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THE CARRIBEAN

How parents can
promote their children's
development

COACHING

Support of change
processes ever
more important

INFRASTRUCTURE

Job growth through
China-Pakistan Economic
Corridor doubted



Pregnancy and childbirth

Summer special

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Pregnancy and childbirth

Still a distant dream

Despite considerable progress, India's Maternal Mortality Ratio remains too high. Though the country did not meet the Millennium Development Goal (MDG) for reducing it, it is not stepping up efforts to meet the follow-up Sustainable Development Goal (SDG), writes Ipsita Sapra, a sociologist. **PAGE 21**

Family planning

Sex education and contraceptives are essential for family planning. Girls in developing countries lack access to both, deplors Renate Bähr of Deutsche Stiftung Weltbevölkerung (DWS). HEPS-Uganda demonstrates how access to a broad variety of contraceptives can be granted. The NGO's staff members Eric Wakabi and Joan Esther Kilande report. **PAGES 23, 26**

Pregnant teenagers

Lack of knowledge and poor reproductive health services are among the reasons for teenage pregnancies, argue Angelina Diesch and Moses Ntenga of Joy for Children Uganda. In Nigeria, tradition and culture supposedly uphold moral standards. In reality, there are too many teenage mothers. Journalist Damilola Oyedele describes the situation. **PAGES 27, 29**

Dangerous for mothers and babies

Female genital mutilation causes serious complications during pregnancy and childbirth that endanger both mother and baby. According to Idah Nabateregga of Terre des Femmes it is urgently necessary to raise awareness of how destructive this procedure is. **PAGE 31**

Anonymity is problematic

Because surrogate motherhood is illegal in Germany, some couples turn to surrogacy abroad – in Ukraine, Kenya or California, for example. Anika König, a social anthropologist, explains in an interview why surrogate mothers have no rights if surrogacy is illegal. **PAGE 32**

Central American traditions

El Salvador has some of the strictest abortion laws in the world. A famous filmmaker has fuelled the reform debate with her personal story, as D+C/E+Z's Katja Dombrowski reports. Barbara Kühlen, a consultant, describes the important role traditional midwives play in Guatemala. **PAGES 33, 35**

Unfinished business

While developing countries have seen improvements in maternal and child health, the Millennium Development Goals (MDGs) in this area were significantly underachieved. This “unfinished business” has been adopted in the Sustainable Development Goals (SDG 3 and 5) of the 2030 Agenda.

The reasons for failing the MDGs for maternal and child health are varied: for one, while progress has been made in many countries with high mortality rates, not all groups have benefited. Poor and marginalised communities (primarily women and girls) have been left behind. Moreover, the data on health issues such as births and deaths is often missing or tend to be poor and unreliable. This has made it difficult to implement effective health and development policies.

In many sub-Saharan countries, teenage pregnancy is a serious problem. According to WHO, complications resulting from pregnancy and birth are the second leading cause of death in girls aged 15 to 19 throughout the world. Expectant mothers are often even younger. Teenage pregnancy is usually a consequence of societal circumstances. The girls concerned mostly grow up in poverty and are not well educated. They are not provided with sufficient sexual education, and many of them do not even know how they become pregnant and how to prevent it. Further, girls are often unable to practise birth control even if they wanted to, because they have no access to contraceptives.

These problems have been documented and identified by the MDGs and by the 2030 Agenda. The obstacles to maternal and child health have been identified and solutions are well understood. Nonetheless, action is missing in many places.

So, what needs to happen? Women and girls are often kept in the dark about sexuality. They lack the right to make their own decisions about their bodies and their lives, especially concerning when and how many children they wish to have. There needs to be societal change. Sexual education should take place in schools, health centres, social institutions and at home as well. This would prevent many unwanted pregnancies and promote female equality.

Every national government should collect better data in order to obtain reliable information, specifically pertaining to the problems faced by women and girls. How many girls are forced to leave school early due to marriage, teenage pregnancy and sexual violence? How many girls under the age of 15 become mothers? To collect this information, civil registries must be established in order to process census data and birth records.

More generally, basic services must be available to all. Countries need comprehensive health-care systems with skilled staff to protect the health of mothers and newborns. Midwives and paramedics need to be trained appropriately. All women and girls must be enabled to exercise their sexual and reproductive rights - and that includes access to contraceptives. This is particularly important for poor and marginalised people. They must be the primary focus of all policies.

► You'll find all contributions of our focus section plus related ones on our website (briefings section): www.dandc.eu/node/3174



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Debate



Reforms in the kingdom?

Last year King Salman of Saudi Arabia announced a comprehensive reform programme called “Vision 2030”. Its aim is to prepare the Saudi economy for a future without oil. Whether it will go smoothly is doubtful, writes Nassir Djafari, an economist and freelance writer. **PAGE 15**

Tribune




Empowering parents

Without nurturing care in early childhood, children are at risk of poor development and face life-long disadvantages. Ensuring that children attain their developmental potential is a critical strategy to promote societal equity. Scholar Susan Walker presents two interventions, developed and evaluated in the Caribbean, to empower parents with the skills to promote their children's development. **PAGE 16**

Supporting improvement

The theoretical framework for Technical Cooperation (TC) has changed considerably since its inception – a change that reflects a new awareness: the emphasis today is on transferring ownership of consultancy to partner countries. According to Cédric Kotitschke and Alexandre Martinez of AMBERO Consulting, TC must hence be more directly targeted to support processes of change. **PAGE 18**



Nicaraguan weltwärts volunteer in
a nursery school of the Red Cross
in Bielefeld, Germany.

Summer special: weltwärts

Young people are curious, inquisitive and the drivers of future development. This is what the weltwärts programme is counting on. It has worked since 2008 to provide youths with opportunities for cooperative exchanges in foreign countries. Young Germans can take part in projects abroad. Since 2013, youths from Africa, Asia and Latin America have also had the opportunity to experience Germany. To date, over 800 young people from the global south have taken advantage of this opportunity. Weltwärts was founded by the Federal Ministry for Economic Cooperation and Development (BMZ) and is coordinated by Engagement Global. About 180 development agencies keep weltwärts staffed with participants. Those who are interested in volunteer work may apply directly to one of these agencies. D+C/E+Z's Linda Engel spoke with weltwärts volunteers from developing countries. In this Summer special, you can read about the experiences of these volunteers in Germany.

<http://www.weltwaerts.de/en/>

SUMMER SPECIAL

“You need to find your feet in a new community“

Lebogang Mokoena is a 25-year-old journalist from Soweto, South Africa. Since September 2016, she has been volunteering in Berlin, Germany in a nursery school based on Waldorf/Steiner education (Freie Waldorfschule Havelhöhe). In Germany, early childhood education largely depends on private institutions which receive government funding. While almost all children over the age of three attend some kind of pre-primary education, the majority of children under three stays at home. However, this is slowly changing: since 2013, every one-year-old child has a right to a nursery or similar form of childcare.

Lebogang Mokoena interviewed by Linda Engel

Lebogang, what kind of work are you doing in Germany?

Lebogang Mokoena



I work in a very special kindergarten which is based on Waldorf education. The Waldorf pedagogy was developed by Rudolf Steiner and stresses children's social and creative learning. Around 70 children between 1,5 and six years visit the nursery school. I am placed in one of the four groups; I play with the kids, tidy up, participate in the different activities and support the day-to-day work.

Did you know about Waldorf beforehand, and what is your first impression?

No, I learned about it when I came to Germany. I generally find it fantastic, but at the same time I believe that there is more than one way to properly raise kids.

Please give us an example of a typical day at the nursery school.

We start at 8 a.m. by welcoming the kids. I then support them in their different activities like drawing and tailoring or building different things. Afterwards we have a breakfast, which is mostly organic and vegetarian. In a setting of a nursery school, this is definitely new to me! Afterwards the children play outside for around one hour regardless of the weather, rain or snow. I think being close to nature is an important part of the Waldorf approach. Later they have lunch and take a nap. A lot of kids are picked up early at around half past two, but we have also an afternoon programme for children who stay until 4 p.m.

What do you think could South African nursery schools learn from Germany and vice versa?

South African nursery schools can learn particularly using affordable methods like teaching outdoors and using natural resources to learn such as wood, grass or flowers. Perhaps, Germany can learn how different communities with diverse backgrounds integrate children and teaching methods in such spaces. I think Germany as a cosmopolitan country, like South Africa, has to start thinking "integration".

How did you hear about the volunteering programme?

In South Africa I did a Bachelor Degree in communications science. At the same time, I got involved in volunteering with kids. For four years, I have been working with the Kliptown Youth Programme (KYP) and other various child-orientated organisations such as Childline Gauteng. I was at first involved in an after-school programme to assist children with homework and other related challenges. I also taught English and, for example, initiated a reading project. It was there that I met a lot of German volunteers and learned about the possibility of volunteering abroad. However, before coming to Berlin, I learned German for 18 months.

What are you teaching your host organisation?

The kids are very much interested in the English language, but I also believe that I have a positive impact simply by engaging with the kids— even if it is not directly tangible.

What kind of lessons are you learning yourself?

I am learning about the Waldorf education, which I didn't know beforehand and of course, the language. Without the language you feel isolated at first. You need to find your feet in a new community. But I am also learning much about Europe, not only Germany, the people and the culture. My other interests have been to look into history, the relationship of Africa and other EU countries and mentalities and stereotypes towards Africans.

What will you take home?

The language! Apart from that, different teaching methods and of course the Waldorf concept, which is international. There are also Waldorf kindergartens in South Africa, something I didn't know before. My career as journalist is equally important for me. That's why in my free time I blog about my stay here. My blog is called „My scripted journey miles away from home: 365 days in Berlin, Germany“. (<https://myscriptedjourneymilesawayfromhome.wordpress.com>). I am also taking a global perspective with me.

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SUMMER SPECIAL

Working and understanding integration in Cologne

Subhadra Kaul from India is 24 years old and came to Germany as a weltwärts volunteer after completing a master's degree in sociology. From June 2016 to April 2017 she worked for the German Red Cross (DRK) in the largest refugee shelter in Cologne. In this article she shares her experience.

By Subhadra Kaul

Initially it took me a long time to figure out my role at the shelter. I was working in a transit camp which had about 600 people, mostly families waiting to be transferred out after their papers went through bureaucratic procedures. For them it was a long, interminable wait, which lasted from three months to two years. During that time the camp was their home and a place of preparation for the country outside.

I was assisting in the day-to-day programmes that were run in the camp, which had a day-care centre (for children aged 3 to 12) and a youth room (for ages 12 to 18). These centres provided facilities where the children could learn German, do their homework and play games. They were primarily a microcosmic social integration project introducing German way of life.

In time, I developed a close bond with the 9 to 12-year-old girls. I noticed them getting restless and feeling out of place in the kindergarten. I had observed that they were in the awkward phase when they were too mature to be in a space full of young children but not old enough to be allowed into the youth room. Moreover, there were more men hanging around smoking, chatting or relaxing outside the centre because it was the only open space available.

So I decided to start the "girls' projekt", with the idea of bringing the girls together in a space for themselves, where they could bond and be at ease. They loved Bollywood numbers, so I started doing Bollywood dancing with them. It took them some time to warm to

the idea of dancing but when they did, it was great fun to see them open up and learn from each other. The Kurdish girls also taught me the steps of dances they had learnt at home!

Many young women have mixed feelings about the experience of coming to Germany. Some found it a liberating experience to stop wearing the hijab in public spaces; others choose to continue wearing it. The mere fact that they have the choice is hugely important; it actually matters more than what the women opt to do.

From my own experience, I found it difficult to engage and make friends in the beginning, but eventually my colleagues became friends and formed an important support system for me. For people in the shelter, it was also hard to engage with locals on a regular basis. Belonging to social groups is a basic need for most people. One volunteer I met, a university student, used to teach a Syrian man German. Later, when he didn't have enough time to teach, the two continued to meet up occasionally to cook together or simply have a chat. In my eyes, that kind of contact is what integration means.

During my time in Germany, I really saw how labour is appreciated and respected as an act of reciprocity. Indian society is incredibly influenced by caste, to say the least, and still has a long way to go in terms of sharing and valuing labour, be it in the home, between husband and wife, or in professional spaces.

Ever since Chancellor Angela Merkel opened the borders in 2015, the integration of refugees has been a hotly debated issue. But Syria's neighbours Turkey and Jordan have accepted many more refugees than European countries. The uproar triggered by the refugee issue in Germany, voicing security concerns and questioning the country's capacity for absorbing migrants, has a great deal to do with politics within Europe. From what I understand, Germany has a decreasing population, and many believe it would profit in the long run from the demographic influx.



Subhadra Kaul

During a vacation in Dresden, I witnessed a Pegida demonstration. Pegida is a German nationalist, anti-Islam movement gaining momentum in the east of the country. Its members meet every Monday to demonstrate against refugees. On returning to Cologne, I found it heartening to learn that there had been a demonstration of solidarity with refugees, in opposition to the right-wing populist AfD party. Cologne has a thriving community called "Köln gegen Rechts", which opposes fascist tendencies.

I am glad that, as volunteers, we got to live and work in a city as colourful and welcoming as Cologne.

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SUMMER SPECIAL

“I can share so much information about Africa”

Valerie Viban from Cameroon is 26 years old and studied International Relations. Before starting his one-year volunteer service in Germany in July 2016 he worked part-time for Pedagogic In-Service Training Programme (ISTP), a partner organisation of the German organisation Bread for the World.

Valerie Viban interviewed by Linda Engel

Valerie, you work as a volunteer for the “Partnership with Africa Foundation” in Potsdam. What does the foundation do?



Valerie Viban

It initiates different projects between Germany and various African countries, by mostly focusing on their civil societies. We try to disseminate correct information about African countries in Germany and vice versa. The foundation also promotes cultural exchanges.

What is your job within the foundation?

Throughout the year I liaised with a lot of African organisations and worked on different projects. For example, we are setting up an exchange programme between schools in Namibia and Potsdam. I created the content for some learning modules about the colonial history of both countries. I also helped organise an event for the festivities during the anniversary of German unification in Dresden last October. Together with Dynamo Dresden, the local football team, we informed Germans about African football players in Europe.

Unfortunately, the anniversary of German unification was overshadowed by xenophobic demonstrations in Dresden. How did you feel?

I stayed in Dresden for three days. The first two days I enjoyed very much, but the third day was horrible with all the rallies. I was even insulted while performing with our “diversity choir”, with participants from all over the world.

Did you face racial prejudice as a Cameroonian in Germany?

No, in general I was perfectly at peace, and this was probably the most memorable year of my life. I am in a wonderful host family in Potsdam who I consider my own family by now, and I have great colleagues that helped me when I struggled with the language in the beginning. In my time here I also lost some stereotypes I had about the country. In Cameroon, there is this picture about Germans being stern, cool and unfriendly. In reality Germans are not unfriendly, but they need some time to make friends.

In social media you call yourself an activist. What does that mean?

I am socially very active and try to advocate for things that are neglected by society. One thing I am fighting for is to improve the quality of education. I am inspired by my own story. I grew up in a village without running water and electricity. But my father gave me this small library, and I started to read when I was five years old. Now I promote reading, especially in rural areas of Cameroon. Together with other people, I also started to lobby to free Cameroonian girls from Kuwait. Thousands of young girls leave for Kuwait with the promise of a good job. Once they are in Kuwait, they are forced to work as domestic helpers and don't have the means to come back. We wanted the Cameroonian government to take action and prevent this form of human trafficking.

What can your host organisation learn from you?

I can share so much information about Africa in general and of course about Cameroon. Most of the staff have not been to Africa, and I can give them first-hand information. In my free time I participated in a film project called “draufsicht”. We produced short movies about development-related topics and also went to Cameroon. Some of the short documentaries are already available on our YouTube channel: <https://www.youtube.com/user/Draufsichtable>.

What will you take home after your German experience?

I realised that the German way of preparing workshops is more practical. In Cameroon we have a preference for power point presentations. In Germany, I learned to use role play and pin boards, and I will integrate them in my future work. For myself I will take home the “planning lesson”. My life is now run by a small book, my diary. I also like the direct communication Germans use, putting things straight and simple. I will try to do the same in Cameroon, and will also teach others, if they like. I also learned to be more liberal and tolerant. Of course, you can only change your immediate circle and not the whole country.

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SUMMER SPECIAL

Taking the best from each culture

Godwin Drofenu from Togo is 22 years old and has been working since January 2017 in a residential community for mentally handicapped people run by the Lindenhof Foundation in Schwäbisch Gmünd. He lives with seven other volunteers from around the world in an apartment within the Foundation.

By Godwin Drofenu

The residential community where I work is the home of 17 people between the ages of 46 and 85 years. It used to be 18, but one housemate died last week. I was not expecting this, and it was a heavy blow. The work is not easy, but I have a great team with wonderful colleagues and one caring mentor supporting me.

I knew what the word “stress” meant, but it was not until I came to Germany that I truly experienced it. Of the 17 residents, only five can walk independently, while two need a walker-rollator. The others sit in wheelchairs, and almost all of them depend upon our assistance. This is stressful, because we are always struggling against time. In the early shift, we have to get the residents ready for the communal room, activity room or workshop. We wash them in bed or bathroom, measure their blood pressure and temperature and check their breathing. Afterwards we prepare their breakfast. It is usually very hectic in the morning.

At the beginning, it was difficult for me, but I have been getting praise almost every day. I originally wanted to work with little children, but I think everyone needs help. Wherever I am placed, I will manage.

Working as a volunteer over the past year, I have developed many qualities including a team spirit, a sense of responsibility and resilience. I did not have a lot of experience working with disabled people. But everything here in the Lindenhof Foundation is organised very well, and I have learned a lot. At the same time, I think my colleagues benefit from my upbeat personality and my jokes. They often think only about work.

Personally, I am very open and flexible, because I think you have to be when you are in a foreign country. I met some German guys right after landing at the airport. Since then, I have made a lot of friends here. I am the spokesperson for the support group Initiative of Christians for Europe (IXE), and am in constant communication with the almost 50 volunteers who are currently placed in Germany. For some volunteers, the work is very complicated. One volunteer quit because he could not handle the intimate side of caretaking, for example changing diapers.

I had learned German back in Togo in high school and college, where I studied German language. When I finished high school, I was the fifth best German student in the entire country. In Togo, I worked with the agency CHE (Cercle Humanitaire pour Enfants), supervising volunteers from European countries. CHE is a partner of Initiative of Christians for Europe. That is how I ended up in Germany for the first time.

At the beginning, I was homesick, but not for long. Maybe just a month. At first, I missed the attitude in Togo. Here, people do not even pay each other compliments. But Germany is not Togo, and every society has its own culture. I take a bit of my culture and a bit of German culture and try to make the best of it. I like that the Germans think about themselves. In Togo, you just do what the boss says, and your own needs come second. Here, you can propose your own initiatives and not have to hold things back. What fascinates me about Germany is that everything is well organised, sometimes “overorganised”. When I return to Kpalimé, the fifth largest city in Togo, I would like to continue working for CHE. This agency is also a partner of weltwärts. I would like to continue supervising volunteers and coordinating their placements.

I am very musical and play the trumpet in an inclusive marching band with the residents and staff members in our facility. About two months ago, I gave a small trumpet recital for the residents. When they laughed, it made me happy, too. It made me feel very good, like I was needed.

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Godwin Drofenu

SUMMER SPECIAL

Return full of experiences and motivation

Natalia Bezhanishvili (20) is from Georgia and works as a volunteer for Grüne Liga Berlin. She supports the IGA-Campus, an environmental education programme at the International Garden Exhibition in Berlin.

Natalia Bezhanishvili interviewed by Linda Engel

Why did you choose to volunteer with an environmental organisation?

Actually, during the first six months, I started as a volunteer somewhere else. But I think my first host organisation was not prepared for a volunteer, and I decided to change the workplace and asked my coordinator for help. I chose Grüne Liga Berlin, because they were planning a huge and interesting project, the IGA-Campus 2017. In Georgia, I participated in an environmental organisation called CENN – Caucasus Environmental NGO Network – which I joined in 2013. That is why I always wanted to get experience in this field abroad. I am studying business management, but in my free time, I enjoy being outdoors, and I love climbing and hiking. So I find environmental protection very important. Together with a friend, I also founded a start-up called Mzelandia. It is a new hiking club with which we plan to run tours in the Caucasus. One of the objectives is to get people excited about nature. I think if people experience nature and its beauty, they will protect it and not damage it.

What kind of challenges did you face in Germany?

As I mentioned, I changed my host organisation, which was not easy at all. Fortunately, I received a lot of help from some very friendly people, even though there were language barriers. Sometimes, I thought I was alone with my problems but talking to other volunteers helped me a lot. Thirteen months are a long time, and I miss everything and everybody in my homeland. But I am doing all these things in the hope of building a bet-

ter future. And I think difficulties are challenges, which help me become stronger.

What kind of lessons are you learning at your workplace?

I remember the day I first saw the site where the IGA-Campus is located today. It was an empty space, and I couldn't imagine that several months on, we would have such a beautiful garden with so many buildings. It is a great experience to work in a team with professionals. I am not afraid of big projects anymore. I think if I have to do something big in the future, I will be more organised. I have also met many volunteers from different countries, and we spend a lot of time together. Despite being born on different continents and coming from different cultures, we have become one big international family. We love each other, and I realise that borders are irrelevant if you are in contact with people.

Based on your experience here, is there anything that Georgia can learn from Germany and vice versa?

It is the reason I am in Germany! Environmental protection means a lot to people here, and they realise how important it is. Government and population work well together for better standards. I like the way German families enthusiastically separate their waste. Georgia has just started all this and is learning a lot. We have beautiful nature in my country, and people are starting to realise it is a big gift.

Do you already know what you will do when you go back to your home country?

First, I will finish university. I also have several ideas in my mind. I want to renovate an old bus, for example, and convert it into a small library and café and screen movies at night. I would like to take it to high mountain regions and give people – especially young people – in the villages an opportunity to have a good time. I would also like to film my work and show the result publicly,



Natalia Bezhanishvili

to inspire others to do good. But I still need to get funding to realise this idea.

What will you take home?

I am happy to be here and will go home full of experiences and motivation. Being away from my home country has changed my perspective. I have become stronger, and I wish to contribute to Georgia's development. Germany has shown me many ways I can do that.

What would you say to other volunteers coming to Germany?

Despite the difficulties I faced as a volunteer, volunteering has many positive aspects. First of all, it helps us to develop personally and professionally. So it is a valuable opportunity. Each individual's personal development also helps our countries evolve in a positive way. However, it is important to read our contracts carefully, and if we realise something isn't going as it should, we should inform our mentors. They will help if they can.

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Worsening censorship

South Sudan's media sector is under great pressure as the government cracks down on press freedom in the course of civil war. Journalists are exposed to a new wave of government censorship.

In April, the Association for Media Development in South Sudan, an umbrella organisation for all media houses, asked President Salva Kiir to help to stop the harassment of journalists. In a petition letter, the lobby group demanded the release of journalists in detention.

Nonetheless, Oliver Modi, who chairs the Union of Journalists of South Sudan, still found reason in June to decry cases of journalists being tortured or even killed. Threats have become all too common. "The media sector is in a dismal state; harassment of journalists is on the rise in the country, and freedom of speech is under threat. More than five media houses have been closed down for critical reporting," Modi said in June, insisting that press freedom is needed to promote dialogue and democratic governance in South Sudan.

From December 2013 to early June 2017, 10 journalists were killed. Three of them died this year. Many others have been forced to flee to neighbouring countries. Masses of people have become refugees, trying to escape the violence perpetrated by both the security forces and various militias.



South Sudanese journalists accuse the government of resorting to media censorship in order to silence its critics. It has become hard to work for the media. "It's extremely difficult to remain objective, because balancing a story with opposition voices is what our government hates most," says Majack Kuany, a reporter of the Nation Mirror, which was one of the country's leading independent daily papers until it was shut down by the National Security Service (NSS) because of critical reporting.

Majack adds that it has become a problem to publish critical views expressed by citizens in general. "There are things that we cannot talk about in the newspapers. We live in a difficult situation – there is no free press," Majack adds.

Foreign journalists who work in South Sudan are also increasingly under pressure. "They are put under surveillance, and their movements are restricted," according to a freelance journalist who requested not to be named.

South Sudan's constitution grants its citizens freedom of speech and press. Nonetheless, observers have noted that the NSS frequently confiscates entire editions of newspapers, claiming that certain articles expose state secrets and endanger the country.

Aleer de Mayen, who is an under-secretary at the Ministry of Information, denies this. He claims that censorship is only applied to stories that incite hatred and disunity. "It is not an institutional policy to censor media," he says, "but should we open doors to the type of press freedom that could result in chaos, hatred and negative propaganda?"

According to Reporters without Borders' World Press Freedom Index, South Sudan has fallen 30 places since the start of the civil war. In the 2017 World Press Freedom Index, its rank is now 145th of 180 countries. According to the international non-government organisation Freedom House, conditions for the media in South Sudan keep getting worse.



PARACH MACH
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DEMOCRACY

The ANC's real crisis

The ANC is not simply South Africa's ruling party. Before assuming power, it was a world-renowned liberation movement, and it has not brought about the social change it promised.

By Majaletje Mathume

The ANC (African National Congress) is celebrating resolutions adopted at its centenary in 2012 this year and commemorates Oliver Tambo, who was one of its outstanding leaders. Its most famous leader, of course, was Nelson Mandela. The celebrations have been declared an opportunity to consider the failures and successes since majority rule was introduced in 1994. Moreover, the party has pledged to recommit to the Freedom Charter, the document which outlined the aspirations of the black liberation movement back in 1955.

The party itself is in crisis, however. Internal battles are raging. The truth is that the ANC has been unable to fulfil the social-justice promises of the liberation movement.

The media tend to say that President Jacob Zuma and his friends are the cause of the crisis because of their corruption. This view is not entirely wrong, but it misses

the whole picture. The core problem is the ANC's political culture.

The ANC is supposed to be a broad church in which communists, liberals and capitalists can join forces. This sense of unity has been hailed as its marvellous strength even though the party has been unable to use compromise to resolve social conflicts.

Its ideology-transcending stance worked in the negotiations that turned South Africa into a real parliamentary democracy in 1994. Indeed, it was probably necessary to overcome the racist Apartheid regime.

Since 1994, however, the big-church approach has not been helpful. South Africa's social disparities remain huge and have probably even grown. Most black people still lack opportunities. Nothing shows the great divide more clearly than land ownership. A white elite is still in control, whilst masses of black people live in crowded townships and informal settlements.

The ANC had promised to tackle the issue of land ownership. Its land redistribution policy was based on voluntary deals and called "willing buyer, willing seller". This approach did not achieve anything meaningful, and the ANC has been discuss-

ing alternatives for a long time. It did not adopt a new policy however.

ANC members are now accusing the leadership of "double speak". It speaks the language of the poor black majority, while protecting the privileged few – who are mostly white – and allowing a handful of black people to rise to middle-class prosperity.

As meaningful redistribution is impossible as long as the governing party stays a broad church, the promises of social change turn out to be lies. Compounding the problems, the ANC lacks internal democracy. The leaders' mindset was formed during the liberation struggle when the organisation was illegal. At that time, strict loyalty could be a matter of life and death, and it was considered unacceptable to challenge leaders in any way. Today, the leaders still demand loyalty and insist that members must not campaign ahead of leadership elections.

As a result, inner-party debate is not transparent, and the party members cannot hold the top brass accountable. The party does not discuss policy options, assess their impacts and then implement convincing ideas. These things should be done in public, but they do not happen.

To bring about change, the ANC needs a coherent programme that provides opportunities to the black majority. That way, the party could live up to the social-justice aspirations that were spelled out in the Freedom Charter in 1955. So long as it pretends to promote everyone's interests, it is basically protecting the predominantly white elite.

Yes, Zuma's corruption is deeply irritating. Ultimately, however, it does not matter whether the ANC is led by him or someone more like the charismatic Nelson Mandela. Thabo Mbeki, Mandela's British-educated successor, lost power to Zuma because he could not bring about change. Now it has become clear that Zuma is not delivering results either, and he will certainly not be in office very much longer. Non-transparent struggles are going on inside the party to replace him.

To escape its malaise, however, the ANC does not simply need a better leader. It needs more inner-party democracy and a programme that leads to meaningful change.



Protesting in Pretoria.



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RIGHT-WING POPULISM

Demonising others

Post-truth populists show no respect for facts. They want everyone to believe that public opinion matters more than empirical reality. Populist leaders equate themselves with “the nation”, and once they rise to power, they brand even the mildest opposition as “anti-national”. Committed patriots, however, do well to defend institutions against the onslaught of populist governments.

By Manoj K. Jha



Narendra Modi visiting Donald Trump in Washington in June.

Swami Adityanath is the new chief minister of Uttar Pradesh, India’s most populous state. He is a Hindu monk and belongs to the BJP, the Hindu-chauvinist party which is led by Prime Minister Narendra Modi. In the election campaign, Adityanath claimed that the previous state government’s policy on electric power distribution had given priority to Muslim villages. He did not provide any proof. In a TV interview after the election, he was confronted with facts that proved his claim wrong. His response was: “Stop quoting data.” What matters in his eyes, is Hindus’ sense of grievance, not whether such feelings are based on real disadvantages.

Disregard for expert knowledge is common among right-wing populists. Michael Gove, a prominent Brexit proponent, famously said before the EU referendum in Britain: “People in this country have had enough of experts.” Leaders like him call those who oppose them “anti-national”.

A nation consists of all its people, but populists like to consider only those who follow them the “real” people, denying legitimacy to all other groups. In this regard, US-President Donald Trump’s statement

that he would only accept the election result if he won made perfect sense.

Right-wing populists are divisive. They thrive on demonising others and amplifying xenophobia. India’s BJP is known for anti-Islamic attitudes. Its leaders largely keep silent when Hindu fanatics perpetrate violence against Muslims. Several Muslims have been killed in recent months. The murderers claimed to be protecting cows and accused their victims of selling or merely eating beef.

It is striking that Trump similarly stays silent when Muslims – or people mistaken for Muslims – are attacked in his country. Just like the BJP, he has stoked anti-Islamic

sentiments. Leaders of this kind prefer neglecting their constitutional duty of protecting minorities to offending any potential supporters. When serving as chief minister of Gujarat in 2002, Modi failed to stop communal riots in which at least 1000 people were killed; the vast majority was Muslims. Rodrigo Duterte, the president of the Philippines goes beyond closing his eyes to murder – he explicitly encourages the security forces and death squads to kill those presumed to be drug dealers or addicts. Acting tough serves the strongman image, but acknowledging crimes in one’s own camp would weaken one’s own camp.

Right-wing populists not only maximise the distance between majority and minority communities, they also appropriate discourse on social justice. They do not, however, make an objective distinction between the oppressors and oppressed. In India, that would be landlords and business owners, who mostly belong to the dominant castes, on the one hand, and exploited people, many of whom are Dalits or Adivasis, on the other hand. Instead of tackling the roots of inequality, populists feed resentment and promote distorted “us versus them” politics. They pretend that “strong” leadership will deliver justice and harmony, restoring things to a supposed natural order.

No such natural order exists – and it never did. Populists promise to deliver the undeliverable. No, Brexit will never free up a weekly 350 million pounds for the National Health Service. No, Mexico will never pay for a border wall. No, India is not even close to creating 20 million new jobs every year.

Democracy is fundamentally about public participation and all major interests being represented in legislative bodies. As early as the 1950s, B.R. Ambedkar, the architect of India’s constitution, warned that democracy in India was “only a top dressing on an Indian soil, which is essentially undemocratic”. He also said that “cult and hero worship” could destroy it. Committed patriots do well to defend their nation’s institutions against the onslaught of self-proclaimed “heroes”.



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EMPLOYMENT

Pakistan needs jobs

The China-Pakistan Economic Corridor (CPEC) is a huge infrastructure programme. Some \$ 51 billion of Chinese funding have been pledged for improving Pakistani highways, rail links, power grids et cetera. The idea is to boost business opportunities, but there is reason to doubt the CPEC will lead to the masses of new jobs that Pakistan needs.

By Afshan Subohi

Big business in Pakistan is visibly uncomfortable with CPEC. No one contests that CPEC projects will ease logistic and energy bottlenecks, but the business community fears that it will not be able to cope with increased Chinese competition. Chinese industries might erode whatever little is left of Pakistan's manufacturing base.

One disgruntled tycoon, who does not wish to be identified, warns that a "mindless liberalisation policy led to an influx of cheap imports that sent many local businesses packing over the past three decades". Not only high-tech goods like mobile phones are brought in from China. So is everything from needles to prayer mats, toys and even chicken

meat. The tycoon points out that even local brands like Service Shoes are sourcing supplies from China.

Most economists agree that Pakistan needs better infrastructure. In the past, cash-strapped government agencies were unable to fund major projects. Other issues, however, hurt the business climate as well, in particular the tough security situation.

Growth in large scale manufacturing has been slow in recent years. Capital has been flowing towards the short-term options of capital markets and real estate. The share of manufacturing in GDP that employs unskilled labour has shrunk. This is a devastating trend, as the country has masses of unemployed youngsters. To reduce poverty, jobs are needed.

Seeing little scope for investments in manufacturing at home, many private-sector managers took interest in investing abroad, and some of them lost a lot of money when Dubai's real estate bubble burst. At the same time, Pakistan hardly attracted any foreign direct investments. As a general rule, foreigners will not invest if they do not see domestic companies doing so.

The CPEC is considered to be beneficial because it is facilitating infrastructure that the country desperately needs. The big question is whether Pakistan's industries will be able to take advantage of opportunities it will offer. The government expresses optimism. Nadeem Jawaid of the Planning Commission of Pakistan says: "We are great champions of market economy." He considers the private sector to be "the key driver of growth" and expects the "business community to remove their reservations". In his eyes, such reservations are often "based on misconceptions peddled by vested interests". He does not name names, but many Pakistanis would read "vested interests" to stand for the USA and India. The governments of both countries are wary of closer ties between Pakistan and China.

Independent observers take a more nuanced stance. The Pakistan Business Council is a think tank of the corporate sector. It has aired concerns over the influx of Chinese experts and possibly even labour in some CPEC projects. Such a trend would undermine the potential for employing Pakistanis. The Business Council demands more transparency with regard to CPEC projects.

The most important question, however, is whether the CPEC will drive long-term employment. It is worrisome that Pakistan does not have a convincing industrial policy. The government has failed to detect and promote niches for businesses to start exporting value-added goods. Bangladesh and Vietnam have done a far better job. Current trends suggest that Pakistan is becoming a country that merely exports commodities and imports manufactures.

The implication is that masses will be stuck in poverty, and discontent will further undermine political stability. The CPEC is unlikely to deliver major competitive advantages, moreover, since China is investing in other Asian countries' infrastructure as well.

For good reason, many western observers worry about labour conditions in Bangladesh and Vietnam. It is true that workers' lot is mostly tough in both countries. It is even worse, however, to find no employment at all – as is the fate of many poor Pakistanis.



The deep-sea port at Gwadar on the Arabian Sea is part of the China-Pakistan Economic Corridor.



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SAUDI ARABIA

How much reform can the kingdom take?

Last year King Salman of Saudi Arabia announced a comprehensive reform programme called “Vision 2030”. Its aim is to prepare the Saudi economy for a future without oil. Whether it will go smoothly is doubtful.

By Nassir Djafari

Over the last 70 years, oil has transformed Saudi Arabia from a poor desert country to a consumer-oriented rent economy. The Saudi nation enjoys the benefits of a welfare system without paying significant levels of tax. Menial work is done by immigrants while the Saudis find well-paid jobs in the public sector. All power resides with the royal family, which clings resolutely to its absolute monarchy. The general public accepts political tutelage as long as its prosperity remains untouched.

But Saudi wealth is built on shaky foundations – not just because of fluctuating oil prices. As long as the population was small, the state could be a generous benefactor. That gets harder as the numbers rise. Today, Saudi Arabia’s population stands at around 31 million. In 1960, it was just 5 million.

In “Vision 2030”, the government set ambitious goals. It aims to treble the size of the non-oil sector by 2020 – a massive challenge considering that oil currently generates 90% of government revenue. To mobilise more capital and also reduce overemployment in the public sector, today’s state-dominated Saudi economy will be opened to the private sector. Renewable energy, mining, infrastructure, transport and tourism are regarded as promising sectors for the future. Investment in education will focus on producing more skilled labour for activities in the non-oil sector. Moreover, the government plans to promote female employment in order to harness the high level of education that women have

now achieved. Finally, more jobs will be created for the country’s growing population. In 2011, a system of quotas, incentives and sanctions was introduced to get private companies to employ more Saudi labour.

However, public-sector employees will need to accept major cuts; salaries have been substantially reduced. What is more, the generous state subsidies paid for electricity, water and petrol will be slashed. And the planned introduction of value added tax will generate further revenue. These measures are designed to reduce the very high



King Salman of Saudi Arabia (left) recently made his son, Prince Mohammad bin Salman, next in line to the throne.

budget deficit. Fiscal consolidation will slow down the already ailing economy but the government expects a major boost from the sale of at least five percent of shares in the state-owned oil company Saudi Aramco. If the sale does impact on economic growth, however, the effect will not be felt in the immediate future.

The driving force behind the reform agenda is Mohammad bin Salman, the 31-year-old son of the king, who has just been promoted from second to first in line to the throne. The future monarch is seen

as a moderniser but also as a hawk on foreign policy. As defence minister, he took the country to war against the Houthi militias in Yemen, involving it in a bitter conflict that has dragged on since 2015.

In terms of both the time frame and the scope of the changes planned, “Vision 2030” is very ambitious. Taken individually, each measure that it encompasses may be economically rational. The programme as a whole, however, could prove a politically explosive mix. The Saudi public, accustomed to prosperity, needs to be prepared for the biggest social cutbacks for decades. Also, a whole range of taboos are set to be broken in an arch-conservative society. It remains to be seen, for instance, how the Wahhabi clergy will react when more women start pursuing a working career. And the Saudis are not going to be keen to do jobs that are done at present by immigrants. If the reform agenda is systematically implemented, the combination of social service cuts, perceived loss of

status and possible conflicts of interest with the clergy at a time of low economic growth could trigger considerable public unrest, for which there is no democratic safety valve. It is not possible to roll out radical economic reform without releasing the ossified social and political system from its chains.



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CHILD DEVELOPMENT

Empowering parents



Toddlers learn a lot when caregivers show and explain things – and everyone involved enjoys it.

Without nurturing care in early childhood, children are at risk of poor development and face life-long disadvantages. Ensuring that children attain their developmental potential is a critical strategy to promote societal equity. Two interventions, developed and evaluated in the Caribbean, empower parents with the skills to promote their children's development.

By Susan Walker

Approximately 250 million children in low- or middle-income countries – 43 % of the world's under-five-year old population – do not develop according to their full potential because of poverty and associated disadvantages. Early childhood is a critical period for development. Inadequate

nutrition hampers physical growth, and early experiences can have long-term effects on brain functions, cognitive ability and behaviour. Children who miss out on appropriate early experiences are at a disadvantage when they go to primary school. For example, they are likely to make slow progress and are at risk of lower educational attainment. That has further impacts on adult cognition, behaviour and incomes. The poverty cycle is not broken.

Promoting development among children in the early years requires nurturing care with attention to nutrition, health, safety and security. Children need quality interactions with caregivers who provide them with varied learning experiences.

Usually, the family is the main provider of care for children under the age

of three. Working with parents to build their care-giving abilities boosts children's learning and behaviour. Policies and programmes that support disadvantaged parents' capacity to provide nurturing care contribute to providing children with a good foundation in early childhood. They add up to a critical strategy to promote equity.

Two specific ways to enhance the capacity of parents to provide stimulation and quality interaction were developed in the Caribbean. They are called "Reach up: An Early Childhood Parenting Programme" and "What You Do with Baby Matters". Both interventions are designed to be feasible in low-resource settings and focus on empowering parents to be better parents.

Reach Up is based on the Jamaica Home Visit (JHV) programme which was designed in the 1970s and 80s by Sally Grantham-McGregor, a prominent British child-development scholar. It was originally devised to boost the development of malnourished children and was shown to benefit stunted children, children with low birth weight and children in general. The JHV programme has also been implemented and evaluated in other countries such as Bangladesh, Colombia and Peru. It is delivered by community workers and can be delivered along with health services.

The JHV comprises weekly home visits by community health workers (CHW) who are trained to conduct play sessions with mother and child. The main goal is to increase mothers' ability to promote development through play. The visits are interactive, involving CHW, mother and child. The play session use games, homemade toys, songs and language activities. Mother-child interaction is emphasised, the visits are fun, and both mother and child get praise. The CHW builds a supportive relationship with the mother and encourages her to make this kind of play part of her daily routines. Toys are left with the family and exchanged at the next visit.

Even though evaluations have shown that this kind of evidence-based parenting intervention is effective, scale-up has been limited. One reason is that civil-society organisations and government agencies lack the skills needed to implement them. To address this gap, the Child Development Research Group at the University of the West Indies developed the Reach Up Early Childhood Parenting Programme in cooperation with international partners, funded by Grand Challenges Canada, a government-funded health initiative.

Reach Up materials comprise a curriculum, manuals for training CHWs and supervisors, films, a toy-making manual and a guide on adaptation and implementation. The films facilitate training of CHWs by illustrating the key steps in a home visit and highlighting particular activities and techniques. Films were produced in collaboration with Development Media International, UK, with filming done in Jamaica, Peru and Bangladesh. The films are available in English, Spanish, French and Bengali.

The training manual includes objectives and activities for each session.

Training is interactive with brainstorming sessions and small-group practice. The curriculum is designed to be used by persons with a minimum of complete primary-level education.

To further improve the package, the Reach Up team is now working with colleagues in Brazil, Zimbabwe and Guatemala. The goal is to better understand implementation challenges so better support can be offered. Reach Up is adaptable. The training can be delivered either weekly or fortnightly and is being used in Asia, Africa and Latin America.

WHAT YOU DO WITH BABY MATTERS

In much of the Caribbean, government-run primary health centres include free child-health clinics which are staffed by nurses and CHWs. Children are brought here for check-ups and immunisation five times from the ages of three to 18 months. What You Do with Baby Matters was developed to use time parents spend waiting at the centres. It was implemented and evaluated in Antigua, Jamaica and St. Lucia with the support of the Inter-American Development Bank.

The CHWs who measure the infants' growth at the clinics were asked to deliver the programme to parents in the clinic waiting areas. CHW training was done in a similar way as in the Reach Up programme. Workshops were held, content and methods were discussed and small-group practice was done. The CHWs were given a manual with guidelines, and nurses also received training so they could ensure the parenting sessions took place. The programme was supervised by a team from the University of the West Indies.

Short films were shown in the clinic waiting areas. They showed mothers practising the behaviours that need to be encouraged. Nine films of approximately three minutes each were produced in Jamaica with five mother-child pairs. Three films with different topics were shown at every session during a clinic visit. Afterwards, the CHW discussed the films with the mothers, demonstrated specific behaviours and activities and encouraged parents to try the activities with their babies. The CHWs also demonstrated how to make simple toys from household materials.

At each visit, nurses gave the mothers message cards with simple language

and pictures that reinforced the topics of the films. They reviewed the cards with the mothers and encouraged them to do the activities. The nurses gave parents a simple picture book when children were aged nine to 12 months and a puzzle and some building blocks at age 18 months.

Mothers and CHWs valued the programme and felt the children benefited. Mothers said they showed more love and talked and played more with their baby. "I didn't use to play with her before," one mother said. "Since I got to know the programme, I sit with her, and I sing and play with her." They also talked about how they felt their child gained from the programme and was learning more.

The CHWs themselves felt they benefited too. One CHW said: "I feel so proud of myself knowing that I can stand up and ask them and get persons to answer. It is so good when you can talk to persons. I feel wonderful doing it."

The evaluation showed parents gained knowledge of how to support their child's development. Children who attended clinics with the programme gained in cognitive development compared with children attending clinics that only offered the usual services. This group intervention provides another approach to increasing parents' ability to promote their children's development that is feasible in the Caribbean and other low- and middle-income countries.



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LINKS

Reach Up:

<https://bernardvanleer.org/blog/helping-children-families-reach-new-training-package-support-parents/>

What You Do with Baby Matters (available in English and Spanish):

<https://publications.iadb.org/handle/11319/7575>

Grand Challenges Canada:

<http://www.grandchallenges.ca/>

COACHING

Supporting the drive for improvement

Technical cooperation (TC) is one of the major building blocks of official development assistance (ODA). The theoretical framework for it has changed considerably since its inception – a change that reflects a new awareness: the emphasis today is on transferring ownership of consultancy to partner countries.

By Cédric Kotitschke and Alexandre Martinez

The role of TC workers has also changed accordingly. In the past, the need was mainly for workers with specialist knowledge and implementation skills. Today, they have to be able to perform various support functions that are incorporated in the consul-

tancy services and depend on the partner's degree of autonomy. They include:

- the function of trainer, passing on knowledge and implementation skills,
- the function of (traditional) advisor, analysing situations, defining goals and sharing personal experience,
- the function of coach, helping partners find their own solutions.

None of these functions stand alone; the aim is to create a combination of functions tailored to the context and to bring- ing about the changes required.

SUPPORTING PROCESSES OF CHANGE

This framework has been acknowledged since the 2000s. However, many TC work-

ers find it difficult to function as a coach. Two major reasons for this are:

- the disparity between the process support paradigm and the profiles of the TC workers recruited. Coaching has a reputation for not offering clients concrete solutions to their problems. In classical development work, however, the aim is to produce tailored solutions. The expertise required is very specific, so recruiters look mainly for specialists, such as agronomists or experts in public finance. The functions of trainer and advisor are required for their work but coaching is almost completely ignored.
- the disparity between rapid results and the time taken by sustainable change processes. Even though TC workers are exclusively involved in capacity development, they are still too frequently judged by the operative results that the consultees are supposed to achieve. In the absence of clearly defined targets in capacity development, it is tempting to prioritise tasks that produce measurable results over process support.

The above disparities can be illustrated by a comparison from the world of sport, where the concept of coaching originates. Athletes are interested in boosting personal or team performance. In competitive sport, at Olympic level for instance, athletes in a particular discipline could be described as experts in their field. At that level, competitive athletes would benefit little from a coach who regarded himself as a specialist and offered more or less standardised solutions.

For the coaching function it is essential that the coach should enhance the performance of the coachee without encroaching on the same territory or offering off-the-peg solutions. One of the first rules of coaching is that the coachee must be recognised as an expert, with the wherewithal to achieve perfection. Coaches need to support coachees in their drive to improve without proposing courses of action or acting on their behalf.

However, many TC programme partners find this approach disconcerting. For decades, they have been accustomed to receiving technical and financial support of a different kind. In many cases, a system of dependence has developed, with both donor and partner tacitly accepting it or at least making no effort to change it.



Arnaud Agon, AMBERO expert from Benin, presents his experiences with the operationalisation of the coaching concept at a workshop in Ouagadougou, Burkina Faso.

OPERATIONALISING A PARADIGM SHIFT

Because of inherent blockades or a lack of concrete guidelines, many TC workers have difficulty performing the function of coach. It is the most complex of the three functions because it draws on approaches, disciplines and skills that are extremely diverse – from fields such as psychology, institutional analysis and change management.

Today, the challenge is to operationalise that paradigm shift. The first step is to recognise the specificity of the coaching function, which – like any occupation – has its own theoretical principles and skills. Coaching can be learned. Corresponding course content should therefore be integrated in master’s or advanced training programmes that are relevant for technical

cooperation. It would also be conceivable to recruit coaches in TC programmes to supervise, train and support TC workers in coaching positions.

The methodical introduction of coaching in TC also means developing service specifications for TC workers that contain targets and indicators designed exclusively to help autonomise the coachee.

The aim is not to create a completely new cooperation mechanism but to reorganise and prioritise the instruments. However, it would be useful to conduct a detailed and structured analysis of a partner’s capacities and capacity development requirements – for instance during project reviews. The main thing here is to define the threshold for deciding whether a TC worker is sent or not.



CÉDRIC KOTITSCHKE is a project manager at **AMBERO Consulting** in charge of a number of long-term GIZ projects in the area of good

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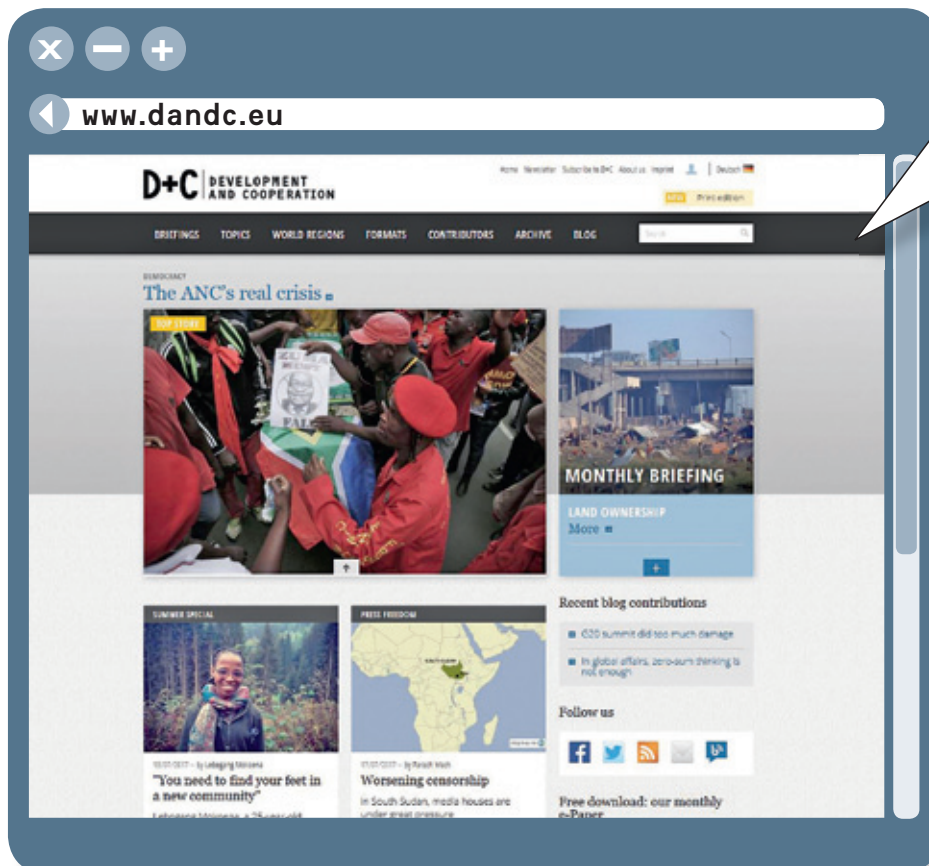
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Pregnancy and childbirth

Improving maternal health remains a major challenge the international community must rise to. There has been progress in many countries, but all too often poor and marginalised communities have been left behind. To make pregnancies and childbirth safer, competent and broad based medical services are needed. Moreover, social taboos relating to sexuality and reproductive health must be tackled. Sex education and contraceptives are needed to prevent teenage pregnancies, for instance. Disadvantaged communities must be the focus of action. Ultimately, all pregnancies should be safe and desired.



Breastfeeding can greatly improve the health of infants: a midwife helps a young mother in a hospital in Cameroon.



Still a distant dream

Despite considerable progress, India's Maternal Mortality Ratio remains too high. The country did not meet the Millennium Development Goal (MDG) for reducing it, so it must step up efforts to meet the follow-up Sustainable Development Goal (SDG). Current momentum is good, but will it last?

By Ipsita Sapra

Pregnancy and child birth are normal physiological processes. Nonetheless, about 800 women around the world die of complications arising from the birthing process every day. In 2015, India accounted for about 15 % of the global number. India's economic growth may look impressive, but in view of such data, it does not mean much.

India's current Maternal Mortality Ratio (MMR) is 167 per 100,000. It means that 167 of 100,000 mothers who give birth die during pregnancy or in the six weeks after giving birth. The current MMR is much better than the one registered in 1990 (560 per 100,000). However, India did not reach the MDG of reducing maternal mortality by 75 % from 1990 to 2015. To do so, the figure would

have had to be 140 per 100,000 two years ago. The SDG is to reduce the MMR to 70 per 100,000 by 2030. To achieve it, India must act more decisively than it has so far.

Maternal mortality is almost entirely preventable. The MMR for Estonia, the world leader, is two deaths per 100,000 births, and Singapore and Greece have an MMR of three per 100,000.

What is needed is good health services. Essential issues include safe institutional deliveries (giving birth in hospitals) in complicated cases, enlarging the choice of safe and reversible contraception and safe options for abortions.

In medical terms, the causes of maternal death include haemorrhage, anaemia and sepsis, obstructed labour, unsafe abortion and others. There are deep underlying socio-economic factors, however. In India, the MRR for the poorest women, who belong to the disadvantaged lowest caste groups and Adivasi tribes, is two and a half times above the national average.

Especially in rural regions, official statistics show an acute shortage of all kinds of physicians – including obstetricians, gynaecologist and paediatricians.

Governmental outreach services, moreover, have largely failed tribal areas. While private services have not ventured into these territories.

Poor rural people are supposed to rely on community health centres (CHCs). These centres, however, tend to be ill-prepared and ill-equipped. They even lack essential drugs. There are too few medical officers and paramedics. The typical CHC does neither have a labour room, nor an operation theatre, nor new-born care facilities.

HITS AND MISSES

Not all government efforts have failed. The Janani Suraksha Joyana (JSY) programme has helped to reduce the MMR. It uses cash transfers as incentives so poor families opt for institutional delivery. Moreover, it provides ante-natal, post-natal and other relevant services to women and children. Its emergency system refers particularly complicated cases to better equipped hospitals, and it demands an audit for every maternal death. The JSY has certainly led to improvements in the management of health services.

There are downsides, however. The most important is ironic: too many women now want institutional deliveries, so some of the most complicated cases are crowded out. Given that health services for poor communities are overstretched, it would be better if more deliveries without complications took place with competent midwife assistance. The hospitals simply cannot handle all births.

Another concern is that migrant women lose out. They do not get continuous care because they are expected to be registered with a single facility as transferring services from one place to another implies complicated paperwork.

The JSY programme comes with conditions, moreover. Its incentives only apply to women above the age of 18 years, though a considerable number of expecting mothers are younger. Adding to the problems, it is only entitled to child-birth services twice, though many have more babies. Women in India's rural areas actually have very little decision-making power

A girl showing photos of her mother who died in child birth.



concerning their age of marriage and number of children. Many do not have access to contraceptives. The JSY conditions thus penalise women who are not in control of their fate.

CONTRACEPTION BURDEN

Apart from not having access to contraceptives, many rural women are not well informed about contraceptive options. Some are illiterate. Men, however, tend not to worry about contraception, and leave the matter to women. On the other hand, many women simply have no say in decision-making. Accordingly, there are too many unsafe abortions (see box below).

The most used means of contraception is women's permanent sterilisation. In a country obsessed with population control, health functionaries are given targets for ensuring that couples adopt family size control methods. They like sterilisation because it is permanent. However, the basic hygiene standards are not maintained in the facilities. There are infections and sometimes deaths. Government agencies have failed properly to promote less intrusive contraceptive methods such as condoms or pills.

According to UN data, 39 % of the Indian couples that use contraceptive methods rely on the woman's permanent sterilisation. That is the highest share world wide. Only six percent use condoms. Male sterilisation is hardly done, even though it is easier to perform. Forced sterilisation of men in the late 1970s have left a mark on society, and the trauma compounds its existing pro-male bias.

The socio-cultural dimensions of maternal mortality are striking. Many of the pregnancy related medical issues that make women suffer or even die plainly result from underdevelopment. Relevant aspects include:

- low levels of awareness due to poor education and impaired access to information,
- lack of healthy diet and nutrition,
- lack of access to contraceptives,
- early marriage and teenage pregnancy,
- birthing in spite of low body-mass index (BMI),
- multiple pregnancies,
- unsafe sterilisations and
- unsafe abortions.

These phenomena are rooted in gendered power relations in the family and exacerbated by poorly performing public health services. Poor women need better health care and more control of their fate.

The good news is that after the embarrassing failure to meet the MDGs, the government seems to be finally waking up. More health workers have been designated for maternal health at the community level and 24 hours call centres for ambulance services are coming up. Technology is being brought to tribal areas, and innovations are being tested. For example, mobile phones and social media like WhatsApp are being used to reach out to more women and stay in touch with them. Databases are being set up to track pregnant individuals' ante-natal visits.

Civil-society organisations are raising awareness of the issues as well. Some even undertake verbal autopsies to ensure that maternal deaths are investigated properly and everyone can understand what went wrong. The government has become more serious about maternal death reviews too. If the current momentum is sustained and built on, India will become a safer place for women to become mothers.



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Avoidable surgical interventions

Unsafe abortion is a huge problem in India. Medical termination of pregnancy (MTP) became legal in India in 1971, but a range of socio-cultural factors and legal ambiguities prevent many women from benefiting from this. The stigma associated with unwanted and unintended pregnancies causes many women to abort secretly in private facilities, which tend to be expensive and unsafe. For obvious reasons, there are no reliable statistics.

Making matters more complicated, a special law prevents the determination of unborn child's sex in India and every aborted female foetus must be reported. The idea is to stem sex-selective abortions of female foetuses (see Nilanjana Ray in D+C/E+Z 2014/04, p. 156). The perverse result of this gender-friendly law, however, is that many doctors, fearing to get entangled in legal issues, refuse abortion services to women.

In past decades, private health care has expanded fast in India. Unfettered commercialisation has led to a rising number of Caesarean sections. The Indian Institute of Population Studies reports that the number of C section deliveries is rising by an annual 16 %.

According to international guidelines defined by the World Health Organization (WHO), 10 to 15 % of deliveries require C sections because of complications. Some Indian states, however, are now reporting rates of up to 65 %. Many C sections are not

necessary. For several reasons, better-off families often opt for this kind of surgery, nonetheless. They want to time the birth, sometimes in the hope of picking an hour that an astrologer deems auspicious. Fear of pain during labour plays a role too. C sections, moreover, seem to fit a modern lifestyle.

There are serious drawbacks, however. C sections are a profitable business, so they are quite expensive. Moreover, they are associated with several health complications that compromise women's well being.

Self-determined life for women

While access to contraceptives has improved for many people over the last few years, there is still an immense need for modern family planning in developing countries. Young women, in particular, find it difficult to obtain age-appropriate information and contraceptives. They face a variety of obstacles.

By Renate Bähr

In 2017, 214 million women and girls in developing countries are unable to use contraception, even if they wanted to. These women and girls are usually poor and young. They have a low level of education

and live in rural areas. The reasons they lack access to contraception include:

- restrictive societal norms and traditions, including gender inequality;
- disadvantages for young people;
- unfavorable political and legal conditions;
- a lack of diversity of high-quality contraceptives and related services;
- personal reservations and insufficient knowledge of what contraceptives exist and how they work; and
- lack of funding.

Dubious programmes continue to discredit the idea of family planning in many countries. There are degrees of “vol-

untary” participation. In India several years ago, money and gifts were granted to the participants of a mass sterilisation project, and in one case there was even a lottery, with the main winner getting a car. These issues distract from personal reasons to have or not to have children. In China too, there are similar reports of contraceptive methods being promoted forcefully. Some programmes violate the basic rights of free choice and physical integrity and are therefore plainly unacceptable.

RESTRICTIVE NORMS AND TRADITIONS

Gender inequality is one of the greatest obstacles in accessing family planning. Girls are often raised to be passive. They are neither made aware of their rights nor of their own sexual and reproductive health. If they try to discuss sexual relations, address contraception or even dare to refuse sex, they frequently meet resistance on the part of their parents and male partners.

In many countries, unmarried people tend not to have access to family-planning services. They should get such access. All too often, families and society in general expect a marriage to produce many children. Some societies only value male offspring, however, so couples continue having children until at least one son is born. Lacking a social safety net, they need a large number of children in order to be taken care of in old age.

In societies that are shaped by religion, children are considered to be a “gift from God”. Family planning is thus out of the question.

For access to family planning to become universal, women and girls need equal rights. A woman must be able to make her own decisions about how many children she will have and when she will have them. Otherwise, she cannot live a self-determined life and will be unable to contribute fully to the economic development of her country. Governments of both industrialised and developing countries need to become more engaged in facilitating universal access to contraceptives.



Education about types of contraception and their use is especially essential for women.

For the sake of equal rights, it is especially important to get men and boys involved in family-planning. They play a major role in letting women and girls make family planning decisions. Men can use contraceptives. They can support their female partners, reject the use of violence and promote the equality of the sexes. Entire communities, including political and religious leaders in particular, must get involved in order to bring about lasting change.

DISADVANTAGED YOUNG PEOPLE

Young people in developing countries – especially young women and girls – struggle to obtain age-appropriate information about sexuality, contraception and birth

control. Comprehensive sexual education is indispensable however. It should start at age 10. The need for action is immense, because school curricula often do not include this kind of education. Even if the topic is discussed, it is usually not done in an adequate way. Studies have shown that teachers are frequently unable to deal with this topic, either because there is not enough time, they lack materials, or they are not sufficiently educated themselves. It is essential to train teachers so they feel comfortable discussing sexuality and contraception with students in an age-appropriate, factually correct and non-judgmental manner.

Deutsche Stiftung Weltbevölkerung (DSW) ran two projects in Kenya and Ugan-

da. They have shown how important comprehensive sexual education is in schools. In many elementary schools, 10 to 14 year old students were already obtaining age-appropriate information about sexuality and contraception. The unique approach of DSW was to involve the students' entire social environment, including parents, teachers, local authorities and health workers. This approach has proven to be very effective. Teachers have reported that the project schools are seeing fewer pregnancies and pregnancy-related dropouts.

Throughout the world, about 62 million girls do not attend school. And many of those who do go to school are likely to drop out soon without getting any sexual education. Sex education must improve for both

Facts and figures on family planning

The number of women in developing countries who use contraception rose from 510 million in 2003 to 671 million in 2017. This is an increase of about 30 percent and looks like a great success at first glance.

But the contraceptive needs of a lot of women (15 to 49 years old) are not being met. They want to avoid pregnancies, but are denied modern methods. Up-to-date contraceptives include intrauterine devices (IUDs), pills, male and female condoms as well as quarterly injections. Traditional methods such as coitus interruptus and menstrual rhythm methods are too unreliable to be considered modern.

Unfortunately, the percentage of women whose con-

traceptive needs are not being met has not changed much because the number of women who want modern contraceptives in developing countries has risen from 720 million in 2003 to 885 million in 2017. That was an increase of over 20 %. Three quarters of this increase can be attributed to population growth alone. Of course, education and the increasing emancipation of women contribute to more women wanting to use modern contraceptives too.

The largest demographic share of women whose family planning needs are not being met are those between the ages of 15 and 19 (60 % unmet), in comparison to the overall percentage of women between 15 and 49 (26 % unmet). The lack



Women often receive insufficient education about family planning and contraceptives.

of access to contraceptives is one reason almost 21 million adolescent girls in developing countries become pregnant every year – about half of them unplanned. Seventeen thousand of them die because of complications in the pregnancy or during birth. This is the number one cause of death for girls between the ages of 15 and 19. In 2017, the cost for modern

contraceptive services for 671 million users in developing countries amount to \$ 5,5 billion. This estimate includes the costs of contraceptive devices, health-worker salaries and programme and system costs. If the 214 million women who lack access to family planning were to have their needs fulfilled, the total cost would rise to an annual \$ 11 billion.

Photo: DSW

boys and girls, and it is important to create new and better opportunities for comprehensive sexual education beyond schools.

PERSONAL REASONS

When asked why they do not use contraceptives in spite of not wanting to get pregnant, many women say that

- contraception would damage their health (for example, due to the side effects of the method);
- they do not believe they are able to conceive at the given time; or
- they (or their families) oppose the prevention of conception in principle.

In order to fight such beliefs, women and girls need better information concerning the risk of pregnancy as well as the entire range of conception-preventing options and their uses. Women need access to a variety of contraceptives, so they can choose a suitable option. Relevant criteria include using contraceptives independently of their partner or without health concerns.

Sexual and reproductive health and rights do not rank high among the priori-

ties of major international donors and governments of developing countries. Despite wordy declarations of the intention to improve the health situation of women, men and children, nothing much is being done. This trend is evident in insufficient funding for family planning.

To enable all women and girls to exercise their right to family planning, the international community must fill a gap of \$ 5.5 billion (Singh et al., 2014). However, the prospects for doing so have recently decreased. Immediately after taking office, US-President Donald Trump reintroduced the so-called Global Gag Rule. This policy completely eliminates US funding for any aid organisation that offers abortion, advocates its legalisation or advises women on the subject of pregnancy termination. Funding for services that have nothing to do with abortion has been discontinued too. Moreover, the USA has completely cut its contributions to the UN Population Fund (UNFPA). The most urgent issue is thus to fill the funding gap that has resulted from Trump's decisions.

The 15th Development Report of Germany's Federal Government was recently

released. It devotes no more than two paragraphs to maternal health and self-determined family planning, and thus does not even come close to doing the topic justice. The Federal Government should emphasise this issue more, and it should increase its UNFPA contributions.



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LINK

Singh, S. et al., 2014: Adding it up. The costs and benefits of investing in sexual and reproductive health.

https://www.guttmacher.org/sites/default/files/report_pdf/addingitup2014.pdf

Make contraceptives available

All people – including those in rural areas – deserve access to a broad variety of contraceptives so they can choose the method that suits them best. The NGO HEPS-Uganda has been driving progress in two districts.

By Eric Wakabi and Joan Esther Kilande

Rose Namukose is stretched out on an examination bed of the Kitayunjwa Health Centre III in Uganda's Kamuli district. She is there to get a contraceptive implant. Two health workers put on gloves. One cleans the spot for the insertion and the other pre-

pares the needle to give Rose a local anaesthetic. Visibly scared of the jab, Rose looks away while a midwife explains the procedure about to be performed. A few minutes later, Rose, who is HIV positive and has a three year old child, walks out of the centre and returns to her home five miles away. She now has one thing less to worry about – she will not have a pregnancy she is not ready for.

Rose is one of the more than 1,000 clients who were sensitised by the non-governmental Coalition for Health Promotion and Social Development (HEPS-Uganda)

about using family planning. HEPS-Uganda demands that women get a full, free and informed choice of method.

With support from the Brussels-based Reproductive Health Supplies Coalition (RHSC), an international multi-stakeholder network, HEPS-Uganda ran a first 18-month project in 2015 and 2016. The goals were to

- ensure that 16 public health facilities in the Mbarara and Kamuli districts had sufficient stocks of relevant family-planning commodities and
- raise community awareness of contraceptive choices.

HEPS-Uganda partnered with radio stations and also used text messaging and web apps to conduct outreach. A community score card (CSC) was done to assess

family-planning services. The term stands for an interactive way of making the staff of public agencies accountable to the people they are supposed to serve. CSCs help to assess, plan, monitor and evaluate services.

More than 200 persons from relevant agencies and local communities took part. On this basis, community action plans were designed and implemented. Ever since, HEPS-Uganda has been using the evidence generated to promote the cause, including among actors at the national level.

The project in the districts of Kamuli and Mbarara revealed some of the major barriers to effective family planning. They include

- the lack of contraceptive choice,
- inadequate skills of health workers,
- lack of skilled staff,
- fear of side effects,
- lacking male involvement, and
- various myths and misconceptions about family planning.

The project showed that it is possible to rise to these challenges. Couples need access to the contraceptive that serves their needs best. A broad range of contraceptives must be made available including

- pills,
- male and female condoms,
- diaphragms and cervical caps,
- intrauterine devices,
- contraceptive implants, sponges, injections and patches,
- spermicides,
- vaginal rings and
- permanent male and female sterilisation.

When the project ended, all health centres in Mbarara district offered at least five different methods. None had provided options before the project started. In Kamuli district, the share of health centres that offered at least three methods rose from 57% to 71%. Overall, the incidence of contraceptives being out of stock was reduced by a quarter.

Awareness raising, moreover, helped to dispel distorted ideas. Magidu Mususwa, a client of the Kitayunjwa Health Centre III, says he used to believe that people who used contraceptives were likely to have disabled children, so he stopped his wife from using them. After being properly informed by a community monitor, however, he changed his mind and now supports contraceptive use. He adds: “I have also encouraged at least two men so far to support family planning.”

In the two districts concerned, the situation has improved. It was important to involve many different stakeholders, including health workers, district offices, international partners and, of course, the people who want contraceptives.

Relevant non-governmental agencies included Marie Stopes International, Cordaid, BUKO Pharma-Kampagne and Reproductive Health Uganda (RHU), which is affiliated to Planned Parenthood in the USA. They helped to ensure that important goods did not run out at the health centres. On request, moreover, Marie Stopes seconded a training midwife at the Nankandulo Health Centre IV, where, for two months, she mentored staff on how to administer long-term methods.

The health centres have changed their procurement policies. Their staff now use

regular meetings with government officials to urge the national pharma supply system to provide more family-planning commodities. The sad truth is that choice still tends to be constrained by a limited number of family-planning methods available in public health facilities. Typically, long-term methods remain unavailable, unless non-governmental development partners lend support.

As Uganda’s government acknowledges, long-acting reversible contraception and permanent methods afford numerous benefits to individuals and health-care systems. These methods are safe and highly effective. They are suitable for use for all categories of clients, for a variety of reproductive health intentions. They are very cost efficient and reduce demand on health-care systems because they do not require continual resupply and have low discontinuation rates.

Lacking funds, however, the government is only providing commodities for short-term methods. Moreover, staff would need to be trained to administer the long-term methods.

Uganda’s Ministry of Health appreciates that family planning is a cost-effective means to lower maternal mortality rates because it reduces the risk of unwanted pregnancy as well as the incidence of abortions. Nonetheless, many people’s family-planning needs remain unmet in the country. Nearly a quarter of all women of reproductive age would like to delay, space or stop having children, but they are not given the choices to do so.

In both project districts, the provision of full choice to family-planning users remains a key challenge. All too often, the health centres still lack the commodities for long-term methods. The implication is that local people are being denied their right to plan their families – and that unwanted pregnancies cause unnecessary suffering.



Empowering people to plan their families.



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Who wants to educate a goat?

Due to poverty, gender discrimination, poor parenting and lack of knowledge, 25% of adolescent Ugandan girls are currently pregnant or have already given birth to their first child. Debate on how to address the issue is hot.

By Angelina Diesch and Moses Ntenga

The East African Legislative Assembly (EALA) – an organ of the East African Community (EAC) – has drafted a bill on sexual and reproductive rights. The goal is to prevent unwanted pregnancies, risky abortions and sexually transmitted diseases, including HIV/Aids. To achieve these things, the bill would ensure good reproductive health care, comprehensive sex education and related services for all citizens of the EAC.

The bill makes sense, but it is highly controversial. It has triggered hot debate in member states, including Uganda. In March 2017, the Daily Monitor, one of Uganda's leading newspapers, actually ran the misleading headline "EALA Bill seeks to introduce contraceptives for children". Though sexually active teenagers are not adults, they are not really "children" either. The question is at which age children become sexually active teenagers. Good sex education is about giving young people reliable information so they

can assume responsibility for their lives, but unfortunately the view is wide spread that sex education basically encourages adolescents to have sex. In view of such public attitudes, the Ministry of Gender, Labour and Social Development banned sex education in schools in October 2016. Society considers children to be innocent, and the only information they supposedly need is that having sexual intercourse too early is dangerous. Young people are told to abstain until they are old enough to get married.

The problem with this approach is that it is evidently not working. Teenage pregnancies are all too common in Uganda. The latest Demographic and Health Survey was published in March 2017 and indicates that the teenage pregnancy rate is 25%. This means that 25% of adolescent girls (ages 15 to 19) have begun childbearing.

The vast majority of the girls concerned did not want to get pregnant and are not prepared for their role as mothers. Most of them did not get good parenting themselves. Some became pregnant because they were eager for affection and/or curious about sex. Others were raped. Typically, the girls lack education in general and sex education in particular. What they know about reproductive health is mixed with miscon-

ceptions that encourage risky behavior. The impacts of teenage pregnancies are often devastating (see box p.28).

ESTHER'S STORY

Esther (name changed) is 19 years old and a single mother of two. Her story is typical in many ways. Her first child lives with the grandmother in a village, while her younger daughter stays with Esther in a Kampala slum. Esther works at a local market stall, selling fruits and vegetables. The lady who owns this small business has become like a second mother to Esther. "If I had known her earlier, I would have never made so many mistakes," Esther says.

As a child, Esther was often neglected. Her parents separated when she was still very young. She first stayed with her father, but he died in a car accident when she was only eight years old. At the time, her elder sister was 16 and found a husband. Esther's younger brother could stay with their mother, who paid his school fees too. There was no one, however, who could take care of Esther, so she dropped out of school after only four years of primary school and started to work as a housemaid. She managed to send her mother some money for building a small mud hut in the village.

Esther was 14 years old when she fell in love with the neighbour's son. At the age of 15, she gave birth to her first child. Her body was too young, there were complications, and she needed a caesarian section. The baby's father was not interested in her. Esther returned to her mother's home, but her mother could not support her and the baby. Esther had to find a job.

She left the baby with the grandmother and moved in with a cousin in Kampala. The cousin earned a living by prostitution. She told Esther that there was no other option for girls like them. Esther started going to night clubs too, but she could not stand selling her body to strangers. At that time, she met her second boyfriend and soon was pregnant again.

Her second child is now two years old. Esther is happy to have found work. The lady who employs her put her in touch with Joy for Children Uganda (JFCU), a non-governmental organisation. JFCU's mission is to improve the lives of children. Core concerns include empowering families, ending child

One aspect of improving the lives of Uganda's children is to prevent teenage pregnancies.



marriage, delaying marriage and promoting health as well as education. Preventing unwanted pregnancies is obviously important.

In four Kampala slums, including the one where Esther lives, JFCU has formed women groups. They meet once a week, share their experiences and receive training. The NGO helped Esther to learn to read and write. She has also gained knowledge about hygiene, nutrition, family planning and parenting. Looking back, she regrets that she dropped out of school and got pregnant twice. She knows better now and is eager to share her experiences with teenage girls, so they will avoid her mistakes.

GENDER DISCRIMINATION AND POVERTY

Uganda's fertility rate is currently 5.4. On average, parents have to take care of more than five children. Especially in rural areas, this responsibility is often left to the mothers, who must also work in the fields and do the entire house work. These things are all considered a woman's duties.

According to the official statistics, the rate of teenage pregnancy is higher in rural than in urban areas (27 % and 19 %, respectively). The reasons are lower levels of education and worse poverty.

The Ugandan government is concerned about poor parenting. The Ministry of

Gender, Labour and Social Development recently drafted guidelines to raise awareness of parents' roles and responsibilities. How effective this effort will be, remains to be seen.

It is obvious, of course, that children do not only need competent guidance. They also need food, shelter and clothes. Moreover, someone must buy school utensils and pay school fees. Most Ugandan parents struggle to come up with the money, so many poor families only invest in the education of their sons. The tradition of bride prices means that "marrying off" girls is a source of income. Poverty and gender discrimination are thus mutually reinforcing. At a Girls Camp that was organised by JFCU, a 15-year-old girl once said: "Our parents see in us cows or goats... Who wants to educate a goat?"

Teenage pregnancies lead to early marriage, and child marriages are a cause of teenage pregnancies. According to UNICEF data, 40 % of Ugandan women who are 20 to 24 years were married before their 18th birthday.

Though teenage pregnancy is considered to be a serious problem by both the government and civil society, no coherent strategy has been adopted to address this issue. A National Strategy to End Child Marriage and Teenage Pregnancy in Uganda was launched in 2015, but it mainly focuses on child marriage. It does not really tackle teenage pregnancy.

Because of the sex-education ban, it has become difficult for civil-society organisations like JFCU to reach out to young people in schools. Health professionals and social workers understand, however, that adolescents know a lot about sex. The information they get from their peers, however, is often distorted and wrong. Teenagers – both girls and boys – deserve to be given correct information so they can make informed decisions regarding their sexuality. The EAC bill is actually pointing in the right direction. Uganda would do well to take a similar approach. Uganda should come up with its own strategy which addresses the need of adolescents and leads to a significant reduction of teenage pregnancy rates.



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Devastating consequences

Teenage pregnancies have various negative impacts, including a higher rate of maternal mortality. According to the recent Uganda Demographic Health Survey, about four percent of the country's girls aged 15 to 19 die because of complications during pregnancy or while giving birth. Roughly one quarter of the girls in this age group gets pregnant, and one sixth of them die.

The bodies of young girls are often not ready for pregnancy and childbirth. For example, some 2,000 new cases of fistula are registered in Uganda annually, according to the UN Population Fund (UNFPH). An obstetric fistula is a hole between the vagina and rectum or bladder that is caused by prolonged obstructed labor, leaving a woman incontinent of urine or feces or both. Fistula

can be avoided by delaying the age of first pregnancy and timely access to skilled health care.

In addition to severe or even deadly health complications, teenage pregnancy results in early school drop out of girls. Without support from parents and teachers, pregnant girls and teenage mothers cannot continue with school which limits their chances of gaining skills and knowledge necessary for finding employment; instead they are often trapped in a vicious cycle of poverty.



Face the truth

In Nigeria, tradition and culture supposedly uphold moral standards. In reality, the incidence of teenage pregnancies is unacceptably high.

By Damilola Oyedele

Due to religious and cultural sensitivities, Nigerians live in denial of just how common teenage sex is. The glaring reality was revealed by the Demographic Health Survey (DHS) in 2013. Only three in ten women reported to first have had sexual intercourse at the age of 20 or later, while 54 % said they had done so before turning 18. A stunning 24 % indicated that they had not even been 15 yet.

The DHS also showed that a mere two percent of sexually active girls between 15 and 19 use contraceptives. An important reason is that they do not have access to contraceptives. It should thus not surprise anybody that 23 % of the girls in this age group have children.

Some girls get pregnant because of voluntary early sex and peer pressure. Others are sexually abused or forced to marry early. In general, they lack proper sex education and information on contraceptives. Very few have access to contraceptives. Condoms, of course, would also protect people from HIV/Aids.

Many teenage girls bask in the euphoria of so far unknown male attention, and some are curious about sex. It makes them more vulnerable that they were raised in a patriarchal society which expects women to be shy and undemanding. Inexperienced teenagers hardly demand that their male partner wear a condom. All too often, they are taken advantage of.

The impacts of teenage pregnancy often ruins girls' lives, whether they are married or not, whether they engaged in sex willingly or were forced. Typically, they drop out of school and do not acquire any skills that would help them earn money. If they aren't married already, they normally end up in a bad marriage, wedded to their child's father who often is too young for parenthood himself.

In many cases, the girls' young bodies cannot cope with the stress of pregnancy and labour. Vaginal fistulas are a common consequence of lacking antenatal and post-natal care. The implication is that patients become incontinent and ostracised by society. All too often, surgery is not available or not done properly, so the persons concerned become marginalised in the long run.

There are many reports of teenage girls experimenting with various dangerous concoctions in the hope of preventing or ending pregnancy. Medical complications are awful. Abortion is illegal in Nigeria – and illegal abortions tend to be unsafe.

The DHS reported the highest figures for teenage pregnancies in the north-western states of Katsina, Jigawa and Zamfara. These states also have the worst data concerning early marriage, fistulas and access to contraceptives. Unsurprisingly, maternal and infant mortality rates are high too.

In 2013, the National Population Commission (NPC) warned that the number of teenage mothers in Nigeria may rise to 60 million by 2015. It argued that aggressive steps must be taken to stop the trend. In

particular, good sex education could make a difference. Some nations provide outspoken and comprehensive sex education to teenagers, helping them to understand what is going on with their bodies and minds. These countries have the lowest rates of teenage pregnancy.

Nigeria, however, is a closeted society. Sexual issues are not discussed freely. Even many married couples do not talk about sex. Advocates of sex education in schools have met with stiff resistance from religious leaders who say that such education would promote immorality. Nigerian society preaches abstinence, ignoring that masses of teenagers are sexually active nonetheless.

In the towns, teenage pregnancy is less prevalent than in rural areas where poverty and illiteracy are worse. But even in a big city a teenage girl is unlikely to go boldly to a family planning centre and demand services. Most are even too embarrassed to ask for condoms or contraceptive pills in a pharmacy.

Some urban parents whose teenage daughters get pregnant ensure that they continue with their education after deliv-



Contraceptive advice given at an Aids clinic in Lagos.



ery. Others arrange illegal abortions. Most teenage mothers in cities, however, suffer similar fates as their rural counterparts do: they are tied to a husband they did not really want, are denied education and professional opportunities and all too often struggle with health issues.

MAKING CHANGE HAPPEN

In Lagos, the government has made adolescent health a priority. A unit called “Hello Lagos” is promoting sex education and reproductive-health services for youngsters. It is running several centres across the state. They encourage teenagers to abstain from sex until they are old enough to deal with the consequences. At the same time, Hello Lagos has been cooperating with the

UN Population Fund (UNFPA) to ensure access to condoms to teenagers who are sexually active. The collaboration involved training and advocacy among health workers to make them less judgmental towards young people.

In northern Nigeria, where early marriage is more prevalent, some non-governmental organisations are reaching out to teenage mothers-to-be, encouraging them to access health care to mitigate the complications associated with pregnancy at an early age. In Niger state, the RAiSE Foundation is raising awareness among faith-based and cultural organisations with a focus on ensuring young mothers get antenatal and postnatal care. RAiSE was started by Amina Abubakar Bello, a gynaecologist (and the state governor’s wife).

The organisation is proud of maternal and infant mortality rates dropping in the state. In Kano state, the Fistula Foundation has been working for years to assist women access surgeries.

Tackling the health issues is important, but ultimately Nigeria must accept that, in spite of religious and cultural teachings, interest in sexuality is part of adolescence. Teenagers must be assisted to navigate this period successfully and provided with all resources they need.



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The fates of two teenage mothers

Maria O. was suddenly feeling nauseous and light hearted. The 14 year old girl had no idea why. She had used tetracycline after she had sex with her new boyfriend, believing that this multi-purpose antibiotic was a contraceptive too. Her understanding of all issues relating to reproductive health and sex was quite poor.

“Everyone used to tell us that if a boy as much as touches you, or even looks at you too intensely, you would get pregnant,” Maria says. “Later, I realised that was an exaggeration.” She heard of several ways to not get pregnant. “A friend said I could use strong antibiotics after sex, so I chose tetracycline.” She did not dare to ask the lady at the pharmacy to recommend something that would prevent pregnancy. The reason was: “She would have told my mother, we attend the same church.”

Maria stopped going to school. Her parents kept her at home until she delivered the baby. At the age of 15, she was a mother, a role she was ill-equipped to handle.

Shame hurt her entire family. Maria’s mother recalls: “My husband and I are normally well respected in church, but we were relegated to background roles.” Members of the community accused them of not having taught their daughter good morals. For a while, Maria’s father even disowned both his daughter and his wife. “After entreaties by some elders, he allowed us back in,” Maria’s mother says.

For some time, Maria’s boyfriend denied having had sex with her. His parents had warned him that if he got a girl pregnant, he would have to marry her. He was outed, however, because he had bragged to friends about “conquering the

bubbly Maria”. A hasty marriage was arranged.

That was six years ago. Maria is now a mother of three. She neither went back to school nor learned a trade. Her husband also dropped out of school. He was informally taught to fix cars by the roadside. The family always lacks money for food, school fees and other necessities.

Making matters worse, Maria’s husband, who is three years older than her, regularly abuses her. “He tells me all the time that I ruined his life,” Maria says. “He says that if I had not gotten pregnant, he might have finished secondary school; that I should have been smarter.” She says she would never have married him had social conventions not forced her to do so.

Aisha M.’s story is depressing in a different way. At the age of 11, she was married, supposedly to fulfil religious norms. She was pregnant soon. By the age of 16, she had three children.

Her young body, however, was not mature enough to withstand the stress of pregnancy and childbirth. Labour complications resulted in vesicovaginal fistula (VVF). This condition occurs when blood supply to the tissues between the vagina and bladder is restricted and tissue necrotises, creating holes through which urine passes.

Aisha underwent surgery twice, but the interventions failed to repair the fistula. Today, she moves around with a catheter inserted into a plastic bag to avoid soiling herself. Her husband did not divorce her, as is common, but he largely neglects her and has married a second wife.

Maria and Aisha live hundreds of miles apart. Their fates are only two examples of the hardships teenage mothers face in Nigeria. Usually, they drop out of school and cannot acquire any professional skills. Many struggle with health problems.

Dangerous for mothers and babies

Female genital mutilation (FGM) often causes serious complications during pregnancy and especially during and after childbirth. Both mother and baby are exposed to risks, some of which prove fatal. It is urgently necessary to raise awareness of how destructive this procedure is.

By Idah Nabateregga

About 200 million girls and women worldwide have been cut. FGM is widespread in 29 African countries, and in over ten of them, at least half of all women have been cut. The practice is also common in Southeast Asia, especially in Indonesia, and in the Middle East. Due to migration, FGM is also prevalent in Europe, the USA, Canada and Australia.

The World Health Organization (WHO) has identified four major types of FGM. The most invasive procedure is type III, also known as infibulation. It involves narrowing the vaginal opening through the creation of a covering seal, formed by cutting and repositioning the labia minora and/or labia majora, with or without the removal of the clitoris. The wound is stitched closed,

leaving only a very small opening to allow for urination and menstruation.

FGM is most often performed on children between infancy and the age of 14. During and immediately after the procedure, complications such as excessive bleeding, severe pain, shock and wound infections usually occur. These eventually leads to long-term consequences like chronic pain, fistulas, urinary and menstrual problems, incontinence, sexual problems, complications relating to the scar tissue, keloids and trauma.

Infibulation also involves de-infibulation and re-infibulation procedures. De-infibulation is the surgical procedure to open up the closed vagina. This is often performed several times, for example on the wedding night to allow for sexual intercourse and prior to childbirth. Re-infibulation (reclosing the vagina) usually takes place after each childbirth. These processes pose serious consequences for both the mother and the unborn child.

The formation of scar tissue prevents the birth canal from expanding the way it should. As a result, deliveries often last longer than normal, with a greater risk of

complications. The scar tissue can tear, which in turn causes tearing in the blood vessels, nerves and muscles of the pelvic floor. Tears that extend into the anal canal are common as well and may result in fistulas and incontinence.

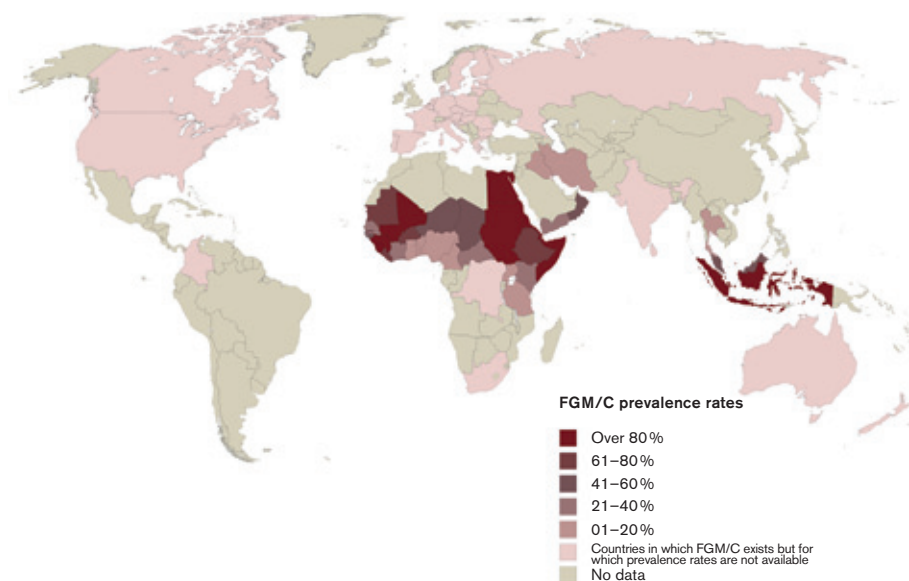
Infibulation also makes birth riskier for babies. Drawn-out deliveries can dangerously limit oxygen levels, causing injury or even death. Tears and wounds in the mother's tissues also make it much more likely that she will transmit HIV/AIDS to the baby. Due to the fact that women may bleed to death during childbirth, many are forced to undertake a caesarean section. In general, childbirth injuries are significantly worse among women who have undergone FGM (particularly type III), thereby increasing the risk of maternal and infant mortality.

Terre des Femmes, a human-rights organisation for women, has been engaged since 1981 in the prevention and cessation of FGM. Since 2016, TDF has been coordinating the EU-funded CHANGE Plus project, training African diaspora communities within the EU to contribute to the abandonment of FGM within their own communities. Sensitisation and awareness-raising are crucial measures.

Doctors, especially gynaecologists, midwives and nurses play a central role in advising, educating and treating women and girls who have been affected by FGM. These professionals are also very likely to encounter survivors of FGM or girls at risk. TDF thus offers training for medical professionals for the purposes of education, prevention and treatment of affected women and those who are at risk.

Since the priority is child protection and support for survivors, awareness must be raised in ways that are respectful, thoughtful, flexible, constructive and well informed.

Prevalence of female genital mutilation worldwide.



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LINKS

Terre des Femmes:

<http://www.frauenrechte.de/online/index.php/en/home-engl>

CHANGE Plus Projekt:

<http://www.change-agent.eu>

Anonymity is problematic

Surrogate motherhood is illegal in Germany. Therefore, some couples, who cannot conceive, but want to have children, turn to surrogacy abroad – in Ukraine, Kenya or California, for example. Anika König is a social anthropologist who does research on these issues. In her eyes, illegal surrogacy means that surrogate mothers have no rights.

**Anika König interviewed
by Hans Dembowski**

Why do couples turn to surrogacy?

I can only speak about Germany and Switzerland, where I have conducted interviews. The people concerned cannot have babies. The reasons are either medical – a history of cancer, for example – or biological, if they are homosexual. The couples consider the situation thoroughly. Media reports, according to which women do not want to interrupt their careers or spare their own bodies the strain of pregnancy are incorrect, at least in Germany and Switzerland. It takes considerable efforts to find and commission a surrogate mother.

But isn't doing so always abuse or exploitation?

I don't agree with such generalisations. Yes, when women become surrogate mothers because they desperately need money, the assignment is likely to be abusive. But if all people involved act with mutual consent and in a fair manner, I do not see an ethical problem.

What motivates women to become surrogate mothers?

There is variety of reasons. In California, where surrogacy is legal, I have met deeply religious women who said they wanted to help others to have a family, because that is what matters most in life according to their faith. Other surrogate mothers know how depressed people are because they cannot conceive, for example if it affects a close friend. They too want to help. Some women, moreover, like being pregnant, but do not want another child of their own. Yet other women consider surrogacy an opportunity

to earn money whilst taking care of their own children at home.

How much must one pay for a surrogate mother in California?

At least \$ 100,000 and more likely \$ 150,000. The surrogate mother will earn about 20 % of that sum. Her agency, insurance companies and lawyers make money too. Health services, moreover, are very expensive in the USA.

So only prosperous people can afford a surrogate mother.

Yes, but that need not be so. In Israel, for example, surrogacy is legal, and under certain conditions the government will pay. Applications for funding are complicated and time-consuming. In Ukraine, surrogate mothers are available at much lower costs than in California. And one of my interviewees recently told me she had been offered the services of an Indian woman in Kenya. Indian law has been changed, so German couples cannot commission a surrogacy there anymore. A ban, however, does not end surrogacy. Desperate couples will find help somewhere else.

Are surrogate mothers' rights better protected when things are legal?

Yes, illegality implies a lack of rights, and that is why Indian surrogate mothers opposed the reform. Their perspective matters too. Some earn more money with a

pregnancy than in a decade of working in a garment factory. Some appreciate living in a hostel with other pregnant surrogate mothers, because – for the first time ever – they must not work hard. They daily get good food and have lots of leisure. I do not approve of huge social disparities, but this is a local reality.

What about the children? Don't they suffer identity problems?

No, not necessarily. It helps to be forthright, as long-term studies have shown. Anonymity causes problems, but the more transparent things are for all people involved, the more normal and self-explaining they are – especially for the children. That is what researchers found out in Britain, where non-commercial surrogacy is legal. Staying in touch, by the way, matters a lot to the surrogate mothers too. They find it hurtful when the social parents, who paid them a lot of attention while they were pregnant, later go silent. In this context too, illegality is harmful.



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LINK

König, A., 2017: Embryos on the move:
Transnational networks of surrogacy.
<http://www.medizinethnologie.net/embryos-on-the-move/>

A British couple with two daughters who were born of surrogate mothers.



Public disclosure

El Salvador has some of the strictest abortion laws in the world. A proposed reform would allow women to seek abortions under certain circumstances without ending up in prison. One famous proponent of this initiative is journalist and filmmaker Marcela Zamora. She described her own abortion in the online magazine *El Faro*, igniting a firestorm.

By Katja Dombrowski

“Yo aborté” – “I had an abortion”. This was the title of Zamora’s article. In the strongly Catholic country of El Salvador, where the termination of unborn life under any circumstances is considered a grave sin and punishable by a prison sentence, such an admission is scandalous. Zamora is not in any legal danger though: the story of her abortion took place more than ten years ago and in another country – where exactly, she does not say. “I checked it out thoroughly. I can tell this story,” writes Zamora. The well-known, award-winning documentarian,

whose work focuses on social and human-rights issues, is making her very personal story public in order to campaign for a reform of Article 133 of the Salvadoran criminal code. The women proposing this reform want to eliminate penalties for abortion in three cases: if the life of the mother is endangered; if the pregnancy is the result of a rape; and if the foetus is not viable outside of the womb (see box, p. 34).

Zamora had an abortion at age 24, while living abroad. “I was studying and in perfect health,” she wrote in *El Faro*. “I was sexually active. I had a steady boyfriend. I took the pill so that I would not get pregnant, because at this time in my life I did not want to have children. I wanted to finish my studies, travel, work for a while, and then become a mother. I wanted to have the right to make my own decisions about my life, my body and my offspring.”

She got pregnant anyway. Because she was not expecting this, and because her period had not completely stopped, she did not see a doctor until three months

into the pregnancy. After performing an ultrasound, he determined that the foetus had a blood clot on its head. He believed the foetus would likely detach from the uterus and cause internal bleeding that could kill Zamora.

According to the doctor, Zamora had two options: “One option was to do surgery that very afternoon and remove the foetus; the other option was to go on bedrest for a month and wait to see if the blood clot disappeared. That meant becoming a mother, even if I had not decided so.” Nevertheless, she chose the second option.

After one week of bedrest, the foetus developed further blood clots. The doctor recommended that Zamora terminate her pregnancy the same day. It was not an easy decision for her: “I asked him a lot of questions. I always had a lot of questions. The ones I remember had to do with the risk of the surgical procedure, whether the foetus would suffer and the possibility of having children at a later time. He took his time and explained that there were risks associated with any surgery, no matter how small, but that it would be performed by specialists with lots of experience. He told me that the foetus does not develop receptors for feeling pain before 20 weeks, or five months, and that the connections to the central nervous system are not yet fully formed. He also assured me that the procedure would not make me infertile, and that I could have children at a later time, if I wanted to.”

The abortion was performed in a public hospital, and Zamora did not have to pay for it herself. She was grateful to the doctors and nurses: “They had saved my life.” Within a month, she had fully recovered from the procedure.

Zamora emphasises that she did not feel guilty, nor did she cry. She also did not feel like a bad mother, because she had never actually been a mother. But she did not decide to give up motherhood forever. “I decided to continue living and not risk losing the chance to become a mother in the future.” Today, Zamora has a four-year-old daughter.

She considers herself lucky that she had the opportunity back then to terminate her dangerous pregnancy – unlike most women in El Salvador today. The reform of Article 133 is intended for cases just like

2014 demonstration for the legalisation of abortion in El Salvador and the release of 17 women who had suffered miscarriages but were given long prison sentences for supposed abortions.



this. Zamora believes that the current law in El Salvador discriminates against poor women. They have no money to fly to another country where abortion is legal. “Middle- and upper-class women have options.” Zamora was one of these privileged women. Her father Rubén Zamora is a well-known politician and currently represents El Salvador in the United Nations.

Zamora’s appeal to her fellow Salvadorans is unmistakable: “The discussion about this reform cannot be based upon the law of God, because not all of our citizens believe in God, and the laws must be

made for all citizens, regardless of race, social status, or religious beliefs. [...] I had an abortion. And my case is neither unique nor different than that of the thousands of women who face one of these three critical situations and have no way out under El Salvador’s current law.”

The article triggered intense reactions. Zamora says she has received more than a thousand hate mails. “Hundreds of people wished that I had been aborted instead, and all of them referred to God in their arguments,” she told the German newspaper *tageszeitung*. But she also re-

ceived many thoughtful emails, even from pastors.



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LINK

Article by Marcela Zamora in *El Faro* (in Spanish):
<https://elfaro.net/es/201701/columnas/19900/Yo-aborté.htm>

International pressure for reform

There is an absolute ban on abortions in El Salvador, with no regard for how the pregnancy came about – for example, through rape – or if the life of the mother is endangered. A miscarriage is considered a termination of pregnancy, and an “induced” miscarriage is considered murder. Parliament is now debating a reform of the controversial law.

If a woman in El Salvador has an abortion or even experiences a miscarriage, she can ex-

pect a prison sentence of up to eight years. The same goes for anyone who performs or assists in an abortion. An intentional termination of pregnancy is punishable by up to 40 years in prison.

The strict law does not completely prevent abortions in this Central American country though. These clandestine abortions are associated not only with legal risks, but also with health consequences for the women involved. The

human-rights organisation Amnesty International notes: “Health risks through unsafe and secret abortions lead to a high maternal mortality rate.”

Now, for the first time in 20 years, there is chance that Article 133 governing abortion in the Salvadoran criminal code will be reformed. On 11 October 2016, Lorena Pena, the head of parliament, and representatives of the ruling party FMLN presented a proposal to reform Article 133, whereby punishment for abortions would be eliminated in the case of rape, danger to the life of the mother and unviability of the foetus.

The debate in parliament is pending. The proponents of the reform want to regain the right to abortion on certain grounds, as was the case in El Salvador until the toughening of the law in 1998. One famous proponent of the reform is the filmmaker Marcela Zamora (see main article).

In a recommendation on 3 March, the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) called for El Salvador to relax the law and proposes a moratorium until then. Amnesty International also supports the reform initiative and has called for a worldwide “Urgent Action” of sending appeals to the lawmakers.

Poor women suffer in particular under El Salvador’s abortion law.



LINKS

Recommendation of the U.N. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) to El Salvador:
http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/SLV/CO/8-9&Lang=En
Urgent Action by Amnesty International:
<http://www.ai-el-salvador.de/abtreibungsverbot.html>

Midwifery is part of the culture

Despite the enormous progress that has been made in reducing rates of maternal and infant mortality, over 300,000 women still die every year of complications from pregnancy and childbirth. Six million children under the age of five die each year as well. Millennium Development Goals (MDGs) 4 and 5 fell shortest of their targets. Traditional midwives play a central role in preventing mortality, attending births and caring for mothers and their newborns. But their possibilities vary greatly.

By Barbara Kühlen

Millions of women in developing countries either have no access to prenatal care during pregnancy or do not know how important it is. Births are not attended by medical professionals, and some women bring their children into the world without any support at all. Women and newborns often receive no care during the postpartum period.

Around 830 women die each day of complications from pregnancy and childbirth, as do 18,000 children under five. The causes are primarily poverty, a lack of information, inaccessible medical facilities, inadequate health services and cultural factors that can include discrimination against certain groups.

The lack of qualified medical personnel is one of the main reasons for high rates of maternal and infant mortality. The World Health Organization (WHO) estimates that in 2013, the world was short of 9 million midwives and nurses, who also frequently attend births. Only 78% of births are attended by qualified medical personnel. That number is even much lower in poor countries.

Maternal mortality is very unequally distributed, not only among continents and countries, but also within individual countries. It varies based on social status, education level, ethnic background and place of residence. Women in rural areas are at a significant disadvantage: of the 40 million births that were not attended by

medical professionals in 2012, 32 million took place in the countryside. Preventive measures are also inadequate. Only about half of all women in developing countries receive the minimum of four prenatal examinations recommended by the WHO.

TRADITIONAL BIRTH ATTENDANTS

In Guatemala, midwife is not an independent profession. Instead, obstetrics is a medical speciality. Births are usually attended by obstetricians or general practitioners in hospitals, but more often by nurses in rural areas and in smaller health centres. There are not nearly enough of them, however. After Haiti and Guyana, Guatemala has the lowest health-worker density in Central America, with 12.5 clinicians per 10,000 residents.

Maternal and infant mortality rates are far above the Central American average. In 2013, the maternal mortality ratio was 113 deaths per 100,000 live births, meaning that rates could not even be cut in half compared to 1990's levels. The goal was to reduce mortality by 75%. The number of deaths is over twice as high among indigenous peoples.

"The prevalence of maternal mortality reflects the position of women in society, their limited access to health and nutritional services and their precarious economic situation," says Aura Pisquiy, a physician and the director of the Guatemalan non-governmental organisation (NGO) PIES de Occidente, which has advocated for better sexual and reproductive health and the rights of indigenous women in the western highlands since 1996.

The overwhelmingly indigenous population in this region often cannot reach health facilities. Even if they do, health workers do not usually speak their language, and patients feel discriminated against. As a result, traditional birth attendants, known as comadronas, assume responsibility for women's care during pregnancy and childbirth. There are 22,500 comadronas officially registered, but their



THE MILLENNIUM DEVELOPMENT GOAL TO REDUCE MATERNAL MORTALITY

- In 2015, around 303,000 women around the world died of complications from pregnancy and childbirth. Ninety-nine percent of them lived in developing countries.
- Of all the Millennium Development Goals, the least amount of progress has been made towards MDG 5: Improve maternal health. Between 1990 and 2015, maternal mortality could only be reduced worldwide by 44% rather than the desired 75%.
- MDG 4 was also missed: the mortality of children under five was cut in half, but the target of reducing deaths by two-thirds between 1990 and 2015 was not met. At the current pace of progress this goal will not be reached until 2028.
- In 2015, 2.7 million newborns died during the first 28 days of life, around 6 million children worldwide did not reach their fifth birthdays, and 2.6 million babies were stillborn.
- Sustainable Development Goal 3.1, adopted in 2015, calls for a global reduction in maternal mortality rates to fewer than 70 per 100,000 live births by 2030.



A traditional midwife in Guatemala examines a pregnant woman.

number may be much higher. According to a national survey of maternal and infant health, they attend 31% of births nationwide and as many as 60% in regions with large indigenous populations.

Comadronas are women who feel “chosen” for this role and have learned midwifery primarily through practical experience and guidance from their mothers. Their responsibilities include prenatal care, birth attendance, postpartum care and care for newborns and babies. If complications arise, they are supposed to bring women to state-run health facilities.

Comadronas are respected authorities in their communities and important confidants for pregnant women. They usually do not receive formal payment for their services, but instead are given what families can afford: a small sack of rice, a couple of eggs, maybe a hen or in some cases money.

Pisquiy explains: “The indigenous comadrona in Guatemala is the bearer of generations of Mayan traditions about care for mothers and newborns. She has a gift for caring for mothers’ health. She was given this gift at birth, and it is either revealed

or confirmed over the course of her life. She enjoys the respect and trust of women and families because she is a part of their culture and speaks their language.”

At PIES, comadronas learn for instance how to clearly recognise dangerous symptoms in pregnancy and to bring their patients to health facilities. Improving cooperation between comadronas and public health facilities and their staff is one of the NGO’s main focuses. “The public health system should value Mayan traditions and recognise that they are part of Guatemala’s cultural and social reality. The two systems should complement one another and cooperate in clearly defined ways,” Pisquiy explains.

But practitioners’ lack of mutual respect and lack of trust in each other’s abilities still often stand in the way of coordinating community-based care with the state-run health system. The comadronas are reluctant to refer patients to public health centres or accompany them there because the staff have treated them badly and discriminated against them many times in the past. Medical professionals frequently have very negative stereotypes about the abilities of the comadronas.

They used to be blamed for the country’s high rates of maternal mortality.

PIES includes health workers in its projects in order to overcome prejudices and improve mutual understanding through personal contact. The comadronas also learn to recognise the limits of their capabilities when it comes to birth attendance.

Pisquiy criticises: “Despite the indisputable support that the comadronas provide and the great responsibility they assume for maternal health, they are still not adequately valued, promoted or supported by the Ministry of Health.” But she thinks attitudes are slowly changing. According to her, there have been slight changes in policy over the last few years (see box, p. 37).



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LINK

PIES de Occidente (in Spanish):
<http://www.asociacionpiesdeoccidente.org>

New legal guidelines

2010 marked the start of a participatory process in Guatemala to formulate the “National Comadrona Guideline”, which was adopted in August 2015. It contains important elements like the promotion and dissemination of the knowledge of traditional birth attendants, the strengthening of their work as “agents of change”, improvement of relations between comadronas and the state-run health system and better institutional consideration of the cultural dimensions of maternal and infant health. The adoption of the guideline was a great achievement, but in practice the policy has so far been largely ignored and is not a priority for the Ministry of Health.

In response to an initiative by an indigenous representative, the congress went a step further and passed a law in February 2017 that recognises the work of comadronas. It requires the Ministry of Health for instance to acknowledge the vital role traditional birth attendants play and provide them with financial support. They are to receive 250 quetzales (about € 30) per month for life. The money is not considered a payment, but rather an economic incentive and recognition of their talent and mission.

President Jimmy Morales vetoed the bill shortly after it was passed, however, presumably upon request of the Ministry of Health and on the basis of a governmental agreement. He claimed that the law failed to respect the multiculturalism

of the Maya given the fact that its name was written in only one of Guatemala’s 22 Mayan languages. It was therefore not inclusive. Moreover, the law allegedly violates Convention 169 of the International Labour Organization (ILO) on the rights of indigenous peoples. According to Morales, since the financial support was tied to the certification and registration of the comadronas, they would have had no choice but to comply. He also felt that the law was not in harmony

with the policies and priorities of the Ministry of Health, which was not consulted as it was being drafted. Another bone of contention is the bill’s financing, which Morales says is unclear. He also claims that there is not enough money in the budget for it.

The government has also criticised the bill for a lack of transparency when it comes to the criteria that will determine how the payments will be distributed. Furthermore, this approach is supposedly fundamentally at odds with the culture of the comadronas, who feel called to help their communities. But in fact the co-

madronas have long requested steady financial support from the government. The law is now being considered by the Constitutional Court and could be sent on to the IACHR (Inter-American Commission on Human Rights).

In reality, financial considerations do seem to play an important role, because even though the planned monthly payments are very low – some comadronas have even called them insulting – the number of potential recipients is so high that they would represent a significant burden on the meagre budget of the Ministry of Health.



Training course for traditional midwives in Guatemala.

More efforts needed

Between 1990 and 2015, maternal mortality has been greatly reduced internationally. Nonetheless, hundreds of thousands of women still die due to complications of pregnancy or childbirth each year. More efforts are needed to reach the target of the third Sustainable Development Goal (SDG) to reduce the global maternal mortality rate (MMR) to less than 70 per 100,000 live births by 2030.

By Katja Dombrowski

In 1990, the global MMR was 385 per 100,000 live births. In 2015, it was 216. That was an improvement of 44% over 25 years, but it fell short of the 75% reduction the UN had pledged to achieve as the fifth Millennium Development Goal (MDG). Thanks to the MDG agenda, initiatives were taken that helped to improve maternal health – but not as much as aspired. The MDGs were adopted in 2000.

Nine of the 95 countries that had an MMR of more than 100 in 1990 achieved the 75% goal: Bhutan, Cambodia, Cabo Verde, Iran, Lao, the Maldives, Mongolia, Rwanda and Timor-Leste. Most countries made progress, but the UN categorised 26 countries as having made no progress in the report “Trends in maternal mortality: 1990 to 2015”. The report was published by several UN agencies.

Developing regions accounted for 99% of the global maternal deaths in 2015, with sub-Saharan Africa alone accounting for 66%. Together with Oceania, it is the region with the highest MMR. The greatest progress was observed in East Asia. The populous countries Nigeria and India were estimated to account for more than one third of all maternal deaths. In relative terms, Sierra Leone was the worst place to become a mother in 2015: the MMR was 1360.

MMR figures are high in regions marked by violent conflicts, disasters and other humanitarian crises. A high MMR is defined to be 300 or above. Seventy-six percent of the countries with high MMRs are fragile states.

HIV/Aids can be a major obstacle to reducing maternal mortality. Where HIV infection rates are high, health systems and infrastructure tend to be overburdened. Some 1.6% of all maternal deaths around the world are estimated to be directly related to Aids. The UN report stresses, moreover, that statistics tend to be particularly poor and unreliable for those regions where the needs are greatest.

Insufficient and unreliable data are a big problem. Since many countries lack comprehensive systems for collecting the necessary data, the report is mainly based on estimates. The uncertainty of the estimates is taken into account too. For exam-

ple, Nigeria had an estimated MMR reduction of 40% between 1990 and 2015. But the uncertainty interval for that estimate ranges from -5% to 56.3%, so there actually may not have been any reduction at all. The authors reckon the likelihood of that being the case is about 10%, so they put Nigeria in the “no progress” group.

Several strategies have proven successful to reduce maternal mortality. They range from improving health systems to reducing social and structural barriers. The World Health Organization (WHO) published “Strategies towards ending preventable maternal mortality” based on the experience of the countries that successfully reduced their MMR. The WHO strategies specify five objectives:

- Address inequities in access to – and the quality of – sexual, reproductive, maternal and newborn health care.
- Ensure universal health coverage for comprehensive sexual, reproductive, maternal and newborn health care.
- Address all causes of maternal mortality, reproductive and maternal morbidities, and related disabilities.
- Strengthen health systems to respond to the needs and priorities of women and girls.
- Ensure accountability to improve quality of care and equity.

In order to achieve the SDG target of less than 70 maternal deaths per 100,000 live births by 2030, the global MMR must be reduced by 7.5% each year. That is more than three times the annual reduction rate of 2.3% observed between 1990 and 2015. According to the authors, the goal is attainable. Their call to action concludes: “With rapid acceleration of the efforts and progress catalysed by MDG 5, ending preventable maternal mortality on a global level can be achieved by 2030.”

LINKS

WHO et al, 2015:
Trends in Maternal Mortality: 1990 to 2015.
http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1

WHO, 2015: Strategies towards ending preventable maternal mortality.
http://who.int/reproductivehealth/topics/maternal_perinatal/epmm/en/

Maternal care can save lives: ultrasound examination in a Vietnamese hospital.



Investing in the world's poorest children

The United Nations International Children's Emergency Fund (UNICEF) is calling for investments in the survival and health of the world's poorest and deprived children. According to a UNICEF study, this is more cost-effective than supporting children who are less poor. To back up this claim, the study gives examples in numerous countries.

By Sabine Balk

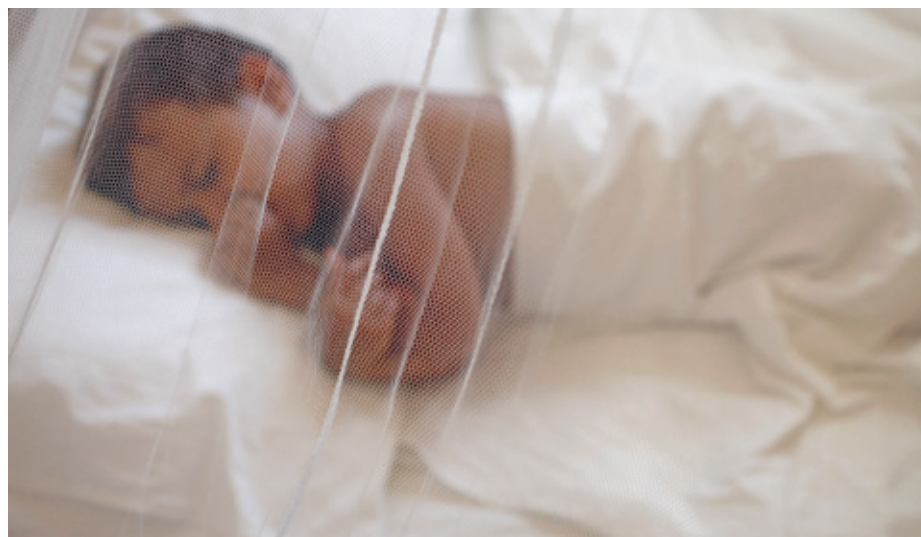
In 2010, UNICEF first claimed that investments in the poorest children were more cost-effective than investments in less de-

investing in effective health and nutrition programmes.

According to UNICEF, it is a great injustice that almost twice as many poor children do not survive to see their fifth birthday than do children in better circumstances. The organisation finds it to be especially tragic that the great majority of child deaths occur needlessly. Most of these deaths can be prevented through practical and affordable measures. Some examples are:

- Mosquito nets for preventing malaria.
- Oral rehydration salts for treating diarrhoea.

Simple precautions, such as the use of mosquito nets, can save the lives of children.



prived groups. The costs of reaching the poorest children are indeed higher than the costs of reaching those who are less poor. However, the added costs are made up for with better results. The agency has recently released new figures that support this presumption. The new study, which was performed between 2003 and 2016, proves that with the same amount of money, almost twice as many lives among the poorest can be saved than among those who are less poor. It is primarily a matter of

- Early vaccinations against avoidable diseases.
- Community-based health services provided by qualified staff to reduce complications during childbirth.
- Breastfeeding babies in the first six months.
- Making sure that parents treat their sick children and bring them to the doctor.

UNICEF regrets the fact that while the poorest would benefit most from interventions, in many countries these pro-

grammes do not reach them. If efforts persist in their current form, without special consideration for the world's poorest population, by 2030 almost 70 million newborns and toddlers will die of preventable causes, warns UNICEF. There is a great need for action in this respect.

Access to health and nutrition programmes for poor populations has improved in recent years, which has led to an essential reduction in inequality. During the 13-year period studied, the mortality rate among poor children under the age of five was reduced three times more quickly than among children who are not poor.

Because the birth rate among the poor is higher than among those who are not poor, the reduction of the child mortality rate has an especially great effect among the poor: 4.2 more lives saved per million people than among those who are not poor. Of the 1.1 million lives saved in 51 countries in one year of the study, almost 85 % were poor children.

An intensive focus on actions and investments for an equity-enhancing approach could help countries achieve the Sustainable Development Goals for reducing newborn and child mortality rates (SDG 3.2), according to UNICEF. Actions for improving child survival that are based upon overcoming inequality could also contribute to breaking the cycle of poverty that has been inherited through generations. When children are healthy, they learn better in school and have better employment opportunities as adults.

According to UNICEF, countries can take the following concrete actions in order to reduce inequity:

- Identify the poorest children and communities.
- Invest in affordable interventions that have been proven to be effective.
- Enhance health-care systems.
- Try harder to access those who are the most difficult to reach.
- Monitor results for equity.

LINK

UNICEF, 2017: **Narrowing the Gaps: The power of investing in the poorest children.** https://www.unicef.org/publications/files/UNICEF_The_power_of_investing_in_the_poorest_children.pdf



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#Democracy
The ANC is not simply South Africa's ruling party. Before assuming power, it was a world-renowned liberation movement, and it has not brought about the social change it promised.

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