health, Women Affairs, Education and Information. Various traditional and religious institutions were also visited as well as embassies, international and donor organizations. The Foundation actively participated at many national, regional and international conferences informing the world about the Foundation and the challenge posed by VVF in Nigeria. A national conference on VVF was organized in 1996 in Zaria and an international conference in 1998 in Abuja. These conferences provided avenues for

disseminating the information about the status of VVF in Nigeria to national and international communities.

## **RESULTS**

The advocacy effort by the NF-VVF yielded significant results. The level of awareness about VVF increased with more people being aware that childbearing at too early an age (below the age of 18) posed the risk of developing VVF at childbirth. Advocacy to the government resulted in increasing support to VVF work and enabling policies by the Federal and State governments. Through the effort of the then Honorable Minister for Health Prof. Olikoye Ransom-Kuti, the Federal government supported the treatment of VVF patients and training of doctors in VVF work through contracting the services of an expatriate surgeon. It also supported NF-VVF to conduct a rapid assessment of the VVF situation in the country to generate data for the development of a national strategic framework for the eradication of VVF in the country.

Human resources issues also received attention with training materials being developed and more doctors, nurses and social workers trained in the care of women with VVF. The Nursing and Midwifery Council of Nigeria approved the training materials for the nurses.

The infrastructural facilities of the few fistula centers were also improved resulting in the equipping and strengthening of the fistula centres in Kano, Katsina, Sokoto and Anua in Akwa Ibom State.

A sharp increase in the number of women who received surgery for VVF was also recorded and has continued to increase. The doctors trained under the human resource development scheme are now active in VVF treatment at their various hospitals across the country. More treatment centres emerged and the centres in Kano and Katsina now receive patients' from as far as Chad and Niger republics.

Fistula workers and advocates now participate actively in National and international conferences while research in VVF related issues started getting attention. A national rapid assessment of VVF situation was conducted in 2003 resulting in the development of the national strategic framework and plan for VVF eradication in Nigeria 2005 to 2010 by the FMOH with the support of UNFPA. Published report in the medical journal increased. The centres in Kano, Katsina, Anua and Jos increasingly attract study and research fellows from abroad. Kelsey Harrison delivered a lecture at the highly prestigious William Meredith Fletcher Shaw Memorial Lecture, titled "poverty, deprivation and maternal Health, at the Royal College Obstetrician and Gynaecologist in London in 1995.

The advocacy work generated increased interest with new entrants in VVF related work at both national and international level. In 2003, UNFPA led other Partners to launch the end fistula campaign that is now in over 30 countries of the developing world of Sub-Saharan Africa, South Asia and the Arab States. In Nigeria, UNFPA has adopted the National Strategic Framework for the eradication of VVF, conducted the first ever fistula fortnight that treated over five women with VVF within two weeks, supporting the

FMOH in the proposed National fistula Centre, strengthening of VVF treatment centres with needed equipment, and continued sustain advocacy work to secure the highest level of commitment and support of political and other leaders (traditional, community, religious). Other entrants into VVF work in Nigeria include Rotary international, USAID through Acquire project and others. Multi-lateral, bilateral organizations and International donor agencies that are now keen on the VVF problems and have given support to the work include UNDP, Japanese government, Netherlands government, Ford Foundation and many others.

Increasing support to VVF work and enabling policies by the Federal and State governments including NGOs has given birth to the development of Child Right Act 2004, establishment of a coordinating unit headed by an officer of Deputy Director cadre in the Federal Ministry of Health and opening and strengthening of more VVF treatment centres like the Evangel VVF Center in Jos. More support also comes to treatment of VVF patients as Rotary international launches the treatment coupon.

### **ADVOCACY: LESSONS LEARNED**

Advocacy is critical in the fight against the menace of VVF. The effort of the Foundation in speaking out about the issue yielded great success and brought the problem to the attention of stakeholders outside the medical paradigm. It became obvious that VVF in a society results from social obstruction and neglect; and so one of the key strategies to deal with it has to involve social context. Advocacy needs to be on a sustained basis to deal with pronouncements and promises received. There is need for commitment to policy statements and undertakings by relevant leaders. Several of such statements which have been made since early 1990s are still awaiting actualization.

It also became obvious that prevention of VVF is Key, and needs to be strategically undertaken within the concept of Safe Motherhood. However significant achievement has not been made in securing total care for the woman with VVF. Care of the VVF sufferers should be comprehensive and to include rehabilitation and re-integration of the women in to the community.

Involvement of VVF sufferers into the advocacy activities on the problem has the potential of provoking deep emotions from the targeted audience. UNFPA Nigeria is already working on that with the project “Fistula Voices” as an advocacy strategy with great success.

### **THE GAPS**

There are still issues that need attention in the fight against VVF. What have been achieved are just the fundamentals of the fight against VVF with the backlog of about one million women, by any definition intimidating. With yearly addition to this figure of about thirteen to twenty thousand new cases is to say the least demoralizing. There is urgent need to secure highest level of commitment and support of political and other leaders. This calls for a strategic partnership of the relevant stakeholders in the various VVF related works. Public education and community sensitization and mobilization are hitherto erratic and need to be sustained. This is the area community dialogue with

community and religious leaders became germane. As custodian of the people's culture and values, there is need to get them fully equipped and involved in the fight against VVF. The goal of getting the community leaders involved is to produce the 'coca cola' (getting it everywhere) effect of the stories about the social and physical consequences of VVF.

Maternal health services in the country are still not positioned to stop more VVF. Even where the services exist, utilization remains an issue. When stories that effective use of maternal health services can prevent VVF becomes a household story, the demand for the services will increase.

Other areas that need attention and advocacy effort include human resources development & sustenance to clear the daunting back log of women suffering with VVF. Follow up to this is institutionalization of training and standardization of care. This can be taken up with the appropriate institutions that coordinate post graduate medical training in the country. Most of the VVF centres are facing serious financial challenges for getting the appropriate equipment and facilities, rebate and subsidy for patient care. Even at the FMOH, the coordinating and monitoring unit need strengthening to effectively carry out their functions. Finally the issues of research and documentation should not be left out. This component of VVF work is required to provide factual data for improved performance and also to inform policy, programmes and project development and reviews.

### **REHABILITATION AND RE-INTEGRATION**

This is a highly needed but relatively new intervention in the care of fistula. The justification is based on the neglect and rejection of the fistula women by people, their families and sometimes even their religion. The profile of a fistula woman is usually that of a poor, powerless, non literate rural young girl who has been probably been abused by the family into forced marriage. These women need holistic care in such a manner that provides emotional, psychological and economic support after a repair. However, in addressing this area of care, the structuring of the intervention should be based on the realities of life after surgeries for women. One important thing to remember is that, for most of the women, full cure and integration is when they remarry and have children again. Because this intervention is an evolving approach, there is therefore need to share experiences on the successes and challenges as we gain more experience with this comprehensive care of the fistula woman.

### **BACKLOG AND NATIONAL RESPONSE**

There has been response by the national government towards the VVF backlog in the country. Some of the interventions have been completed and others in progress. These include national reproductive health policy, national VVF Program in collaboration with the Katsina state government: Katsina Project; Road Map for Accelerating MDGs for Safe Motherhood & Child survival in Nigeria; National strategic framework and plan for VVF eradication in Nigeria 2005 – 2010. The Child Act Law, domestication of CEDAW, National Standard of Practice and the National Obstetric Fistula Center. All

these intervention strategies except the last two are aimed at addressing the fundamental causes of VVF in our society.

## **RECOMMENDATION**

These recommendations are grouped into:

### Immediate:

The public education and community sensitization and mobilization on VVF related issues should be sustained. But this activity needs fund and wide range of collaboration. Our women who chose to procreate are on national service to preserve our future. They need nothing short of quality maternal health services, particularly skilled attendant at birth and effective, accessible and affordable emergency critical care that will save their lives and prevent VVF. There should be free maternal health services at all level. This is achievable with some states in the country are already embarking on it. What is left is to ensure that the quality of the free care is of a sufficient standard and the coverage is as widespread as it should be.

Critics of this programme argue that in some states where maternal cares has been free for several years, there is no commensurate reduction in maternal deaths and VVF. This could be the result of an increased demand for the free services which invariably overwhelms the already stretched human resources. There should be exemption of VVF sufferers from payment of hospital charges for surgical repairs and subsequent deliveries. Most importantly there should be budgetary provision for reproductive health, particularly safe motherhood and VVF related work by all the three tiers of government on a sustained basis if these recommendations are to work.

### Fundamentals:

The immediate interventions can only work if there is political will to improve living condition of populace, commitment to social justice and strong desire to improve the social and economic infrastructure through the NEEDS, SEEDS and LEEDS – the povert reduction strategy papers (PRSPs) of the government of Nigeria at levels.

All the children born should go to school, particularly the girl child to at least nine years of learning. There is need to mainstream gender equity and empowerment into our social life.

Other fundamental issues that need to be addressed as we face the challenge of VVF problem among us is child survival. Families need to be guaranteed the survival of the children they bear by provision of effective child survival strategies. This is critical because mother s temptation for higher order deliveries become strong with the consequent complications as they bury their children.

Finally there should be a concerted effort by all of us to fight corruption to the minimum in our private and public economic and social systems. The health and medical education in the country too need to be strengthened to meet with the challenges of the providing quality care especially fistula surgeries and dealing with obstetric emergencies. After developing the human resources for providing the required service, adequate compensation and incentive should also be provided, particularly for those willing to work under challenging environment. ‘Brain drain’ and incessant labour strike in the

health sector greatly contribute to the adverse outcome of pregnancies and childbirth in this country.

#### Community Participation

Social mobilization through community dialogue meeting should be encouraged to support VVF related work at the community level. Presence of facility does not necessarily translate to its utilization. The communities have to be encouraged to own the facilities. Community input will also ensure sustainability. Therefore it will be important to involve traditional rulers, politicians, women group, motor union members and importantly the VVF women themselves. A functional feedback mechanism will also help with the review of the programme and project for effective outcome.

#### Legislative Advocacy

Advocacy to parliamentarian with the aim to make child bearing less of a risk & less burdensome is also important in the fight against VVF. Many states in this country have not domesticated the Child Right Act and this is happening in the states that the law is most needed. The issues of harmful traditional practices also need attention. It is time to starting thinking on legislating on mandatory registration & confidential enquiry of maternal death. Advanced pregnancy is not a hidden physiological event and so is maternal death even in the remote communities. Immediate family members know when a woman dies of pregnancy or childbirth and so the neighborhoods. Traditional rulers can take up responsibility of reporting maternal death. If the desire for the information is devoid of punitive effect, but purely programme reviews and management, cooperation will be more secured. The bill for the institute of reproductive health that was “killed” in the federal parliament needs to be revisited.

### **CONCLUSION**

Let me conclude this discussion with a quotation from the world famous advocates and fighters of the menace of VVF on the African continent, Drs Reginald & Catherine Hamlin, “To meet one of these mothers is to be profoundly moved. Mourning the stillbirth of their only baby, incontinence of urine, ashamed of their offensiveness, often spurned by their husbands, homeless, unemployable except in the field, they endure, they exist without friends, without hope. No world charities have ever heard of them. They bear their sorrows in silent shame. Their miseries untreated, are utterly lonely and alone”.

Hundreds of thousand young mothers in Africa, Nigeria annually suffer childbirth injuries that reduce them to ultimate state of human wretchedness. We need to stop the scourge and make childbearing a rewarding experience.

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**Nigerian Country Experience On The Use Of Multi-Media Communication Strategies For Maternal Health And Obstetric Fistula Advocacy By The Population Media Centre (PMC)**

**Background of PMC**

The mission of PMC is to work with mass media and other organizations worldwide, to bring about stabilization of human population numbers at a level that can be sustained by the world's natural resources, to lessen the harmful impact of expanding humanity on the earth's environment and to help large numbers of disadvantaged people move out of poverty. The emphasis of the organization's work is to educate people about the benefits of child spacing, encourage the use of effective family planning methods, increase knowledge of Reproductive health, elevate women's status, promote the concept of gender equity and protect children from exploitation.

PMC strives to improve the health and well being of people around the world through the use of entertainment-education strategies, like serialized dramas on radio and television, in which characters evolve into role models for the audience for positive behavior change. The strategy that PMC uses makes life-saving information accessible and enjoyable to people who have access to either radio or television.

PMC uses a specialized methodology created by Miguel Sabido of Mexico for developing serialized programs that are effective in changing attitudes and behavior related to people's health and well-being. These social-content serial dramas are based on extensive formative research regarding audience attitudes, behavior and beliefs. The programs are written and produced locally to be country specific and culturally sensitive. The dramas do more than provide audiences with information; they effectively change attitudes and behavior. The advantages of using long-running, entertainment serial dramas include their huge audience appeal and the emotional bonds that are formed between the audience members and

characters, which can lead to strongly positive influences of the characters on attitudes and behaviors by audience members.

PMC was founded in 1998 with the intention of using the extensive experience of its key personnel to spread the application of the Sabido methodology to address critical global sustainability issues in countries that had not benefited from it. In addition to Miguel Sabido, PMC's training team includes many of the people who have been trained by Sabido and have successfully applied the methodology in various cultural settings.

To date, the organization has worked in Brazil, Botswana, Burkina Faso, Cote d'Ivoire, the Eastern Caribbean, Ethiopia, Ghana, Jamaica, Mexico, Malawi, Mali, Niger, Nigeria, the Philippines, Rwanda, Senegal, Sudan, Swaziland, the United States, Vietnam, the Western Pacific, and Zimbabwe. In addition, PMC has provided training to radio personnel from Angola, Guinea Bissau, Mozambique, Namibia, South Africa, Cambodia, Mongolia, Nepal, Papua New Guinea, and Vietnam. Prior to PMC's formation, PMC personnel also worked in Brazil, China, India, Kenya, Madagascar, Mexico, the Philippines, St. Lucia, and Tanzania. PMC is currently developing projects in China, Democratic Republic of the Congo, Egypt, Guatemala, Honduras, Kenya, Madagascar, Morocco, Mozambique, Namibia, and Uganda and anticipates undertaking exploration of project opportunities over the coming year in Bangladesh, India, Nepal, Pakistan, Papua New Guinea, and Tanzania.

PMC takes a rights-based approach to addressing global sustainability issues. PMC's programs work to build societal understanding of the rights of the most vulnerable in society, especially women, children and people living with HIV/AIDS.

There is a critical need to broaden people's perspective on the range of reproductive choices available to them, to build their sense of self-efficacy with regard to having the ability and right to make decisions about reproduction and reproductive health, and to help them understand the likely consequences of each choice, so that they can make informed and voluntary reproductive decisions. Doing so in the context of serialized melodramas helps to ensure that large numbers of people are reached and that the emotional content of the program will cause them to remember the lessons learned.

This strategy is far more respectful of human rights than telling people what to do. It is also more effective than purely informational programs at changing social norms with regard to ideal family size, acceptance and use of family planning, and women's self-efficacy with regard to decision making about family matters. It is also an effective strategy for providing correct information about the relative safety of contraception compared to early and repeated childbearing.

PMC's programs have been demonstrated to bring about fundamental changes in social norms with regard to the rights and status of women, education of daughters, protection of children from exploitation, reduction of gender-based violence and abduction, avoidance of HIV/AIDS, spousal communication about sexual and reproductive health issues, the right to women's employment outside the home, and many related issues.

## THE SABIDO METHODOLOGY FOR BEHAVIOR CHANGE COMMUNICATION

### **Ethiopia: *Yeken Kignit***

In Ethiopia, PMC recently completed production of a radio serial drama, *Yeken Kignit* (“Looking Over One’s Daily Life”), which was broadcast over Radio Ethiopia in 257 episodes between June 2, 2002 and November 27, 2004. *Yeken Kignit* addressed issues of reproductive health and women’s status, including HIV/AIDS, family planning, marriage by abduction, education of daughters, spousal communication and related issues.

An independent evaluation of the impact of the program was conducted in December 2004. Preliminary findings from this study show significant results in terms of family planning and HIV/AIDS knowledge and practice. In most cases, there were significant differences in these knowledge and behavior change measures between listeners and non-listeners of *Yeken Kignit*, showing that the program had a differential effect on knowledge and behavior between listeners and non-listeners.

For example, among married women who are listeners to *Yeken Kignit*, current use of any family planning method increased from 12.3 percent to 43.5 percent (a 31.2 percentage point increase). Among non-listeners, use increased from 12.3 percent to 31.1 percent, an increase of only 18.8 percentage points. Among married men who are listeners to *Yeken Kignit*, current use of any method increased from 18.1 percent to 42.4 percent, an increase of 24.3 percentage points. Among non-listeners, use increased by only 14.6 percentage points. Male listeners went for HIV testing at four times the rate of non-listeners and female listeners sought HIV testing at three times the rate of non-listeners.

The projects in Ethiopia was supported and funded by David & Lucile Packard Foundation, the HIV/AIDS Prevention and Control Office of the Government of Ethiopia (HAPCO), the Hughes Memorial Foundation, the Flora L. Thornton Foundation, CARE-Ethiopia, Save the Children-U.S., the UN Population Fund and individual contributions.

### **Kenya**

PMC is working to develop a Sabido-style radio serial for broadcast in Kenya. Tom Kazungu, who was the first person in Africa and the first radio producer trained by Miguel Sabido, will produce the program.

### **Malawi**

In June 2004, UNFPA invited PMC to conduct a training workshop for writer, producers, and advisors with a project of the Ministry of Information that involved development of a radio serial drama to be broadcast by the Malawi Broadcasting Corporation. The program addressed HIV/AIDS, sexual and Reproductive Health and the general public.

### **Rwanda**

A radio serial drama was developed in Rwanda to address Reproductive Health, prevention of HIV/AIDS and related issues. UNFPA-Kigali, the Mulago Foundation, and the Flora L. Thornton Foundation funded the program. The program, Umurage Urukwiye

(“Rwanda’s Brighter Future”), began broadcasting nationwide in April 2007 on Contact FM on Mondays, Wednesdays and Saturdays and on Sundays and will run for two years. The program is so popular, that just three month after broadcast launch, UNFPA has asked PMC to increase the number of weekly broadcast from three to five.

### **Mali, Cote d’Ivoire and Burkina Faso**

In West Africa, PMC produced a radio serial drama to address issues of child slavery and the link between this problem and poverty-inducing factors, such as unwanted pregnancy and HIV/AIDS. PMC established an office in Bamako, Mali to oversee the project. Formative research was completed, and training was conducted for the producer and writers in June 2004. The radio serial drama went on the air in November 2004 and was completed in October 2005. The program, *Cesiri Tono* (“Fruits of Perseverance”) was done in partnership with First Voice International, which distributed the program via WorldSpace satellite to 169 community radio stations. These stations then broadcast the program throughout Mali, Cote d’Ivoire, and Burkina Faso. PMC received a grant from USAID to support this work. The Ashoka Foundation awarded PMC the Change makers Innovation Award (one of three worldwide) in their global competition for the most creative programs designed to prevent human trafficking.

A random-sample, household evaluation survey was conducted in Mali, Burkina Faso, and Cote d’Ivoire in December 2005 to determine the impact listening to *Cesiri Tono* had on awareness of and attitudes towards child trafficking and exploitation and its underlying causes in the three countries. The survey data indicated that the program produced the following results:

### **MALI**

- 22.4% of respondents listened to the drama, which translates to approximately 3.1 million Malians.
- Listeners in Mali were half as likely as non-listeners to prioritize educating boys over girls (11% vs. 22%).
- 31% of listeners in Mali had discussed exploitative child labor during the period of the program, compared to 17% of non-listeners during the same period.
- The belief that it is acceptable for women to work outside of the home was 53% higher among listeners than it had been at baseline.

### **BURKINA FASO**

- In Burkina Faso, 23% of listeners had taken action against exploitative child labor, compared to 9% of non-listeners in Burkina Faso.
- 96% of listeners in Burkina Faso could identify at least one place that provides family planning/reproductive health services, compared to 80% of non-listeners.

## **COTE D'IVOIRE**

- 43% of listeners in Cote d'Ivoire had discussed children's rights in the 12 months before the end of the program, while only 25% of non-listeners had discussed children's rights in the same period.
- 32% of listeners in Cote d'Ivoire knew at least three factors that can lead to child trafficking, compared to 14% of non-listeners.

## **ALL THREE COUNTRIES**

- Listeners in all three countries were substantially more aware of child trafficking than non-listeners.

PMC and First Voice International are working together to create a new program for West Africa and are seeking funding, with endorsement by the Clinton Global Initiative.

### **Mozambique**

PMC has been invited to be the communications partner of the Inter Religious Campaign against Malaria in Mozambique (IRCMM). As part of the process of developing a communications strategy, a PMC delegation visited Mozambique in June 2006. PMC anticipates that the communications initiative will include a variety of issues in addition to malaria prevention, including elevation of women's status and promotion of reproductive health.

### **Niger**

In March 2005, PMC received USAID funding to implement a two-year radio serial drama project in Niger to address similar issues to those addressed in Mali, Ivory Coast and Burkina Faso. A Country Representative was brought on board, formative research was completed, and an in-depth workshop was held to train the producer and scriptwriters. The program, entitled *Gobe da Haske* ("Tomorrow will be a Brighter Day") went on the air on February 12, 2006 and was distributed by First Voice International via WorldSpace satellite to community radio stations in Niger. The program completed broadcasting on January 14, 2007. A final evaluation survey was completed in March 2007. USAID provided PMC with a no-cost extension through December 2007, to allow for re-broadcast of the program throughout Niger.

The final evaluation provided strong evidence of widespread listenership and significant changes in several indicators among listeners, as opposed to non-listeners.

- Of all households surveyed, 67.2% were familiar with the serial drama program.
- The vast majority of the listeners (94%) had no education or only primary education.
- 39% of listeners could identify at least three methods of family planning, compared to 10% of non-listeners.
- 67% of listeners had heard about exploitative child labor, compared to 28% of non-listeners.
- 55% of listeners had heard of child trafficking, compared to 28% of non-listeners.

- 23% of listeners knew the link between use of family planning and reducing exploitative child labor, compared to 6% of non-listeners.
- 40% of listeners had discussed exploitative child labor during the past 12 months, compared to 19% of non-listeners.
- 34% of listeners could cite at least three practices that lead to exploitative child labor, compared to 15% of non-listeners.

29% of listeners could cite at least three practices that lead to child trafficking, compared to 14% of non-listeners.

### **Senegal**

Population Media Center has received funding from USAID and UNFPA-Senegal for two radio serial dramas that will go on the air in April 2008. One serial drama, funded by USAID, will be written and produced in the Wolof language, and broadcast nationwide throughout Senegal. This program will address USAID/Senegal's core themes of reproductive health, HIV/AIDS, child survival, and malaria prevention. The second serial drama, funded by UNFPA, will be written in the Pulaar language for broadcast in the UNFPA target region of Matam. This program will target youth and will focus on HIV and STI prevention, and sexual and reproductive health. The Matam region has been identified by UNFPA as a priority region, having a high need for youth health interventions. For the USAID program, PMC is a subcontractor to the *Agence pour le Développement de Marketing Social (ADEMAS)*, which implements USAID/Senegal's health social marketing activities. For both programs, PMC is working in coordination with RAES (*Réseau Africain de l'Education pour la Santé*) based in Dakar, Senegal and the University of California, Los Angeles, School of Public Health.

### **Sudan**

In August 2006, PMC completed a radio serial drama project dealing with reproductive health issues and elevation of the status of women and girls. PMC conducted formative and baseline research during the second half of 2003, and conducted a training workshop for the producer and writers in February 2004. The results of the formative research were presented during this training workshop, to provide a basis for development of the storyline, characters, and scripts. Broadcast of the program, *Ashreat Al Amal* ("Sails of Hope"), began in November 2004 over Radio Omdurman, with free air time provided by the government's Ministry of Information and Communication. The program was completed in June 2006, and evaluation research was conducted in July 2006 by a team from Ohio University led by communications scholar Professor Arvind Singhal. The David and Lucile Packard Foundation provided support for the work in Sudan.

Highlights of the results of the project in Sudan include the following:

- Monitoring data showed that among the targeted group (women of reproductive age) there was high listenership. Data gathered from clinic clients in 2005 indicated that between 29% and 39% of clinic clients listened to *Ashreat al Amal*.
- Attitudes toward female circumcision: There was a consistent increase over the project period in the percentage of the population who believe that female circumcision should be eradicated (from 28.6% to 65.4%). The qualitative evaluation

found that after the broadcast of *Ashreat al Amal*, listeners overwhelmingly supported eradicating the practice of female circumcision.

- There was an increase in the percentage of listeners who discussed HIV/AIDS with partners: Respondents to the impact evaluation were over 2 ½ times more likely to have discussed HIV/AIDS with their partners after the program than respondents at the baseline.

**Tanzania: *Twende na Wakati***

One of the most extensive evaluations of the effects of a social content serial drama occurred from 1993 to 1997 in Tanzania in a research project facilitated by PMC President William Ryerson. There, with funding from UNFPA, Radio Tanzania broadcast a serial melodrama that attracted 58 percent of the population (age 15 to 45) in areas of the broadcast. By design, in one region of the country, the area surrounding the city of Dodoma, a music program was heard instead of the soap opera during the first two years of the project (1993-95). From 1995-97, the program was then broadcast in its entirety in the Dodoma comparison area.

Independent research by the University of New Mexico and the Population Family Life Education Programme of the Government of Tanzania measured the effects caused by the program with regard to such issues as AIDS prevention behavior, ideal age of marriage for women, and use of family planning. While the population of the Dodoma comparison area was more urban than the rest of the country, a multiple regression analysis eliminated the influence such differences might have accounted for. Nationwide random sample surveys of 2750 people were conducted before, during and after the broadcast of the program. Data was also collected from the AIDS Control Programme of the government, the Ministry of Health, and the Demographic and Health Survey, all of which reinforced the finding of dramatic impacts on attitudes and behavior.

Among the findings were a significant increase in the percentage of the population who perceive that they may be at risk of HIV infection; an increase in people's belief that they can take effective action to prevent HIV/AIDS; an increase in interpersonal communication about HIV/AIDS; an increase in the belief that individuals, rather than their deity or fate, can determine how many children they will have; an increase in the belief that children in small families have better lives than children in large families; and an increase in the percentage of respondents who approve of family planning.

The study also provided evidence that the Tanzanian radio serial stimulated important behavioral changes. Over half the population of the areas where the serial was broadcast identified themselves as listeners, with more men than women in the audience. One of the key characters in the soap opera was a truck driver with many girl friends along the truck route. In the program he contracts HIV. Of the listeners surveyed, 82 percent said the program had caused them to change their own behavior to avoid HIV infection, through adoption of monogamy and through condom use. Independent data from the AIDS Control Programme of the government of Tanzania showed a 153 percent increase in condom distribution in the broadcast areas during the first year of the soap opera, while

condom distribution in the Dodoma non-broadcast area increased only 16 percent in the same time period.

The program was also effective in promoting family planning. There was a strong positive relationship between listenership levels by district and the change in the percentage of men and women who were currently using any family planning method. The research also showed an increase in the percentage of Tanzanians in the areas of the broadcast who discussed family planning with their spouses. The program also had a significant effect in raising the ideal age of marriage for women and the ideal age of first birth for women.

In regions where the program was broadcast, the percentage of married women who were currently using a family planning method increased 10 percentage points in the first two years of the program, while that percentage stayed flat in the Dodoma area during the time the program was not broadcast there. Then, when the program was broadcast in Dodoma, the contraceptive prevalence rate there increased 16 percentage points. In regions where the program was broadcast, the average number of new family planning adopters per clinic, in a sample of 21 clinics, increased by 32 percent from June 1993 (the month before the show began airing) to December 1994. Over the same period, the average number of new adopters at clinics in the Dodoma area remained roughly the same.

Independent data from Ministry of Health clinics showed that 41 percent of new adopters of family planning methods were influenced by the soap opera to seek family planning. This included 25 percent who cited the soap opera by name when asked why they had come to the clinic, and another 16 percent who cited “something on the radio” and then identified the soap opera when shown a list of programs currently on the air. Another family planning serial drama using a different methodology that was broadcast nationwide by Radio Tanzania at the same time was cited by just eleven percent of new family planning adopters at the same Ministry of Health clinics. These data point to the importance of the methodology used in the design of the serial drama.

Counting all of the costs of the radio serial, the cost per new adopter of family planning was under 80 cents (U.S.), a cost-effectiveness unmatched by any other known strategy. The cost per person who changed behavior to avoid HIV/AIDS was 8 cents (U.S.).

## ***LATIN AMERICA AND THE CARIBBEAN***

### **Brazil**

In Brazil, PMC is working in partnership with Comunicarte, a non-governmental organization in Rio de Janeiro, to assist TV Globo to incorporate social and health issues in its entertainment programs. The staff of this project meets regularly with the writers of the prime-time soap operas on TV Globo to suggest themes and storylines related to reproductive health. In 2006, the project was successful in getting TV Globo to integrate 1,148 scenes dealing with reproductive health, small family size, gender relations, and related social and health issues. These programs are broadcast nationwide in Brazil and

exported to dozens of countries worldwide, dubbed into various languages. The project is supported by the Hughes Memorial Foundation, the Mulago Foundation, and the Weeden Foundation.

One of the *telenovelas* TV Globo produced and broadcast was a 203-episode *telenovela* titled *Paginas da Vida* (“Pages of Life”) which completed broadcast on March 2, 2007. PMC/Comunicarte, the Brazilian national Down Syndrome Association, and BEMFAM (the Brazilian family planning association) worked with TV Globo to incorporate social messages into the *telenovela* about family planning and Down syndrome.

At the conclusion of the program, women were interviewed at reproductive health clinics throughout Brazil to monitor the effects of *Paginas da Vida* on decisions to seek family planning services. The data points to the widespread effects of this popular *telenovela*:

- 83.3% of women interviewed watched *Paginas da Vida* at least twice per week
- There was more than a 50% increase in knowledge among women interviewed with regard to various reproductive health issues such as: contraceptive methods, family planning, maternal health, maternity/paternity, unwanted pregnancy, adolescent pregnancy, and HIV/AIDS.
- 60% of women age 18-24 said that scenes in *Paginas da Vida* served as a stimulus for them to seek a health service.
- 65.4% of women interviewed said they would be “more careful” to prevent unwanted pregnancy.

## **PMC INTERVENTIONS IN NIGERIA**

### **GUGAR GOGGE:**

Rotary International estimates that about one million women in Nigeria have obstetric fistulae. To try to help, Rotary International helped set up clinics to repair the holes and alleviate the related incontinence, infections, and other injuries.

Rotary embarked on a comprehensive strategy of building the capacity of health personnel, then equipping hospital facilities, creating access to the facilities, and then communication. All other components were very successful, but communication was not as effective. With this, PMC was then invited by Rotary International to develop and broadcast a social-content radio serial drama in Nigeria so as to strengthen the communication component of the intervention.

PMC implemented a well-tested methodology for creating behavior change communication to address reproductive health in a way that honors a people’s value system. PMC used this methodology, called the Sabido methodology, to produce and broadcast *Gugar Goge* (“Tell It To Me Straight”), a 70-episode radio serial drama addressing maternal health, reproductive health, family planning, and obstetric fistula in northern Nigeria. The target audience for the radio serial drama was Hausa-speaking persons aged 15 and above. *Gugar Goge* was broadcast on Radio Kano AM service airing every Sunday 8 – 8:15 pm. On Radio Nigeria-Kaduna, Hausa Service, it aired every Tuesday 10 – 10:15 a.m. and Saturday 9:15 – 9:30 p.m.

During broadcast, five clinics in the broadcast area of Kano and Kaduna states conducted 764 client exit interviews, and data showed that mid-way through the 70-episode broadcast (September 2006), 33% of clients seeking reproductive health services and 54% of VVF clients were motivated by *Gugar Goge*. An endline study conducted at the conclusion of the broadcast showed that 83% of the audience listened to the program on a regular basis. Key program indicator changes from baseline to endline showed that knowledge of family planning increased from 62.4% to 76.1%, a relative percentage increase of 22 points; partner communication increased from 32.6% to 38.7%, an 18.7% relative increase; and the percentage of the population able to identify a source of contraceptives increased from 75.4% to 87%, a 15.3% relative increase.

To qualitatively evaluate the program from the listeners' perspective, communication scholar Arvind Singhal visited Kano immediately after the final episode of *Gugar Goge* in February 2007. For one week, Dr. Singhal held focus group discussions with listeners' groups to hear – from the audience's perspective – how the drama personally affected them. Results showed that participants liked the serial drama, found the information useful, and changed their attitudes or behavior as a result of the topics presented. The program also receive support from the David and Lucile Packard Foundation, individual support and the Conservation, Food and Health Foundation.

### **A LISTENER'S SUCCESS STORY**

Hajara Nasiru is from Angwan Luran Wali, a village near the borders of Kaduna and Kano States. During her last delivery, she developed fistula after having about 8 deliveries in which only 3 survived. Hajara had a prolonged, obstructed labor for 2 days, during which 2 traditional healers were called on to assist in the delivery. However, their efforts failed and the child died in the process. As a result of the delivery, Hajara developed fistula. She had been leaking urine for 9 weeks before she started listening to *Gugar Goge*. She became a regular listener and even called her husband to join her in listening to some of the episodes. At the end, not only did they become ardent listeners, they went to Kofan Goyan, a VVF Specialist hospital in Zaria, southern Kaduna to seek treatment. Hajara had a successful fistula surgery. This is just one of many similar stories from listeners that benefited from the program.

### **RUWAN DARE:**

Based on the tremendous success of *Gugar Goge*, PMC carried out a sequel radio serial drama project in Northern Nigeria in 2007. The new program, *Ruwan Dare* ("Midnight Rain"), began broadcasting in Kano, Kaduna, Katsina and Sokoto states on July 13, 2007. It is a 234 episode serial drama, addressing family planning, maternal health and fistula, provides information on family planning and Vesico Vagina Fistula. It will be broadcast over a period of two years within a three-year project.

The project consists of multi stage research including formative (literature review, media and health services analysis, individual interviews and focus group discussions), pretest, baseline and monitoring and evaluation researches. Also, the producers, scriptwriters and actors/actresses of the radio serial drama were trained in the Sabido Methodology used by

PMC in the serial drama. Broadcast of the program began in July 2007 on FRCN Kaduna; it comes on the air every Tuesday 9.45am-10.00am and Saturday 6pm-6.15pm. On Freedom Radio Kano, the serial drama is aired on Tuesday 8pm-8.15pm and Friday 8pm-8.15pm, while it is aired on Rima Radio Sokoto on Monday 9.30am-9.45am and Friday 6.15pm-6.30pm and on Companion FM, Katsina on Wednesday 8.30pm-8.45pm and Sunday 8.30pm-8.45pm. The program has aired 78 episodes so far, and in the monitoring interviews conducted at reproductive health and family planning clinics, about 220 clients in October – December showed that 55% of the clients reported that it was Ruwan Dare that motivated their visit to the clinic.

The second monitoring report carried out in January 2008 showed that 75.6% of clinic clients heard about Reproductive Health (RH) issues from the radio serial drama. More than 57.8% clients said the serial was their primary motivation to seek medical services.

The project monitoring report is based on facility assessment (client exit interviews) at reproductive health and family planning clinics to find out what motivated clients to seek services. 11 clinics research sites, one health post, one clinic and Planned Parenthood Federation of Nigeria clinic was chosen in Kano. In Sokoto, we have 1 basic Health center, 1 clinic and 1 PPFN clinic, Sokoto have 2 PPFN clinics, while in Katsina 1 clinic, 1 General hospital and 1 PPFN clinic was chosen, and 2 PPFN clinics were chosen in Kaduna for the client exits interview.

Based on the turn out of listeners who had fistula that came out for fistula repair, PMC received funding support from UNFPA to train women who are or had suffered from fistula. This training was organized in Kano from October 29 through November 6, 2007, where 10 women who were selected for this training. None of them was fluent in English, and the training had to be conducted in English with Hausa interpreters. The workshop was tagged, "*Fistula Voices*". The goal of *Fistula Voices* is to use the power of the media and community mobilization to change attitudes and behaviors, which lead to fistula. Trainees, who have experience with fistula, have the potential to be powerful "voices" for fistula awareness and education. They can learn communication and media skills and mobilize men and other community groups to advocate for fistula prevention and treatment.

The UNFPA strategy aims at postponing marriage and pregnancy for young girls to minimize the risk of complications from childbirth. The training also aims to build the capacity of these women to serve as community mobilizers in their community to fellow women who are suffering from fistula to go and get treatment.

## **CONCLUSION:**

PMC programs have been proven to be effective in countries that are applying the Sabido Methodology (which is based on several theories of behavioral psychology and communication) for behavior change communication. These have been independently evaluated by researchers, and have demonstrated its effectiveness. The effectiveness of

these programmes has been proven to motivate behavior change among target audience members. With continuous support, PMC Behavior Change Communication tools can be used to influence listeners to seek medical attention and sustainability of the world's natural resources.

## WHAT IS GENDER BASED VIOLENCE?

Presented by UNFPA, Nigeria

The definition of the 1993 UN Declaration of Violence against Women is;

*“Violence directed against a woman because she is a woman or that affects women disproportionately – that results in, or is likely to result in physical, sexual or psychological harm to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”<sup>1</sup>.*

Violence Against Women (VAW) has been called "the most pervasive yet least recognized human rights abuse in the world." VAW jeopardizes women's lives, bodies, psychological integrity and freedom. Around the world, as many as one in every three women has been beaten, coerced into sex, or abused in some other way — most often by someone she knows, including by her husband or another male family member; one in four women has been abused during pregnancy.

**"Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms...In all societies, to a greater or lesser degree, women and girls are subjected to physical, sexual and psychological abuse that cuts across lines of income, class and culture."--Beijing Declaration and Platform for Action, paragraph 112**

Gender-based violence both reflects and reinforces inequities between men and women and compromises the health, dignity, security and autonomy of its victims. It encompasses a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, as well as trafficking of women and girls and several harmful traditional practices. Any one of these abuses can leave deep psychological scars, damage the health of women and girls in general, including their reproductive and sexual health, and in some instances, results in death.

Violence may have profound effects – direct and indirect – on a woman's reproductive health, including:

- Unwanted pregnancies and restricted access to family planning information and contraceptives

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<sup>1</sup> This definition is adapted from General Recommendation 19 adopted by the Committee on the Elimination of Discrimination against Women; entitled “Violence against Women” in which the Committee formally included gender-based violence under gender based discrimination.

- Unsafe abortion or injuries sustained during the process after an unwanted pregnancy
- Complications from frequent, high-risk pregnancies and lack of follow-up care
- Sexually transmitted infections, including HIV/AIDS
- Persistent gynecological problems
- Psychological problems

Gender-based violence also serves – by intention or effect – to perpetuate male power and control. It is sustained by a culture of silence and denial of the seriousness of the health consequences of the abuse. In addition to the harm they exact on the individual level, these consequences also exact a social toll and places a heavy and unnecessary burden on health services. The chart below shows the different stages of life during which a women may face different forms of violence.

### Gender Based Violence throughout a Woman's Life

Phase	Type of Violence
<b>Prenatal</b>	Prenatal sex selection, battering during pregnancy, coerced pregnancy (rape during war)
<b>Infancy</b>	Female infanticide, emotional and physical abuse, differential access to food and medical care
<b>Childhood</b>	Genital cutting; incest and sexual abuse; differential access to food, medical care, and education; child prostitution; rape
<b>Adolescence</b>	Dating and courtship violence, economically coerced sex, sexual abuse in the workplace, rape, sexual harassment, forced prostitution
<b>Reproductive</b>	Abuse of women by intimate partners, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape, abuse of women with disabilities
<b>Old Age</b>	Abuse of widows, elder abuse (which affects mostly women)

*Source: Heise, L. 1994. Violence Against Women: The Hidden Health Burden. World Bank Discussion Paper. Washington, D.C. The World Bank*

### Nigerian Context

VAW cuts across lines of status, income, class, religion and culture and it affects every section of people especially vulnerable groups. It takes place in the family, community, public places, faith-based and educational institutions, as well as at work places. It makes women in particular, to continue to experience limited protection of their rights. Gender Based Violence (GBV) and Violence Against Women (VAW) in particular is rampant in Nigeria and has grown out of proportion in recent years, manifesting through a series of horrendous acts of body parts mutilation, spouse battering and sexual abuse in the form of rape, defilement and incest with fatal consequences.

Many have argued that the prevalence may not have increased but what has increased is the level of reportage. If this is true, then it shows that on-going efforts of development partners like UNFPA and local NGOs in creating awareness is yielding results in breaking the silence surrounding cases of GBV. However, the increased reportage indicates an alarming rate of older men raping very young girls. This trend has elicited condemnation by many stakeholders and with increased media coverage and discussions of VAW in general. UNFPA supports efforts that enable women to speak out against gender-based violence and access help when they are victims of it. The Fund is also committed to keeping gender-based violence in the spotlight as a major health and human rights concern. UNFPA advocates for legislative reform and enforcement of laws for the promotion and protection of women's rights to reproductive health choices and giving informed consent to partners. Equally, UNFPA promotes women's awareness of laws, regulations and policies that affect their rights and responsibilities in family life.

From 25 November to 10 December 2005, UNFPA joined other human rights organizations worldwide to bring greater attention to violence against women, a pervasive and deeply entrenched human rights violation. The 16 Days of Activism to End Violence Against Women involved groups all over the world who spoke up for support services for survivors, called for greater prevention efforts, pressed for legal and judicial reforms, and use of international human rights instruments to address the issue.

### **Countering Social Attitudes that Perpetuate Gender-based Violence and ending Widespread Violence Against Women**

Gender-based violence manifests itself in different ways in different societies. It may range from psychological abuse and physical harm within the family, to early marriage and other harmful practices. As noted in a major report issued by the UN Secretary-General, all forms of violence against women represent unacceptable violations of human rights and together they form a major impediment to gender equality. Within the UN system, UNFPA has been a leader in highlighting this important issue as a priority agenda for governments and helping national and sub-national authorities to develop strategies that address Gender equality and GBV within action plans.

Most domestic violence involves male anger directed against their women partners. This gender difference appears to be rooted in the way boys and men are socialized -- biological factors do not account for the dramatic differences in behaviour in this regard between men and women. Cross-cultural studies of wife abuse have found that nearly a fifth of peasant and small-scale societies are essentially free of family violence. The existence of such cultures proves that male violence against women is not the inevitable result of male biology or sexuality, but more a matter of how society views masculinity. Pregnant women are particularly vulnerable to gender-based violence. Some husbands become more violent during the wife's pregnancy, even kicking or hitting their wives in the belly. These women run twice the risk of miscarriage and four times the risk of having a low birth-weight baby.

Studies of very young boys and girls show that although boys may have a lower tolerance for frustration, and a tendency towards rough-and-tumble play, these tendencies are dwarfed by the importance of male socialization and peer pressure into gender roles. The prevalence of domestic violence in a given society, therefore, is the result of tacit acceptance by that society. The way men view themselves as men, and the way they view women, will determine whether they use violence or coercion against women. Ending gender-based violence will require remolding cultural concepts about masculinity, and that process must actively engage men, whether they be policy makers, parents, spouses or young boys.

The majority of sexual assault victims are young. Women in positions of abject dependence on male authorities are also particularly subject to unwanted sexual coercion. Rape in time of war is still common. It has been extensively documented in recent civil conflicts, and has been used systematically as an instrument of torture or ethnic domination. Now, with precedents set at the International Criminal Tribunal for Rwanda, in Tanzania, and the International Criminal Tribunal for the Former Yugoslavia, at The Hague, for mass rape, other acts such as sexual assault, sexual slavery, forced prostitution, forced sterilization, forced abortion, and forced pregnancy may qualify as crimes of torture, crimes against humanity, and even some as crimes of genocide.

### **The UN Response**

The United Nations Resolution 1325 on Women, Peace and Security was adopted on 31<sup>st</sup> October 2000 following initiation by the then Minister of Women Affairs in Namibia. The Resolution calls for:

- Prosecuting people for crimes against women (often committed with impunity);
- Extra protection of girls and women in war zones as they are more often deliberately victimized;
- Appointing more women for peacekeeping operations;
- Involving more women in negotiations, peace talks and post-war reconstruction planning;
- Women's equal and full participation as active agents in peace and security.

The key provisions of the resolution can be captured by three “P’s”

1. **Protection** of the human rights of women and girls during times of conflict,
2. **Prevention** of gender based violence (GBV)
3. equal **Participation** of women in peace building and reconstruction

UNFPA promotes zero tolerance of all forms of violence against women and works for the eradication of traditional practices that are harmful to women's reproductive and sexual health, such as rituals associated with puberty. UNFPA supports training of medical professionals, to make them more sensitive towards women who may have experienced violence and to meet their health needs. UNFPA promotes the provision of legal and psychological support, as well as medical referrals when necessary for GBV victims. Community involvement through creation of support networks for gender-based violence victims should include the police and health-care providers, along with counselling services.

Additional strategies the Fund employs to address gender-based violence include:

- Strengthening advocacy on gender-based violence in all country programmes, in conjunction with other United Nations partners and NGOs.
- Advocating for women with parliamentarians and women's national networks.
- Integrating messages on the prevention of gender-based violence into information, education and communication projects.
- Conducting more research on gender-based violence.

## **Conclusion**

The Millennium Development Goal 3 in particular and other MDGs will not be met unless greater attention and resources are devoted to women's empowerment, gender equality, and violence against women and girls is ended. As the world fights to eradicate extreme poverty and hunger, the human potential of every individual must be preserved and nurtured

The health related MDGs 4, 5 and 6 are affected by consequences of violence against women, which increases the spread of HIV, and rates of maternal and child mortality. Eliminating violence against women aids the achievement of universal primary education, while empowerment and advancement of women are key to national development.

**If women and girls, and communities as a whole, are threatened by gender-based violence, then there is no real chance for peace and security. " — Thoraya Ahmed Obaid, UNFPA Executive Director**

# **GIRL CHILD EDUCATION AND ITS IMPACT ON MATERNAL MORBIDITY AND MORTALITY.**

**Presented by  
Sr. Ngozi Uti, Director, Centre for Women Studies and Intervention (CWSI)**

## **Introduction**

I would want to begin this presentation by expressing my joy and thanking UNFPA Nigeria for organizing this International Meeting of African Traditional/Religious Leaders on Maternal Mortality. This is for one simple reason: international communities would always talk about Africa as an entity not the individual countries, yet, we as Africans very rarely come together at grassroots level to discuss issues and come up with solution(s) that will move the continent forward. It is my hope now that other big organizations will follow in the foot steps of UNFPA.

It is difficult to talk about Girl Child Education without highlighting the Human Rights of women in relation to education.

## **HUMAN RIGHTS**

In very simple terms, they are those rights we all have and own as human beings. Day by day, the world's situation is becoming less secure and stable. Wars, famine, economic and political chaos threaten the lives of millions. Thus the concept of human rights has assumed greater importance in our time and has drawn the attention of scholars, governments, activists and the international community. It is virtually impossible to listen to the news, read the dailies or attend talks on religion, politics, economics and international relations without encountering the human rights issue in one form or the other. These human rights include the:

- Right to life
- Right to education
- Right to good housing
- Right to health care services

## **WOMEN'S RIGHTS IN THE FAMILY**

In the African context where the man is the head of the family and the woman is seen as an appendage, the position of the woman in a typical family is subject to that of a husband or father. However, in recognition of fundamental human rights as recognized by constitutions and religions alike, the rights of a woman in the family should include the following:-

- Right to decide the number of children a couple would want to have and if possible spacing.
- Right to decision making in the family as regards health care and other key issues

- Right to know her husband's income and all that he owns.
- Right to acquire and own property

## **GIRL CHILD EDUCATION**

When Benazir Bhutto was Prime Minister of Pakistan, she said: “*Women can't control their own life, if not through economic independence, and for this achievement it's essential to provide education for all*”. There is no argument about the fact that education has been an important instrument of transformation and empowerment essential for both men and women. The right to education is contained in the Universal Declaration, however, over the years, the girl child has been denied the right to education.

To recount history, we look at the missionaries who came to Africa and brought with them Christianity and Western education, which was also Victorian in nature. Early accounts of enrolment in schools showed that girls were the first to embrace western education in some parts of Nigeria. Hastings points out that “*Onitsha ... the first Primary School, opened in November 1858, consisted of 14 girls*” (1989: 40). Education at this time was considered good enough for slaves and girls but not for boys:

*It is noticeable that the first converts were often women. This may in part have been due to a feeling that they did not matter: the adherence of some women to the missionaries was seen at first as permissible, simply because it was socially and politically so insignificant. The same could be true of male slaves (Hastings, 1989: 38)<sup>3</sup>.*

In the early days of missionary activities, education was not considered significant by Nigerians and so it was good for women, a classic example of societal stereotyping. This is the reverse of attitudes in western societies at the time where education was for boys:

*In the very early period of a mission too, while boys would see no point in coming to school, girls might begin to do so. ... Occasionally there, we read, a group of boys 'would rush into the house, proudly gaze at the alphabet board and with an air of disdain mimic the names of the letters pronounced by the schoolmaster and repeated by the girls, as if it were a thing only fit for female' (Hastings, 1989: 40).*

Suddenly, with the realization of the importance of education, the girls who were the first to embrace western education were no longer allowed access to education. Male-domination started and it became the norm to keep the girls and women at home. According to Hastings:

*By this time - the 1920s and 30s - African women had been far overtaken by men on the educational front. We noticed how initially women were often ahead of men in elementary schooling. This did not last long, and it was, surely, an expression of the low esteem in which western education was held.*

Once society saw the point in schooling, it was the boys who got it (1989: 45).

By 1906 enrolment figures, drawn from the Annual Report of the Department of Education showed the following:

**Table 1**

Year	Boys	Girls	Mission
1906	1592	132	United Free Church of Scotland
1906	213	109	Roman Catholic Mission
1906	538	184	Niger Delta Pastorate
1909	4302	279	

*Annual Report of the Department of Education (Nwabara 1977:60)*

**Table 2**

Year	Boys	Girls
1911	1160	20

*Annual Colonial Report Details from (Nwabara 1977:60)*

This low enrolment pattern of girls into schools continued well into the 1960s and even recently enrolment of girls into schools in some parts of Nigeria has remained low. In addition to this, there was disparity in the school curriculum for boys and girls. While boys were prepared for administrative positions, girls were prepared for their duties in the home (Amaduime<sup>4</sup>, 1987; Hastings, 1989).

### **RELATIONSHIP BETWEEN GIRL CHILD EDUCATION AND MATERNAL MORTALITY AND MORBIDITY**

- a) Poverty/lack of economic empowerment
- b) Ignorance and lack of information
- c) Social or cultural barriers
- d) Lack of decision making powers
- e) Excessive physical labour
- f) Poor nutrition

In acknowledgment of the fact that education is empowering and that women have had to struggle a lot to overcome huge obstacles in order to attain the educational qualifications that enable them compete favourably and as equals with men. *Education is power*. It is not because women do not have the intelligence that men have that they cannot compete with men, but simply because of societal stigmas and cultures

In attaining Millennium Development Goal 5 (*Improving maternal health*) a certain level of education is required for the girl child and women. A look at the various linkages between education and maternal health will be looked into a bit closely.

## **POVERTY**

Poverty is deprivation of those things that determine the quality of life, including food, clothing, shelter, health care and safe drinking water, but also “intangibles” such as the opportunity to learn and to enjoy the respect of fellow citizens.

A World Bank report shows that majority of people in Africa still live on less than US\$1 (the equivalent of N117) per day. Equally, its 2007 report on “Global Economic Prospects” states:

*However, much of Africa will have difficulty keeping pace with the rest of the developing world and even if conditions there improve in absolute terms, the report warns, Africa in 2030 will be home to a larger proportion of the world's poorest people than it is today.*

The impact of poverty on education is that due to limited funds parents may be forced to make choices as to which of their children would be sponsored through school, if any. In Africa, when this situation arises, the preference is most often made in favour of the boy child, being that the girl is perceived to leave home in marriage. The lack of education of the girl child limits her empowerment status which reflects on her ability to seek and access reproductive health services from pre-teen years to adult life.

## **IGNORANCE**

The major cause of ignorance can be attributed to lack of education. An educated woman has access to information which will help take care of her health needs and those of her children, husband and community. For example, inadequate nutrition in childhood undermines the ability of individuals to develop their full human capabilities. Lack of essential minerals such as iodine and iron can impair brain development. Information and proper understanding of immunization is very important to the woman as this helps the growth of her child and saves him/her from all the other medical complications that could arise. The trauma a woman suffers from sicknesses that could have been avoided can be a source of death.

A scenario of Nneka, who is expecting her sixth child poses as a good example. She is very worried and afraid because she already has five girls and her husband and in-laws are threatening to throw her out of her matrimonial home if she begets another girl. Nneka, had complications during her last delivery. Her problem is compounded because she is a full time house wife, with only a primary school certificate. If thrown out of her matrimonial home she has nothing to fall back on. Education would have helped her challenge her husband and in-laws. Above all, her life is in danger.

## **SOCIAL OR CULTURAL BARRIERS**

Lack of education relegates women to the background as their supposed “inferior status” does not allow them a voice even in matters that affect their health and that of their children. An educated woman is highly respected and listened to.

Culturally, there are so many ‘taboos’ that a woman should know are not good for her health especially during pregnancy. There are cultural practices in some countries that do not allow a woman – pregnant or not – to eat certain food e.g. eggs, chicken, snails etc. these are healthy food that the woman needs. Education enables the woman to rise above such cultural beliefs and practices.

In some cultures it is believed that a woman who is not circumcised cannot have a normal delivery. However female genital cutting (FGC) predisposes a woman to VVF. Proper education would avail the women information on the implications of FGC..

Additionally, education avails the woman of sexual education, which allows for informed decision making on family planning issues. Most African cultures believe in the fact that children are gifts from God that cannot be refused. This is true, however, the principle of responsible parenthood demands that parents should have the number of children they can take care of. There is the need to educate men and women on family planning.

## **LACK OF DECISION MAKING POWER**

Most women do not have decision making powers, even in matters that concern them directly. In some African cultures, a woman cannot take the decision to go to the hospital even when in labour without the consent of her husband. In addition, there are cultures where the husband’s sister or auntie can take such decisions for the woman. This makes her a perpetual **minor** who cannot take a decision for herself. Education which is empowering will give women the courage to ask to be part of and take decisions that affect them and their family.

We look at the life of Lami, a trader in a market in the Federal Capital Territory of Nigeria - Abuja. She laments about the fact that she is not educated even though she is very successful in her business. She is involved in women’s issues in the FCT where she has become a leader amongst the local women. In spite of her inability to read and write she has empowered herself enough to express herself in any gathering in Pidgin English and her native language. Her daughter got pregnant while in the Junior Secondary School. The advice from her husband and other relations was for the pregnancy to be terminated or the girl to be forced into marriage. Lami had attended several workshops on maternal mortality and so was aware of the dangers of unsafe abortion and the consequences of early marriage. She decided to encourage her daughter to have the baby and took care of her from her earnings. After delivery, she sent her back to school for which she continued till she got a first degree. Today Lami’s daughter is happily married to the same man who got her pregnant.

Lami's daughter could have died if not for her mother who stood solidly beside her. Lami's exposure to informal education through participation at workshops helped her to be part of the decision making in her daughters' case. In addition to this, she was able to support her daughter financially. Her daughter is a happy woman today, because with the support of her mother, she has acquired good education in addition to marrying a man she loves because she was given a choice.

### **EXCESSIVE PHYSICAL LABOUR**

Uneducated rural African women suffer a lot of physical labour that are injurious to their health even during pregnancy. Most of these women in this category are house wives, farmers, etc and are required to trek long distances to fetch water for cooking, cleaning, washing, and general cleanliness of the family in addition to fetching fire wood. Tired and exhausted, they are required to thereafter do the cooking, clean the house and take care of every member of the family.

Education averts such situations as the women would overcome this excessive "physical drain" on their person by empowering the women to earn income that would enable them afford some of the modern labour saving devices beginning with a kerosene stove. This will enhance the quality of life especially during pregnancy and reduce maternal mortality and morbidity.

### **POOR NUTRITION**

Poor nutrition can be attributed to poverty and also to ignorance. Lack of proper understanding of the nutritional requirements for a girl child and a pregnant woman affects the physical development of the girl child and advancement of pregnancy. Education would avail women of such information on required food necessary.

### **CONCLUSION**

The relationship between female education and maternal mortality and morbidity borders on the sub-topics discussed above. Women have rights to equal and qualitative education just as their male counterparts. Lack of such education puts a woman in a disadvantaged position to cater for her reproductive health needs.

To be able to achieve the fifth millennium development goals of reducing maternal mortality and morbidity there is an urgent need to prioritize girl-child education because of its direct relationship with the reduction of maternal mortality and morbidity. The period of studies would prevent the girl-child from getting married too early in life and prepare her better for marriage. Men need to be active collaborators in this process to educate the girl-child and women and thereby reducing maternal mortality and morbidity.

I would like to conclude with a quotation from Baha'i writing:

*The world of humanity possesses two wings: One is woman and the other one man. As long as the two wings are not equally developed, the bird cannot fly. If one of the wings remains weak, flight is impossible<sup>5</sup>.*

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### ***General papers from countries***

#### ***Role of Traditional/Religious Leaders on Reduction of Maternal Mortality and morbidity/survival of women***

***By***

***CIPK KENYA***

***Hon. Sheikh Muhamad Dor Muhamad***

#### ***Abstract***

*Reduction of maternal mortality is presently considered a high priority in all health programmes in the world. Unfortunately although much effort is directed towards improving the situation, they still sound insufficient in an attempt to achieve this fifth millennium goal.*

*Strong commitment, intensive efforts and effective national policies and strategies are urgently required in order to translate visions into actions. Such efforts and plans must target the expansion in the coverage of effective integrated interventions, and the recognition of the essential role of religious and traditional leaders. Though changes have been happening, still, most segments of communities have remarkable levels of trust in religious and traditional leaders-generally higher than their trust in other societal institutions. Religious leaders are listened to and respected; they shape opinions and influence decisions even at family levels. In this view religious leaders can therefore make substantial contributions to facilitate reduction in maternal mortality and promote*

*well being of families and communities provided they are sufficiently informed, effectively mobilized and positively challenged.*

*It is with this background that the Council of Imams and Preachers of Kenya (CIPK) has been undertaking programmes/activities meant to contribute to the millennium agenda and more specifically efforts to reduce maternal mortality and morbidity in the country.*

*This short presentation shed light to CIPK efforts in trying to contribute to this noble cause.*

## **Background and justification**

Excerpts of Abuja Declaration 17/3/05 states:

‘Given the high number of maternal and child deaths in Africa, we support all appropriate measures, within the context of Islam, to curb and reverse the trend that claims the lives of more than I million women and children each year in Africa. Hence, we strongly support efforts to provide women with reproductive health care during pregnancy and childbirth; skilled medical attendance at birth; emergency medical services to handle complications during childbirth, as well as to provide the means to enable men and women to make their own decisions on the number and spacing of their children .These health services must reach all those who need them the most.

We urge all communities, governments, civil society organizations, international organizations, development partners and the private sector to support such services. We call on all community, Islamic religious leaders, traditional and cultural leaders to speak out and explain the importance of the health services mentioned above to their respective communities.

Female genital mutilation is not an obligation and is not the tradition of the prophet (SAW).It is medically a harmful practice. It is a form of violence against women, which should be eradicated’.<sup>2</sup>

In Kenya, the 2003 demographic and health survey indicates that although the national prevalence rate is declining slowly over time, one third of all women aged 15-49 years interviewed reported having been circumcised. The survey demonstrates huge differentials in prevalence across ethnic groups, with prevalence rates being 96% among the Kisii, 94% for the ,Maasai, and 97% among the Somali where it is virtually universally practiced. It is however much lower in other ethnic groups with a prevalence of 62% among the Taita /Taveta, 49% among the ,Kalenjin and between 41-43% among the Meru/Embu.. There are also marked variations in the age at which the procedure is carried out, the type of cutting done, and the reasons for sustaining the practice.

Evidence from the research studies recently undertaken in North Eastern province including Tana River indicate that the practice among the Somali community (including the Orma and Wardei) is particularly severe. Not only is it virtually universal in this group, but also the most severe form (infibulation) is practiced on girls as young as four years. A higher level of maternal mortality (17/1000 births) was found among Somali women delivering in the Provincial General Hospital at Garissa in the North Eastern

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<sup>2</sup> Abuja declaration

Province compared to women delivering in Machakos (9.45/1000) and Nairobi (0.56/1000), where women are more able to access safe motherhood services and where relatively fewer women are cut, or are cut less severely. A study carried out in six African countries including Kenya, where Garissa General Hospital was one of the study sites, shows that infibulated women run greater risks during childbirth. These obstetric rates are higher for women with no access to or with limited access to healthcare as is the case in this province.

The Kenyan government endorsed the millennium declaration at the millennium summit. The declaration set millennium goals (MDGs) which are sets of quantified and time bound achievable goals. Luckily the aforesaid development goals place health at the heart of development. While three of the eight MDG's goals relate directly to health, all others have indirect effects on health.

It is on this weight that Council of Imams and Preachers of Kenya (CIPK) as a faith based organization bringing together respected Islamic scholars work to contribute largely to the national policies with a base of providing direction which are compatible with Islamic principles.

### **Maternal mortality and morbidity at the Coast of Kenya**

Until recently, reliable data on maternal mortality and morbidity have been scarce, particularly at the Coast of Kenya. Most countries do not have a single population-based survey and often rely on statistics from central referral hospitals to assess the magnitude of the problem.

For Kenya, population –based data are available from many longitudinal studies. For instance it was revealed in a study that about 1 in every 14 babies born in Kenya will die before their first birthday and about 9 before their fifth birthday<sup>3</sup>. Alternatively in another report it was revealed that the maternal mortality ratio (MMR) is estimated at 414/100000 and remains the highest in some regions. Furthermore approximately 14700 women of reproductive age die each year due to pregnancy related complications, while between 294,000 and 331,000 suffer from disabilities caused by complications during pregnancy and childbirth<sup>4</sup>. Another local study, reveals that there are 414 maternal deaths per 100,000 live births, that is 1 in 25 lifetime risk of dying from a maternal related cause<sup>5</sup>

At the Kenyan coast it is estimated that maternal mortality for the community is 14.3 per 1000 live birth. The peri-natal mortality rate in the hospital is however contradicting and is at first sight disturbingly high, with 44% of these deaths being either macerated stillbirths or death due to premature deliveries. In another survey carried at the Coast General Hospital in Mombasa, among the 336 women who participated in the survey; 35.2% received ante natal care from doctors, 52.3% through nurse /mid wivies and 1.2%

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<sup>3</sup> Overview of social protection systems in Kenya analysis ,2007

<sup>4</sup> millennium development goals, status for Kenya

<sup>5</sup> Kenya service provision assessment survey (KASPA) 2004

from traditional birth attendants and others.<sup>6</sup> In terms of place of delivery, 67.4% deliver at home while 23.7% deliver in hospital and 7.5 % in private clinics.<sup>7</sup>

Shedding light to the causes of morbidity and mortality amongst Kenyan women, complications related to pregnancy and child birth are among the leading causes. From this short overview, it is clear that maternal mortality ratio (MMR) in Kenya and specifically at the Coast still lacks a current and a reliable picture of regional differential. The available multiple data sources reveal a high burden of unsafe motherhood in Kenya, with wide regional variations..

## **Roles of religious leaders in reduction of maternal mortality and morbidity**

### **1. Advocating for political commitment**

Religious leaders play vital roles in the lives of people. They shape opinions and decisions both nationally and even at family level.

It is therefore an important opportunity for religious leaders to advocate for the political commitment of the state to develop maternal health policies which prioritize the intervention required to reach the population groups most in need ,bring all elements of maternal health in a policy document and reallocate resources.

It is therefore in this view important to have a well managed advocacy – based on solid data, to create awareness of the scale and consequences of the problem. The lobby must spread beyond the experts working in the area of maternal and child health and include religious leaders.

### **2. Empowering women, families and communities**

A number of strategies are required to work effectively with women, their families and communities to strengthen their capacities to provide appropriate care in the homes; to make healthy decisions, including the important role as partners in improving maternal and newborn health. Islamic perspective should form the baseline and the strategy for interventions whereby education and community action should be integrated. These key interventions should contribute to the empowerment of women, families and communities to improve and increase their control over maternal and newborn health, as well as to increase access and use of quality health services. Religious leaders are in a better position to do this as a result of their influence and trust within the communities. What is mostly encouraged in this pretext is the need to integrate the approach and provide real Islamic guidelines which would add the trust bestowed on religious leaders. Failure to do this, the aforesaid method would definitely fail and result to a more destructive rather than a constructive mode.

## **CIPK's experiences in program implementation**

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<sup>6</sup> Kenya demographic and health survey (KDHS 2003)

<sup>7</sup> Kenya demographic and health survey (KDHS 2003)

Council of Imams and Preachers of Kenya (CIPK) has actively involved itself as a faith based organization in reduction of maternal mortality and morbidity. More than half of the Kenyan population lives below the poverty line and health facilities are not available everywhere. Coast province where CIPK implements its programs is ranked amongst the poorest in the country. E.g. Lamu has only 1 District hospital at Amu division and the community is scattered along the island. Kilifi, Taita Taveta, Kwale and Tana River have been mentioned to be four poorest districts according to the United Nations. Our approach in addition to what has been mentioned earlier is our pivotal role to sensitize and advocate against pharaonic circumcision mainly in Tana River district and against early marriages in Kwale district in particular.

### ***Female genital mutilation (FGM)***

From our experience, this practice is widely practiced in the country especially in the North Eastern province and the Tana River district which is part of our working jurisdiction.<sup>8</sup>It has severe subsequent complications for young girls and women from the day of the operation to the rest of their lives. A large percentage of these girls have the worst type of mutilation, which is the pharaonic circumcision.

As we know in type (3) infibulations the whole clitoris, the labia minor and part of the labia major are removed and the remaining parts stitched .This practice leads to delayed birth and consequently increase maternal mortality. Most of the people wrongly believe that pharaonic circumcision has a religious basis to an extent that they are against eradicating this harmful tradition. However, nowadays many people accepted to change the typology of the circumcision from pharaonic to *sunna* type. Unfortunately on this issue religious leaders have no clear stand towards the *shariah* status of the practice.

### ***Early marriages***

Some studies show that 18% of women give birth to their first child before the age of 18 years. Serious and sincere debate based on Islamic sharia with the assistance of reliable and agreed sources need to urgently be conducted to shed light on this practice. Although different opinions from prominent Islamic scholars have been received on this issue, I feel that there is a dire need to revisit the issue of concern and give a way forward especially during such important conferences.

Experts argue that early marriages results in adverse effect on the young mothers and their new-born especially during delivery. Complicated and obstructed labour is very common amongst young girls. Early age also predisposes some genetic disorders to the offspring such as down's syndrome. Alternatively it has further being argued that some ladies do have small bodies which could not withstand the delivery process which predisposes them to a further risks of maternal morbidity and mortality.

### ***Empowering traditional birth attendants (TBA's)***

The determinants of maternal mortality and morbidity in Kenya are multiple and closely interwoven. They include complications of unsafe delivery and inadequate and poor quality of ante natal care services (ANC), delivery and post natal services (PNC).

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<sup>8</sup> overview of social protection systems in Kenya 2006

Although international and national policies do not encourage and recognize the services of traditional birth attendants, the African context and reality should be considered in handling the issue. Taking the example of the World Health Organization (WHO) which is totally against TBAs; a concern about the 3<sup>rd</sup> world peculiar and economical circumstances should be kept into consideration. A local survey carried within the coastal community revealed that only 42% of women have skilled attendant present at delivery, while 28% deliver with a traditional birth attendant. 3 out of 5 births occur at home.<sup>9</sup>

Early efforts of KASPA to reduce maternal mortality is focused on training TBA's to screen high risk pregnancies for complications and efforts are now towards providing women with access to skilled care during pregnancies and deliveries.

It is CIPK approach and believes that the TBAs should be trained to effectively offer their mentioned services. Inadequate health facilities is currently a challenge to majority of countries represented in this conference .Therefore an alternative and a short time solution is mandatory to save noble lives. CIPK is struggling to increase professionally attended deliveries to 90% and we are working closely with health facilities in this regards. It is also engaged in supporting the training of health professionals as well as mobilizing women to attend ANC and delivery in health facilities including strengthening referrals.

CIPK was able to work with other stakeholders and train over 100 TBAs in 2004 and 2005 from Coast region in general hygiene, PMTCT etc. It's our belief that traditional old values of home and family should be revived to give these health initiatives more strength and until such a time when our government can provide adequate mid-wifery facilities should we think of doing-away with the TBAs

### **Way forward**

It's our firm belief that no organization can work alone. It is therefore our recommendation that more networks and partnerships should be formed, and the present or existing ones strengthened to most effectively share expertise, views and common experiences in a much more focused and quicker fashion. Furthermore integrated Islamic approaches should be the base steering any initiative whereby Islamic scholars participate. The efforts should be backed with real Islamic directives and authorities and no scholar should bend over backwards to please any institution in place of this noble religion which provides solutions to the different problems we face. We should conclude by noting again that, we shall in future support initiatives and innovations with Islamic bases which are solely intended to bring solutions or alternatives not only to maternal mortality but any other problem or challenge facing us.

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<sup>9</sup> Kenya service provision assessment survey (KASPA) 2004

## Role of Religious Leaders in Reduction of Maternal Mortality/Survival of Women

**Prepared by the Ugandan Delegation**

### BACKGROUND

Uganda's population grew from 5 million in 1949 to 24.4 million in 2002 and is currently projected at 28.2 million (2006). At the current growth rate of 3.2% per annum which is among the highest in the world, the population is projected to almost double to 55 million by 2025 and more than double yet again to 130 million by 2050 (UN Projections 2006). The rapid population growth is attributed to the high total fertility rate of 6.7 which has remained high for the last 40 years and a high unmet need for family planning at 41%. Uganda's population is mainly rural (88%) and youthful with 52% below 15 years and 20% aged 15-24 years

Uganda's Maternal Mortality Ratio (MMR) has remained high for 15 years with no significant decline between 1990 and 2000 (527 to 505) deaths per 100.000 live births). The Uganda Demographic and Health Survey of 2005 / 2006 registered a modest decline to 435 deaths per 100.000 live births. The Maternal Mortality Ratio translates to about 6.000 women dying every year due to pregnancy related causes. In addition, for every woman who dies, six survive with chronic ill health such as fistulae (Leakage of urine or faeces from the birth canal).

Between 1995 and 2000, infant mortality increased from 81 to 88 deaths per 1.000 live births, and later declined to 83 and 76 per live births in 2003 and 2006 respectively. About 29% of all infant deaths occur in the neonatal period (within the first month). Three quarters of neonatal deaths happen in the first week and the highest risk of death is within the first 24 hours. Perinatal mortality rate is 70 per 1000 live births and under- five mortality is 137 per 1000 live births. (UDHS1995, UDHS 2006)

Trends of selected maternal and newborn health indicators in the table below;

INDICATOR	PERIOD			
	1991	1995	2001	2006
Maternal Mortality Ratio (MMR)	527	506	505	435
Infant Mortality Rate ( IMR)	122	81	88	76
Neonatal Mortality	n/a	27	33.2	29
Perinatal Mortality	n/a	n/a	n/a	n/a
Under- 5 years Mortality	203	147	152	137
Stunting (Chronic Malnutrition)	38	38	39	32.2

Children under 2 years fully immunized	31	47.4	37	46
Deliveries under skilled personnel	38	38	38	46
Deliveries at health facilities Gou and PNFP	n/a	n/a	22.6	29
HIV/AIDS prevalence	18.5	14	6.1	6.4
Total Fertility rate	7.3	6.9	6.9	6.7
Unmet need for family planning (%)	54	29	35	41
Contraceptive Prevalence Rate ( % )	5	14.8	22.8	23.7

Source: UDHS, EPI Coverage Survey 2005

### National situation analysis of maternal and newborn health services

#### The Burden of Maternal and Neonatal Morbidity and Mortality

Maternal and child morbidity account for the highest disease burden in Uganda. The burden of disease pattern shows that over 75% of life years lost due to premature deaths are due to ten preventable diseases (UDHS 2000/01). Peri - natal and maternal conditions account for 20.4%, Malaria for 15.4%, acute lower respiratory tract infections for 10.5% and HIV/AIDS for 9.1%.

- Adolescent sexual and reproductive health (ASRH): The Population of Uganda is mainly youthful with 52% below 15 years and 20% aged 15-24 years. The National Adolescent Health Policy (2000) provides for establishment of youth friendly services as a component of the health care system. However very few health facilities currently provide adolescent friendly services.

Young women in Uganda are particularly vulnerable to consequences of early pregnancy, unsafe abortion and unsafe sex, school drop out due to pregnancy related issues. By the age of 17, half (51.1%) of young women are sexually active and 62.7% have already begun childbearing by the age of 19. (POPSEC.MOH and ED, November 2001). There is high teenage pregnancy rate of 31% (UDHS) and limited access to adolescent friendly sexual and reproductive health information and services which contributes to maternal and neonatal mortality and morbidity.

- Antenatal care (ANC): Effective antenatal care can improve the mother and newborn's health. At least four antenatal care (ANC) visits are recommended for a normal pregnancy, aimed at identifying and treating problems such as anemia, infections, and for preventive services. About 94% of pregnant women make one visit to antenatal clinics while only 42% make the recommended four visits. The high drop out rate especially in the rural areas is attributed to the poor quality of antenatal care services in relation to lack of laboratory services for antenatal care (ANC) clients, stock out of drugs, understaffing and lack of privacy in most clinics. Besides the poor

health seeking behaviour of women due to negative social cultures, reliance on traditional medicines and heavy workload at the ANC clinics remain a challenge.

- **Skilled Attendance at Birth:** The availability of skilled attendance at birth is essential for reducing maternal mortality. Even with good antenatal care (ANC) up to 15% of all births are complicated by a potentially fatal condition, yet skilled attendance at child birth is available for only 41% of women. The single most critical input for safe motherhood is to ensure the presence of a health worker with midwifery skills at every birth. Other important inputs are appropriate equipment and supplies and available transport that can facilitate the transfer of women with complications to higher levels of care.

**Emergency Obstetric Care (EmOC):** About 15% of all pregnancies develop life threatening complications and require emergency obstetric care, according to the 2004 (EmOC) Needs Assessment. The national met need for EmOC was 23.9% whereas it should be 100%, if all women with complications were to be treated. Approximately 11.7% of women give birth in fully functional comprehensive EmOC facilities as opposed to 15% which is the minimum required. The nearest health facility to the community at which Basic EmOC is provided is HC III and yet only 14.4% could provide this service. Comprehensive EmOC is available in 8.1% of the facilities.

**Post partum Care:** Postpartum care for women and newborns is still poor with only one out of ten receiving care (UDHS 2000/02) and yet, the majority of deaths occur in the postpartum period particularly in the first 24 hours. For women who deliver in health facilities, postpartum care is characterized by lack of records and staff inefficiencies. This has significantly impacted on health of mothers and newborns that develop complications during the period. This poor coverage for postpartum care also has a negative impact on services such as follow up of mothers and newborns in the Prevention of Mother –To Child Transmission (PMTCT) of HIV infection and uptake of Family Planning services.

**Abortion Care Services:** Unsafe abortion is estimated to contribute to about 26% of maternal deaths and a much higher proportion of reproductive ill health. An estimated 297,000 unsafe abortions occur every year with over half of them (55%) occurring among young women aged 15 to 20 years (National abortion survey report 2005). Most of these abortions take place in an environment of restrictive laws and lack of other supportive services. Therefore, there exists a high risk of unsafe abortion with consequences of ill health and death. Approximately 15-23% of female youths (15-24 years of age) who had ever been pregnant have had an abortion and as many as, 1,200 unsafe abortions result in death each year. Nearly a quarter (23%) abortions result in serious complications. While Post Abortion Care (PAC) services are supposed to be provided in HC III and HC IV, the high prevalence of abortions require that most of the health facilities need to be fully equipped to provide Post Abortion Care (PAC) services.

Uganda has yet to focus on comprehensive abortion care to address more specifically issues of prevention, abortion care, post abortion care services including counseling and family planning services. In particular the communities, men and women, girls and boys need to deal with issues that bring about unwanted pregnancies and subsequently unsafe abortions and loss of lives. Such circumstances include, rape and defilement , incest, men not taking responsibility for pregnancies and many men refusing their partners to use contraceptives and sometimes contraceptive failures. Service providers require to be trained in safer ways of managing abortion complications

Family planning (FP): Family planning is a cost effective means to lower maternal mortality rates because it reduces the risk of exposure to pregnancy and death; reducing the incidence of abortion by averting unwanted and unplanned pregnancies and by averting pregnancies that occur too early, too late or too frequently during the woman's reproductive cycle and those that are inadequately spaced. Although promotion of family planning is an official government policy and is supported with both government and donor resources, there is a lack of a national consensus to practice family planning. Other challenges to increasing the use of family planning include: Lack of accurate information, lack of access to quality services, contraceptive stock outs at health facility level, low resource allocation for family planning , conflicting social , cultural and religious values as well as myths and misconceptions.

Despite the knowledge on contraception being very high at 96% the contraceptive prevalence rate only increased from 5% in 1989 to 23% in 2001. Only 48% of the married women have spousal approval to use family planning. Knowledge on contraception among adolescents aged 15-19years is 92% for girls and 96 % for boys. Despite this the contraceptive prevalence among girls in this age group is only 9%. By age 15, 14.2 % of women 15-19 years were already sexually active. Overall the most commonly cited reasons for not using contraception are side effects (18 percent) and desire to have children (11 percent) (UDHS 1995 and UDHS 2000 -01)

HIV / AIDS: HIV is a significant indirect cause of maternal and newborn morbidity and mortality in the last fifteen years. Threatening to reverse the gains made in maternal and child survival interventions in Uganda. The national serosurvey carried out in 2004/5 reported national adult prevalence of 7.1. Among adolescents and young people, girls are disproportionately more affected than boys /men (4:1) due to gender, cultural and socio economic factors. The HIV/AIDS Sero prevalence in pregnant women stabilized at around 6.2% over the last four years, against the 2005 National target of 5%. Although VCT, PMTCT and ART were successfully introduced in the 1980s, the coverage of VCT and PMTCT services is still limited due to inadequate access to safe blood, inadequate access to IEC messages and limited availability of condoms in rural areas as well as stigma and discrimination. Overall reduction of HIV prevalence is important for attainment of the MDGs on maternal and child health.

Gender based violence is still rampant in Uganda as a cause of HIV transmission or the effect of domestic violence in maternal mortality. Anecdotal data shows that pregnant women are suffering a great deal more than those who are not pregnant.

#### Causes of high maternal and neonatal mortality in Uganda

A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy. A neonatal death is defined as death during the first 28 days of life (0-27days).

Maternal death is caused by either complications that develop directly as a result of pregnancy, delivery or the postpartum period ( a direct obstetric death) or due to an existing medical condition (an indirect obstetric cause). The major direct obstetric complications responsible for maternal deaths in Uganda include bleeding, infection, obstructed labour , unsafe abortion and hypertensive diseases.

#### Cause of maternal deaths in Uganda

1.	Hemorrhage ( Bleeding)	26%
2.	Sepsis ( Infections)	22%
3.	Obstructed Labour	13%
4.	Unsafe abortion	8%
5.	Pre – eclampsia and Eclampsia (High blood Pressure)	6%
6.	Other causes( e.g. Malaria, HIV etc	25%

Source: REDUCE 2004

It is now widely recognized that maternal deaths occurs as a result of factors described in the three delays Model

- The first delay occurs within the household /family level related to the limited ability of the woman and her close relatives to make a decision to seek care. This is closely linked to the inability to appreciate danger signs of pregnancy, delivery and postpartum due to inadequate knowledge. In addition, some cultural practices restrict women from seeking health care, while poverty at the household level also limits decision making to seek health care.
- The second delay is related to inability of pregnant women with labour complications to access available health facilities when need arises. This is due to lack of adequate community support, timely means of transport or resources to pay for long distance travels, poor roads and inadequate communication. More than 38% of the population lives below the absolute poverty line, underpinning the role of poverty in birth preparedness.
- The third delay is in receiving care at the health facilities. At the facility level, preparedness to respond to obstetric and newborn emergencies is critical to the survival of women and the newborn. Many health facilities , particularly Health Centre IIIs and IIs lack adequate skilled attendants, equipment, drugs and supplies for appropriate care during pregnancy and after child birth

There are many factors contributing to high maternal mortality rates in Uganda. These include high and unregulated fertility, short birth intervals, high rates of teenage pregnancy and abortion, and large number of women delivering without skilled attendance. Other factors include: low perception of risks, low level of male involvement in reproductive health and rights, harmful and negative culture on reproduction, food / nutrition taboos and poor gender relations.,

In its 2004 Poverty Eradication Action Plan (PEAP), the Government of Uganda reaffirmed its commitment to achieving the Millennium Development Goals (MDGs) by year 2015 especially as it relates to poverty and maternal and infant mortality reduction.

The persistent high maternal mortality rates (435 per 1000.000 lives per birth) are indicative of inaccessible, costly, poor quality services, staff inefficiency, lack of effective referral services, inadequate drugs, supplies, and equipment, weak supervision and monitoring and evaluation system, poor coordination and monitoring which called for immediate attention by the government Uganda to take further action through an overall plan called *a road map for accelerating reduction of maternal mortality* ;

in addition to the existing health strategic plan 11 in order to reduce maternal and child health and poverty in Uganda.

**The overall goal of the Roadmap:**

To accelerate the reduction of maternal and neonatal morbidity and mortality in Uganda and help the country achieve the Millennium Development Goals (MDGs).

Objectives are namely:-

1. To increase the availability, accessibility and utilization of quality skilled care during pregnancy, childbirth and postnatal period at all levels of the health care delivery system.
2. To promote and support appropriate health seeking behaviour among pregnant women, their families and the community.
3. To strengthen family planning information and service provision for women /men/couples who want to space or limit their childbearing thus reducing unwanted and/or untimely pregnancies that increase the risk of maternal death.

In order to achieve the above objectives, the following strategies and intervention are being employed.

**Strategies and interventions include:**

1. Improve legal and policy environment for effective formulation and implementation of maternal and newborn health programmes
  - Developing, reviewing and updating policies, guidelines and protocols that enable health professionals use their skills.
  - Ensure adequate staffing at the health facilities to provide the Maternal and Newborn essential health care package
2. **Improving the availability, accessibility to and utilization of quality maternal and newborn care services, particularly at sub counties levels.**
  - Provide skilled attendance at births
  - Scale up emergency obstetric care, goal oriented ANC, Neonatal and Postnatal care and PMTCT services, particularly at sub county levels.
  - Increase access to accurate and quality Family Planning information and services
  - Establish an appropriate and effective referral system
  - Strengthen youth friendly sexual and reproductive health services

3. **Strengthen human resources and building capacity to provide quality maternal and newborn skilled health care**
    - Build the capacity of training institutions and service providers for key maternal and newborn health issues.
  4. **Advocate for increased resource allocation for maternal and newborn health care.**
    - Review resource allocation and utilization mechanism to improve accountability at all levels
    - Strengthen the capacity of districts to ensure prioritization of maternal and newborn health in their development and annual implementation plans.
  5. **Strengthen coordination and Management of Maternal and Newborn Care Services**
    - Improve multi sectoral partnership, collaboration and coordination between and among all stakeholders
    - Promote effective public /provide partnership
  6. **Empower communities to ensure a continuum of care between the household and the health care facility**
    - Empower communities to demand for maternal and newborn health service
    - Strengthen the capacity of health planning teams and health facilities to manage maternal and newborn health service
  7. **Strengthen monitoring and evaluation mechanisms for better decision making and services delivery of Maternal and newborn services**
    - Improve accessibility and utilization of quality data and information for planning and management of maternal and newborn health programmes.
    - Review the Health Management Information System (HMIS) to capture all essential information on maternal and newborn health
- [
- Strengthen Ministry of Health and Local Government capacity for monitoring and evaluation
  - Provide technical support and supervision to enhance quality of care

- Conduct maternal and newborn death audits and reviews
- Establish a Monitoring and Evaluation System for the Road map

## THE ROLE OF TRADITIONAL / RELIGIOUS LEADERS IN REDUCTION OF MATERNAL MORTALITY / SURVIVAL OF WOMEN

Efforts at promoting utilization of health services

Adapted 3 pronged approaches.

1. **Advocacy**
2. **Information, Education and Communication**
3. **Service delivery**

### ADVOCACY

- **Health policy formulation at Headquarters.**
- **Strengthen private not for profit partnership with Government and Development, partners**
- **Decentralization of Health departments at Diocesan, District and County and Sub County levels– up to grassroots**
- **Establishment of Institutions of higher learning (Univerties and Technical Institutions )**
- **Formulation of networks for Advocacy on Reproductive Health, Population and Development( Uganda Reproductive Health Advocacy Network, Uganda Muslim Social Organizations Network)**
- **Formulation of Inter religious Council of Uganda**

### INFORMATION, EDUCATION AND COMMUNICATION (IEC) / BEHAVIOUR CHANGE COMMUNICATION ( BCC )

Use of Church and Mosque structures

- **Train lower level religious leaders like fathers/Mothers Union, Ulamas, District and community Imams in basic Reproductive Health and develop messages on reproductive health and communication skills for sensitization of the congregations about health issues and maternal and child health in particular.**
- Use religious and health structures to reach out to communities on health issues

- Use religious functions like weddings, Mawuledi, baptisms, confirmations to talk about health issues
- Organize workshops / seminar / meetings and health rallies for communities.
- Religious leaders to conduct home visits with maternal health and HIV / AIDS messages.
- Churches and Mosques support having manageable families and reduction of maternal mortality
- Integrating FP issues in other programmes
- Strengthen the Interdenominational Parent -Child Communication, Project for Anglicans, Catholics, Muslim and Orthodox congregations

#### SERVICE DELIVERY

- Strengthen Medical Bureaus; Uganda Catholic Medical Bureau; Uganda Protestant Medical Bureau, Uganda Muslim Medical Bureau and Joint Medical Stores to continue working jointly with Government through PNF.
- Strengthen Hospitals, Health Centre 11, 111. 1V and Health Training Institutions for health workers to provide counseling services, treatment and outreaches and Home Based Care and referrals for improved delivery of services.
- Medical Bureaus conduct trainings for health workers, religious leaders and the community leaders on health issues,
- Establishment of Institutions of higher learning (Universities and Technical Institutions) for the training of highly skilled health personnel and experts.

### POPULATION AND DEVELOPMENT IN ISLAM

#### By Republic of Gambia

##### *Introduction*

As a religion and a civilization, Islam attaches great significance to human development, progress and productivity. Society in Islam has always been well organised and built upon foundations of principles like justice, piety, fairness, truthfulness, as well as the provision of relevant education, health and social welfare services. It also seeks to promote productive and vibrant youth population, respect for and observance of the rule of law, human dignity and obeying those who are in authority (Ali Al-Hashimi, 1979: 55-68).

Although Islam encourages population growth and development, it strongly urges Muslims to organise themselves, carefully plan and properly manage the way they grow in numbers, so that the *Ummah* can effectively carry out its social responsibility. The Prophet of Islam (SAW) urges Muslim youths to marry pious and fertile women, so that

he (The Prophet) will be proud of (leading) a large number of followers in the hereafter. This *Hadith* is said to be confined only to a well-organised, carefully planned, managed and balanced population growth.

Thus, Islamic *Shariah* was revealed for the preservation of five major objectives, which dictate that both the individual and society must ensure their realisation and protection. Such objectives are: preservation of religion, soul, life, mind, intellect, lineage and wealth and property (Al-Shatibie - Latest Edition, 1997: 325-329). The achievement of these would bring about a satisfactory, prosperous and happy life. The preservation of soul, life, intellect and lineage can be achieved through preventive as well as medical measures. Therefore, drug abuse, teenage pregnancy, baby-dumping, child pornography, illicit sexual relations, unplanned family life, poverty, unemployment, environmental degradation, pollution and all other practices that negatively affect the reproductive health of women hamper progress and development in society must be discouraged and completely eradicated from Muslim societies. All the measures and practices of the medical and other disciplines, must seek to safeguard human life, the soul, the mind, intellect and lineage. When these values are effectively protected, the other two values, that is, religion and wealth, are safeguarded and truly preserved.

Finally, since Islam is a religion of the present and the future, and because population issues are both related to the present and future, Islam has provided comprehensive guiding principles on all population and development matters. The fundamental aim of these principles is to ensure the improvement of human life and eradication of hardships from Muslim communities and countries. For Islam, the concept of population is linked with that of vicegerent (*Khilafa*). Moderation in population growth is the target of Islamic socio-economic plans. Neither very rapid (unplanned) nor very slow population growth is acceptable in Islam.

A number of modern social ills such as: environmental degradation, drug abuse, domestic violence, child trafficking, child pornography and idle old aged in society, are in one way or the other related to population problems. In Islam, a balanced population growth is a pre-conditional for reassessing and re-evaluating the institution of marriage, the practice of breast-feeding, birth spacing, early sexual education and running of the entire family system. It is therefore the duty of every Muslim to propagate the Islamic values related to 'population and development', among and within countries and communities, through information, education and communication. This process should also include efforts to eradicate misconceptions and misinterpretations of Islamic values on population and development issues. Islam as a religion and a civilisation calls for an optimistic outlook to life in general and to human habitation, rehabilitation and reproduction, in particular.

To conclude, the National Network of Islamic Organisations on Population and Development in The Gambia (of the Committee on Islam, Population and Development) hereby appeals primarily to Islamic scholars, who have the privilege of access to social fora, and the Muslim communities and individuals in The Gambia and beyond, to assume their responsibilities of sensitising people on the Islamic values of population and development, human rights and other related issues of life in their countries and societies.

Furthermore, international Islamic organizations and Muslim Communities are urged to adhere to their obligation of respecting, incorporating and enforcing international agreements and declarations on population and development in a manner that is compatible with Islamic teachings and values. In the same vein, they are all called upon to seek appropriate ways and means, which are compatible with the values of Islam, to enhance and the improve quality of life of the present and future generations.

It is in line with this call and obligation that the following Information Guidelines are prepared and published for distribution by the National Network of Islamic Organisations on Population and Development. The Guidelines contain information on the key population and development issues from the Islamic perspective. All the key issues are arranged and explained under their respective headings.

## **A GUIDE TO ISLAMIC PRECEPTS AND PRACTICES ON POPULATION AND DEVELOPMENT**

### **I. REPRODUCTIVE HEALTH**

Reproductive health refers to the health and safety of mothers and their off-springs, throughout the period of reproduction and nurturing of children. Usually mothers and children are deprived of proper health care in our societies. Infant and maternal mortality rates therefore become very high in the Developing Muslim communities, compared to the Developed countries. Lack of proper health care, repeated and unwanted pregnancies, un-Islamic traditional practices and poverty are among the causal factors. To ensure the reproductive health of the family the following measures most be taken:

- Muslim couples should participate in reproductive health programmes;
- health education, including reproductive health, must be promoted;
- reproductive health problems should be addressed as a matter of priority. They include:
  - a. reproductive health complications of the middle-aged. particularly during the period following the end of menstruation;
  - b. problems of infertility;
  - c. avoidance of any food, drink or mode of dressing prohibited by *Shariah*;
  - d. avoiding any food or drink that is proven to be medically harmful and detrimental to the health, productivity or fertility of mothers and their children, during the period of reproduction and child- rearing;
  - e. preventing early pregnancy and early introduction to sex.

The Reproductive Health programme training methods or techniques, which are to be applied, must be more responsive to the social, psychological and physical health needs of women. They should be designed and disseminate in accordance with *Shariah*. Women must participate in all decision-making processes about their health and well-being.

### ***1. Child Health and Safe Motherhood in Islam***

Islam attaches great importance to the welfare and health of its adherents in the nation, particularly the children. Islam views children as divine gifts and blessings from the Almighty to their parents. For Islam, child health, welfare and safe motherhood constitute the foundation in the process of raising and building a good, pious and productive people, who would be the Vicegerent of God on earth.

Muslim parents are duty bound to be kind and merciful to their children and also to appreciate and be thankful to God for having been blessed with children. One way of fulfilling this duty is to take responsibility for ensuring the health and welfare of children.

### **2. Health-care in Islam**

Every Muslim is obliged to look after his/her own health and that of the family.

### **3. Safe Motherhood**

*Islam believes and teaches that:*

- a. Anti-natal health care is a religious obligation, in order to safeguard the life of the mother and the unborn baby as well as prevent abortion.
- b. Post-natal health care is another Islamic injunction aimed at ensuring the security, health and survival of both the mother and her child. Consequently, the mother is strictly prohibited to eat or drink anything that could harm her own health and that of the unborn and newly-born baby or interrupt the process of breast-feeding. Islam also strictly prohibits mothers and families from observing traditional practices that are harmful to their own health and the health of their children or destroy human life.

### **c. Procedures for Ensuring Proper Islamic Post-natal Care**

The following measures must be taken by the family immediately after delivery:

- breast-feeding must be observed to keep the newly-born baby well nourished and healthy;

- to ensure proper sanitation and cleanness of the post-natal environment – that is, the house, the compound the mother herself, the child, its food, cloths, water and everything that relates to the process of rearing the newly-born;
- regular and punctual visits to Reproductive Health clinics hospitals or any other place designated to look after the health of children and their mothers;
- all financial costs involved in the nursing and rearing process should be borne by the father;
- nursing mothers must be provided with adequate and nutritious diets to ensure their health and safety, throughout the nursing period;
- all medical and social expenses incurred by the nursing mother must be borne by her husband/the child's father;
- pregnant, breast-feeding or nursing mothers are to be exempted from observing the fast in the month of Ramadan, as fasting could affect their children's or their own health;
- if need be, (such as, if a mother loses earnings because of stopping to work while nursing babies) the father may be asked to pay allowances or stipends to the mother for breast-feeding the child.

#### ***4. Breast-feeding***

Islam strictly orders parents to observe breast-feeding, as it is the best and primary source of food for infants. According to the holy Quran (al-Baqara: 2: 33), mothers shall breast feed their offspring for a whole period of two years. However, for families who desire to go beyond that term, the fathers must bear the cost of good food for the nursing mothers in an equitable way. Breast feeding is one of the basic rights of the child, which shall be observed under all circumstances. The milk that the infant sucks from the mother's breast contains all nutritional elements and everything else that the child needs for its daily nutrition, healthy growth and survival.

Thus for Islam, there is no alternative to breast nursing. However, nursing women may suffer from congenital or other forms of health complications, which could make it extremely difficult or impossible for them to breastfeed. Should this occur, they will be allowed to apply an alternative method of feeding their babies, provided that such methods are in line with the teachings of Islam.

#### **5. Family Planning**

The family is considered as the basic social unit of Islamic society; as such, it is accorded great importance by Islam. In this connection, Islam provides a number of valuable

principles that govern marriage and the family as a whole, to ensure its well-being. Some of those principles are:

- a. that peace and spiritual serenity should prevail in the life of the family. For this to be achieved, there must be unity, compassion and forgiveness between husband and wife;
- b. the sound and Islamically disciplined upbringing of children;
- c. providing the reasonable needs for the family.

Therefore the life of the family as a whole needs some sort of planning. Here, planning means: 'giving anything its *best image*'. The term Family Planning in this regard, covers various fields, including: care for pregnant women (the mother and the embryo) and children; care for adults and the elderly; treating sterility in both men and women; raising the economic, social and cultural levels of the family and many other things that come within the purview of "Family Planning", that is compliant with the principles that are defined above.

It is obvious therefore, that family planning in Islam does not only mean a mere regulation of reproduction and the frequency of pregnancies. The former Sheikh of al-Azhar University was quoted as saying that "Family Planning is not forbidden by any *Sunnah* text". Family Planning in the sense of giving it its 'best image', using methods compatible with the objectives of *Shariah*, is a religious duty of every Muslim (International Islamic Centre for Population Studies of Al-Zhar University Series, 1998: 17).

## **II. SOCIO-CULTURAL ISSUES:**

### **1. Population and Family Life Education**

Population and Family Life Education (Pop/FLE) in The Gambia focuses on the interplay between population, fertility, morality and migration, as they affect the people's quality of life. It is also extended to include knowledge about one's environment, and how to care for the environment. It also deals with many controversial, ethical, value-laden issues and problems.

It is perceived that through Pop/FLE government will be able to address issues of rapid population growth, migration, environmental degradation, high mortality rates, drugs and alcohol abuse, early pregnancies, harmful traditional practices and other problems affecting teenagers, at the school level. It is expected that through the Pop/FLE educational exposure, youths will be equipped with relevant knowledge, information and skills necessary to enable them to understand, decide and act rationally on issues that affect the quality of their lives.

Nevertheless, from the Islamic point of view, the guidelines for proper population growth should be injected into and instilled by the Family Life Education programmes. Thus, Islamic early childhood education becomes pivotal. In order to design proper guidelines, the relationship between the Gambian household management and the city management must be revisited to ensure that the programmes for Pop/FLE are properly designed and implemented, in accordance with the teachings of Islam. In view of this, Islamic virtues of respect for authority, righteousness, fairness, sense of propriety, decency in every aspect of life and cleanliness must be included.

When this reviewing of Pop/FLE along Islamic lines is achieved, it should enable youths to develop an understanding and appreciation of socio-cultural values, beliefs, attitudes and practices, which influence decision-making on population issues. To this end Pop/FLE **must** cover issues relating to the teachings of Islam on polygamy, female, circumcision, early marriage and all other population issues highlighted above. Youths need to understand and appreciate the fact that chastity before marriage is valued and is strongly encouraged. Also that pre-marital sex; adultery and fornication are prohibited and ought to be discouraged.

## **2. Early Marriage**

As a general rule of Islamic law there is no minimum age for marriage. Islam has no objection to early marriage, if the couple postpones the first pregnancy till the wife becomes physically, psychologically and socially fit and capable to raise her children. However, medical science has established that pregnancy before the mother is 18 years old may imply serious health hazards for both mother and child. Furthermore, the modern demands of effective national development dictate the desirability that all youth, (especially young girls who are trailing behind the boys) complete their secondary quality education, before producing children. Consequently, Muslim parents are under obligation in Islamic law to ensure that before girls are given in marriage, they are physically, mentally, psychologically (implying, educationally) and socially fit and strong to bear and raise children.

## **3. Early Introduction to Sex and Teenage Pregnancy**

Islam strictly prohibits any form of sexual intercourse out of wedlock. Both fornication and adultery are strictly and absolutely forbidden and punishable with severe measures in this world and the hereafter, whether it has resulted into pregnancy or not. The Quran says: “Do not come near adultery, for it is an indecent (deed) and an evil way” (Al-Ishraa: 32). Adultery is shameful in itself and inconsistent with self respect and respect for others. It opens the road to many evils and destroys the basis of the family.

As for pregnancy, if a girl child is given in marriage before the age of maturity or before she is physically, psychological, socially and mentally fit to bear and raise children, pregnancy must be avoided by using all means acceptable to Islam. This is because every Muslim is strictly prohibited to do to himself or to others anything that can destroy life or health. (Al-Quran: al-Baqurah, 195).

#### **4. Baby-Dumping and Infanticide**

Baby-dumping or infanticide is a serious crime in Islam punishable with severe measures both in this world and the hereafter. The newly-born infant or child is not responsible for the manner in which and the parents to whom he/she is born and should therefore not be penalised for it. According to Islamic *Shariah* the life and dignity of the human person, whether a man, a woman, an adult, a child, an infant and a foetus, born or unborn, must be preserved, protected and respected under all circumstances (Al-Shatibie, ib.id). Thus, baby-dumping and infanticide constitute a serious violation of human dignity and rights. It is therefore a crime against humanity under Islamic law and the national Constitution.

#### **5. Female Circumcision**

There is no obligation in Islamic *shariah* to perform female circumcision. There are some differences among Muslim jurists of the modern time about whether it should be recommended or banned, but none of the past and present jurists has established that it was obligatory for Muslim women to be circumcised. However, medical scientists in Egypt and elsewhere in the Islamic world have at the highest level provided convincing evidence, which has proved the health and psychological risks associated with female circumcision. For this reason and in line with Quranic injunctions prohibiting the destruction of life or any thing leading to it, the practice should be discouraged.

#### **6. Child Pornography**

Pornography is another form of sexual exploitation of children. This is, basically any representation, by whatever means, of a child engaged in real or simulated explicit activities or any representation of the sexual parts of a child for primarily sexual purposes. These include photographs, magazines, books, movies, videotapes, computer disks etc. At present pornography, sexual abuse of children and trafficking in children are major issues, both at this international level and in the Gambia. Adult pornography is also strictly prohibited by Islam. Thus the National Network of Islamic Organisations on Population and Development calls upon government agencies, Islamic scholars, Civil Society Organisations, women's groups and International Organisations to work individually and collectively to stop all forms of pornography particularly, child pornography.

#### **7. Drug Abuse**

The social phenomenon of drug abuse is widely rampant among youths living in less religious communities, where there is little or no effort to bring up children in accordance with the teachings of Islam.

Drug consumption and addiction is strictly prohibited in Islam because of the high health risks involved. It destroys the mental, physical and psychological health as well as the moral values of youths. Drug abuse makes youths to be lazy, useless, non-productive and

sometimes become criminals in their communities. Islam therefore strongly urges the community, society and the state to take decisive measures to effectively combat the social phenomenon of drug abuse and addiction. Parents, religious and traditional leaders as well as educationists have a very important role to play in that process.

## **8. Islam and HIV/AIDS Prevention**

Islam views every disease or sickness, including HIV/AIDS, as a test from God. As a result of this, with prayers and medical care the sick person could receive God's mercy by having the illness cured or completely washed away.

According to the prophet of Islam (SAW), only those whom Almighty Allah has blessed fall sick, as a manifestation of God's testing of them. Islam believes also that all sickness/defects must be medically treated so that they may be eventually cured by God.

Islam recognizes the economic, social and human costs of HIV/AIDS and urges Islamic governments, Muslim communities and societies, humanitarian organizations and individuals to promote an awareness of the disease and provide effective measures and strategies for prevention and cure for those who are infected by it. To stop the spread of the disease, Islam strictly prohibits any form of discrimination against people living with HIV/AIDS and all other sick persons. Instead the sick persons should be encouraged, cared for and given all forms of support.

## **9. Education, Upbringing and Development in Islam**

Islam emphasizes the importance of rearing children by inculcating moral and ethical values in them to become good persons. To this end, Muslim parents must take the responsibility of rearing and educating their children particularly the girls. According to Islam children have rights that should be honoured by parents, notably, the right to education, which includes ethical and moral education, provision of knowledge of worldly and religious affairs, the right to recreation, good living standards coupled with fair and equal treatment of all children. In a *Hadith* reported by al-Bukhari, prophet Muhammad (SAW) says: "Fear God and be fair with your children" (Sahih al-Bukhari, chapter 11: p.134). This underscores the fact that good and relevant education is the key to success, happiness, prosperity and sustainable development.

## **10. Youths and Nation Building**

Islam recognizes the importance of youth and the centrality of their role to nation building. It teaches that youth should be encouraged and assisted, particularly during adolescence, to invest their time and efforts in education, career building and in whatever is beneficial to their life, social well-being or makes them most productive and effective in their contribution to national development. Youth should be equipped with Islamic education and ethical values as tools to keep them away from different kinds of temptation, immoral vices, drug abuse and all other destructive activities.

## **11. The Elderly**

Islam emphasizes the role of family, individually and collectively, to care for elderly, people in accordance with the principles of *Shariah*. The state, society and the community must provide special assistance to individuals, groups or families, who are taking care of elderly persons. Special systems of social security must be introduced to strengthen the capacities of individuals, groups, families or organizations taking care of the elderly, who in their youth had exhausted their time, efforts, wealth, energy and wisdom for the benefit of the current generation. Balanced diets, specific health care services, clean and healthy environment are among the most basic assistance and support that the elderly will need from those who are providing care for them.

## **12. Disabled Persons**

Society, family members and the state are under obligation in Islamic law, to provide the necessary care and support for disabled persons in the community. They must be involved in development activities and efforts aimed at creating conditions that will help them achieve meaningful success in various areas of life. Islam strictly prohibits all forms of discrimination against the disabled people. As a preventive strategy, parents, families, society and the states are encouraged by Islam to make early investigations and interventions, in order to identify congenital defects for early treatment of them. Also to extend all physical, health, psychological and social care to pregnant women so as to lessen the risks of giving birth to babies with physical or mental defects. Care for the disabled should include efforts to ensure proper care for disabled children and children with ‘special needs’.

Islam advocates that disabled children are entitled to all human rights and fundamental freedoms, including education, health, privacy, development and respect for their dignity.

## **III. DEMOGRAPHIC, ECONOMIC AND POLITICAL ISSUES**

### **1. Rural-urban Migration**

Random and cumulative migration from rural to urban areas has become a serious socio-economic problem affecting almost all Muslim countries, particularly those that are in Africa. This situation has a negative impact globally. For example, the rural areas being the main source of agricultural exports will be denied the opportunity to be developed economically, socially and financially, as a result of migration. Migration of able workers from rural to urban areas has an adverse effect on the productive capacity of the country concerned, to the extent that many Muslim states become importers of agricultural produce, essential food stuffs and other basic needs for which payment will be made in foreign currency, which may not be available.

Urban areas are also negatively affected by internal migration. As a result Cities, towns and major settlements are usually over-crowded, dirty or noisy and the population density per household increases. This situation puts great pressure on roads, services, schools,

hospitals and employment opportunities. Many immigrants to urban areas are not equipped with the required vocational and professional skills to work and live comfortably in the new environment. As a result, they accept low wages and live in poor quarters or slums that lack basic services and infrastructure. Some of them will then become unemployed or criminals, who will be a liability to the state, the community or their parents. The youths should be encouraged and supported, particularly during adolescence, to invest their time, efforts, income and energy in whatever will be useful to their quality of life and social well-being.

Islam therefore encourages governments, communities, Non- Governmental Organizations and individuals to work together to ensure that the youth are morally, financial, socially, culturally, physically supported and encouraged to stay in their home communities and effectively participate in national development.

## **2. Development and Poverty Eradication**

For Muslims development means planned and deliberate change that aims at improving and enhancing life through self-help and full participation of the members of the community. This change should include spiritual, physical, social, cultural, maternal and other aspects of life of the people through optimal utilization of human and natural resources of the community. Thus the human element is not only important, but it is at centre stage of the process of development.

This means that, women, children, the youth, the disabled, the poor, the marginalized and disadvantaged groups have a role to play in the development process. It implies also that, the fruits or benefits of development must reach them all. The best means to achieve over all and sound development for both individuals and society is to inculcate good moral and positive values in every person and then to develop or build capacities and ensure fair and equitable social systems. As the development of human resources underlies true socio-economic development in any country, it should always be consolidated to achieve the best and sustainable results. Islam believes that it is only in this way that development can be achieved and poverty be eradicated.

## **3. Poverty Eradication**

Islam calls for poverty eradication in society. To effectively do this, compassionate alms-giving (*Zakat*) was prescribed upon Muslims. Islam's call upon Muslim communities and societies to provide their people, particularly the youth with education, skill and professional training facilities, job opportunities, housing and similar measures that would preserve the quality of life and social well-being of the people.

Society should fight unemployment, encouraging and exhorting its wealthy members to invest in and create employment opportunities for others as well as assist the poor,

through humane gestures like gifts, alms-giving or ‘charity’, benevolent loan schemes and donations.

#### **4. Women’s Rights and their Role in Nation-building**

Women in Islam play a critical role in the overall process of life in human societies. They promote the welfare of humankind and shoulder great, multiple responsibilities in their homes and communities, as they struggle to reconcile their triple roles within and outside the household. Women continue to serve their husbands, children, employers, in-laws and even their parents, after marriage.

Thus, according to the teachings of Islam, a woman is entitled to dignified work that contributes to national and community development. They can and do engage in work to earn a living primarily to help family members, other women and their communities, at large. They can work in the education, medical, agricultural, commercial, political, economic, industrial and different sectors of life provided that they strictly, like men, observe the teachings of Islam in all respects, particularly those that concern the dress code, social and ethical values of Islam.

Islam guarantees women all human rights and fundamental freedoms of the human person which include the rights to education, health, employment. Also it accords them freedom of movement, association, assembly, expression and participation in the political and economic life of the state as well as the right to fight against discrimination of any sort (Universal Islamic Declaration of Human Rights of 1981: Arts. 1-23). Thus Islam does not only guarantee, but it also provides appropriate measures and mechanisms for the promotion and protection of the fundamental human rights of women.

#### **5. Protection and Management of the Environment**

The population should be made to understand that in relation to God’s work of creating the world, the environment embraces the totality of all social, technological, biological, physical and chemical elements, which compose the surroundings of man. Therefore, the economic development, physical growth and technical progress of man can be compared with the protection of the environment, so as to show how essential the environment is to human life. In the opinion of Islam while the protection of the environment is an obligation imposed on human beings, it is equally important for them to note that efficient environmental management also promotes the physical, social, health and economic development of a people. Hence it is the physical environment that provides the necessary resources for man’s survival. For instance, it provides resources such as food, energy, air, water, mineral and material resources, land as well as a place for the disposal of waste products, which promote the health and well-being of the society and people.

Consequent on this perception of the nature of the environment, Islam strictly orders that the environment should be protected under all circumstances. The State, society,

individuals and organisations are urged to apply the following or similar measures in their efforts to protect the environment:

- devise policies and programmes to address the problems of demographic growth and demographic structures in their respective communities and settlements;
  - design and enforce compelling policies and strategies to control environmental pollution and degradation;
  - protect trees, plants, the atmosphere, water ways and eco-systems, as well as encourage tree-planting exercises.
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