Caring for the Nation’s Women
Dear KMWA members,

Welcome to our second edition of KMWA NEWS. 2010 was an action packed year with highlights such as the Symposium on Maternal Health – Yesterday, Today and Tomorrow, new interactive KMWA website; CME’s on pertinent health issues; health talks and participation in international conferences.

We continue to develop strategic partnerships locally with the government, civil society organizations in our field and international partners to move our strategic plan forward.

Our newsletter this year focuses on reproductive health issues and issues relating to cancer. We trust that it shall be informative and a good read as well. Also included are the achievements for the previous year and particulars of the activities carried out.

In partnership with IPM, we shall also have CME’s in our branches in Machakos, Eldoret, Kisumu and Mombasa focusing on new and emerging HIV prevention technologies. We also have other CME’s planned for the year and they are all KMPDB approved CME’s with CPD points.

Thank you all for the many articles that you have sent in and we look forward to receiving comments.

Dr. Jacqueline W. Kitulu Chairperson KMWA

KMWA ACHIEVEMENTS FOR 2010

CHAIRPERSON’S LETTER

Jessica Nyaribo KMWA Administrator

“Equal opportunities at the workplace”

This is a project supported by the Business Advocacy Fund. The main aim was to develop a policy paper on Equal Opportunities at the Workplace and the lead consultant was Dr. Agnes Zani. The organizations that were included in this project were diverse – Ministries of the Government of Kenya, Parastatal Organizations, Civil Society Organizations and the Private Sector. The tools used to collect data included 500 questionnaires to the organizations and the responses were analyzed. This led further to 4 Focus Group Discussions and finally to a one day workshop. The policy paper is in the process of being finalized to be shared with the public.

“Advocacy for Microbicides”

This is a project supported by the International Partnership for Microbicides. This is a new frontier in HIV prevention strategies. KMWA members attended International Conferences on Microbicides to gain more knowledge and then to disseminate this further to the other members. The project also supported the Symposium that was held on 16th October, 2010 on “Maternal Health, Yesterday, Today and Tomorrow” and CMEs in Nairobi and Kisumu.

“Well Woman Clinic”

This encompasses both the WWC in Nairobi West and the Cornelia Shrine Dispensary that is at the Deep Sea Slum area in Westlands District.

The WWC has seen an increase in uptake of its services as KMWA engaged a consultant obstetrician / gynaecologist (Dr. Brigid Monda) and we have a nurse permanently based there. The services offered include family planning/advise for contraception, ante-natal and post-natal care; gynecology clinic; breast examination, immunization against cervical cancer, and health education.

The Deep Sea Clinic has been able to attend to 1,784 patients and KMWA has supported them by paying for a medical doctor (Dr. Phenny Kachumba) to attend to the patients once a week. The conditions treated there include respiratory infections, malaria, HIV/AIDS, genitourinary infections, hypertension, diabetes mellitus, peptic ulcer disease, skin and soft tissue diseases and gynecological issues.

“Trainings & Workshops”

- KMWA supported the Association of Medical Students of the University of Nairobi during their Conference held from 5th – 8th October 2010 themed “Promoting Pediatrics and Child Health: Safeguarding the Future”;
- CME on Microbicides held on 8th July, 2010 in Nairobi;
- CME on Cervical Cancer & Microbicides in Kisumu on 20th August, 2010;
- CME on Women’s Health. Our Nation’s Health held on 14th December, 2010 in collaboration with the Kenya Obstetrical and Gynaecological Society;
- KMWA members attended various workshops throughout the year focusing on the Proposed Constitution, Reproductive Health Issues (Technical working Group in the division of Reproductive Health; National Roadmap for Accelerating Attainment of MDG’s related to Maternal & Newborn Health in Kenya Preventing/stopping Medicalization of FGM for health providers.
- KMWA members attended and participated in four international conferences related to HIV and Microbicides in Vienna, Pittsburg, Muenster and Washington.
- KMWA Symposium on Maternal Health – Yesterday, Today and Tomorrow held on 16th October, 2010 for the KMWA members.
- KMWA is now an accredited Continuous Professional Development (CPD) provider by the Medical Dentists and Practitioners Board (MPDB), Kenya. Please visit www. kmwa.or.ke for the entire Calendar of events.

“Health Talks & Medical Camps”

Health talks were presented and held at the International Christian Church (18th July, 2010); The Women’s Show (19th – 22nd August, 2010); University of Nairobi (29th September, 2010); Catholic University (15th October, 2010); Daystar University (29th October, 2010); H. Young (21st October, 2010).

KMWA supported the Nairobi Pentecostal Church Woodley in organizing a medical camp on 23rd October, 2010.

KMWA presented an article on “Stress & Addiction in the Medical Profession during the British International Doctors’ Association meeting held in Nairobi from 27th –28th September, 2010.

KMWA Sub-Committees 2011

Sub-Committee Convenor

1. Finance & Administration Dr. Lillian Apadet
2. Health, Education & Research Dr. Praxedis Okutoyi
3. Fundraising & Public Relations Dr. Catherine Gachangi
4. Strategic Planning Implementation Dr. Pamela Njuguna
5. Well Woman Clinic Dr. Carol – Odula-Obonyo
6. Adolescent, Sexual & Reproductive Health Dr. Catherine Labolo – Lore
7. Welfare Dr. Noelle Orata

The above sub-committees were formed due to KMWA’s growth and expansion of activities and service provision to its members and the general public. They all have their terms of reference. We encourage KMWA members to join one of the sub-committees in order to improve on the implementation and service delivery as per our 2010 – 2014 Strategic Plan. Please call the KMWA Secretariat for further details.

Strategic Themes:

1. Reduced Child Mortality
2. Improved Maternal Health Care
3. Gender Equality Promoted and Women Empowered
4. Strengthened membership and increased involvement of members in the association activities.
5. Increased visibility and leverage as a major stakeholder in health issues.
6. Institutional strengthening.

For further details, please visit www.kmwa.or.ke for the entire Calendar of events.

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Dr. Jacqueline W. Kitulu Chairperson KMWA
CARING FOR THE NATION’S WOMEN

Dr Julia Songok
KMWA Eldoret Branch

A healthy, educated and empowered woman is an asset to herself, her immediate family as well as to the society at large. Taking care of this woman starts right from the time that she is born. Allow me to do a longitudinal follow-up of a KMWA woman right from the time she is born to the time she becomes successful. Did her mother attend antenatal clinic (ANC) during pregnancy to ensure proper assessment, follow-up, supplements, vaccinations and anticipation of any risks? Did her mother deliver in a setting where there was a skilled birth attendant who could assist the baby at birth? Did she receive appropriate routine newborn care that every child should receive after birth? Were the vaccines available and did she receive the birth doses before going home? Did her mother receive appropriate education on postnatal issues like cord care, hand washing, exclusive breastfeeding? Did she get proper diet and did she get all the recommended vaccines? At the time to start school, did she get equal opportunity as the other siblings? While at home, did she share house chores and responsibilities with other household members? While in school, did the teacher give her equal attention like all the other children in the class? Did she have an equal opportunity of getting a good secondary school that would increase her chances of passing and joining a college or university? Did she get mentor and role models that assisted her in choosing a career or did she end up thinking that the only prestigious course which is a sign of accomplishment is going to medical school and becoming a neurosurgeon? Did she get information on the challenges of being in college/university like peer pressure, lack of school fees, lack of money for upkeep? Did she anticipate that with academic success and continued achievements, the chances of getting a marriage partner diminishes both due to spending longer years studying as well as the fact that some men are not comfortable being married to women who are learned and independent? Did she anticipate that long years in studies translates to starting to have children later than the average woman and that would come with challenges and risks of old primigravidae? Is she worried of the little time she spends with her husband and children because of pressure from work as well as continuing with studies? Was she warned that with success in academics, the society would automatically assume that she has lots of money to support relatives, friends, take her children to the most expensive schools, foot hospital bills etc? As an educated woman, did she know that society expected her to have answers to all problems? Did she take a course in psychology or counseling to allow her to handle all that is placed on her hands? While competing for recognitions and promotions at work, did she get equal opportunities as her male counterparts? How many times has she been criticized for being too independent?

The questions are endless! As the acting chair of Eldoret KMWA branch, I am glad to be a KMWA member. Before we take care of the nation’s women, we have to first take care of each other. Charity begins at home. Our home in this case being KMWA. KMWA started small and has grown immensely and so moving forward we need to chart ways of addressing issues that directly affect members. If in the midst of all odds, we still emerged as influential people in society, how much will we accomplish when we put efforts together and when we address the issues that are obstacles to our personal and professional lives?

MATERNAL MORTALITY: THE 4 W’S AND AN H

By Dr. Angie Dawu

The What?

Maternal Mortality is the term given to the death of a woman from pregnancy or complications of childbirth. Until very recently, the global maternal mortality was estimated to be around 500,000 women per year. (Approx 1,500 women per day).

In addition, for every woman who dies in childbirth, around 20 more suffer injury, infection or disease – approximately 10 million women each year.

Maternal Mortality Rate is the number of women who die per 100,000 women who live.

The where?

Maternal mortality is largely an African problem. A total of 99% of all maternal deaths occur in developing countries, where 85% of the world’s population live. More than half of these deaths occur in sub-Saharan Africa and one third in South Asia. The maternal mortality ratio in developing countries is 450 deaths per 100,000 live births versus 9 in developed countries. Fourteen countries have maternal mortality rates of 1000 per 100,000 live births, of which all but Afghanistan are in sub-Saharan Africa. These countries are: Afghanistan, Angola, Burundi, Cameroon, Chad, the Democratic Republic of the Congo, Guinea-Bissau, Liberia, Malawi, Niger, Nigeria, Rwanda, Sierra Leone and Somalia.

Because women in developing countries have many pregnancies on average, their lifetime risk more accurately reflects the overall burden of these women. A woman’s lifetime risk of maternal death is 1 in 730 in developed countries versus 1 in 75 in developing countries.

The Who?

In addition to the differences between countries, there are also large disparities within countries between people with high and low income and between rural and urban populations.

Age and parity are other influencing factors. This feeds into the “four toos” concept:
  - too young
  - too old
  - too many, and
  - too frequent

The Why?

Women die from a wide range of complications in pregnancy, childbirth and the postpartum period. Most of these complications develop because of their pregnant status and some because pregnancy-aggravated an existing disease.

Five direct complications account for more than half the maternal deaths: haemorrhage (24%), infection (15%), unsafe abortion (13%), eclampsia (very high blood pressure leading to seizures – 1%) and obstructed labour (8%).

The indirect causes account for 20% of maternal deaths and include diseases that complicate pregnancy or are aggravated by pregnancy, such as malaria, anaemia and HIV. Women also die because of poor health at conception and a lack of adequate care needed for the healthy outcome of the pregnancy for themselves and their babies.

The Where?

of maternal mortality in many countries) the right to health. b) Gender inequality (one of the root causes of high maternal mortality) is linked to the principle of non-discrimination, to equality before the law, and to rights related to marriage and family.

The How?

Women need not die in childbirth. We must give a young woman the information and support she needs to control her reproductive health, help her through a pregnancy, and care for her and her newborn well into childhood. The vast majority of maternal deaths could be prevented if women had access to quality family planning services, skilled care during pregnancy, childbirth and the first month after delivery, or post abortion care services and where permissible, safe abortion services. 15% of pregnancies and childbirths need emergency obstetric care because of risks that are difficult to predict. A working health system with skilled personnel is key to saving these women’s lives.

Mental health problems associated with reproduction

MENTAL HEALTH PROBLEMS ASSOCIATED WITH REPRODUCTION

By Dr. Monique Mucheru

Mental health problems can occur at any stage of the life cycle that is, from childhood to old age. They can occur before conception, during pregnancy or even after delivery.

How common is postnatal depression?

It occurs in 1 every 10 women after having a baby. Men may also be affected as a result of added responsibility, decreased attention from wife and the belief that the child is a binding force in an unsatisfactory marriage. Men are more likely to get depressed if they are not getting along with the partner, if unemployed and move history of mental illness.

What does it feel to have postnatal depression?

• Depressed: Low moods, unhappy and wretched for most or all the time. It may sometimes seem like life is not worth living.
• Irritable: One gets very easily annoyed that they feel physically ill.
• Tired: All new mothers get weary but depression makes one feel so exhausted.
• Unable to enjoy anything: This may appear as sadness, crying and lack of interest in all activities
• Guilt: Depression alters one’s thinking and one sees things in a negative light. This leads to feelings of self-blame.
• Anxious: One may be afraid to be with the baby, they worry that the child might scream, choke or be harmed in some way. They feel detached as opposed to feeling close to the baby.

What treatment options are available for postnatal depression?

1) Talking treatments – talking to a sympathetic, understanding uncentrical listener (could be a friend, relative or a professional).
2) Medication – In more severe depression or when hasn’t improved with support & reassurance, antidepressants would probably help. The antidepressants correct biochemical imbalance in the brain. They take about two weeks to start acting and should be taken for four to six months after the patient starts feeling better.

What is postnatal depression?

• Having suffered depression before especially postnatal depression.
• Not having a supportive partner.
• Having a premature (born before term) or sick baby.
• Having lost your own mother when you were a child.
• Having experienced several stresses in a short period of time for instance loss of a loved one, loss of a job or financial problems.

Having the above risk factors does not necessarily mean one will develop postnatal depression. On the other hand, one may have no obvious risk factor but still suffer from it.

Do hormonal changes lead to postnatal depression?

No. Research has shown no differences in hormone changes of women who do and those who don’t suffer from the illness.

What are other mental health problems occurring after childbirth?

• Baby blues: Mothers may feel like weeping, low and unsure of themselves. This occurs on the 3rd or 4th day post delivery and may last days to weeks. They occur in 50% of women who give birth. These females have no suicidal thoughts and rarely have thoughts of harming the baby.
• Puerperal psychosis: The mother may experience rapid mood swings, have strange or bizarre beliefs or hear voices from the ears. This affects 1 in every 500 women and requires medical help, probably in a hospital.

Risk factors for puerperal psychosis:

• Family history of puerperal psychosis
• Family history of bipolar illness (swings between extreme happiness and extreme sadness)
• Previous episode of puerperal psychosis or bipolar illness in the patient

Risk factors for postnatal depression:

• Having experienced several stresses in a short period of time for instance loss of a loved one, loss of a job or financial problems.
• DO find time to have fun with your partner. Try to find a baby sitter, go out together for a meal or to see friends. This however does not mean you don’t breastfeed exclusively for the first 6 months.
• Do NOT try to be “Superwoman”. Don’t over-tire yourself during pregnancy.
• Do find someone to talk to.
• Do go for ante-natal classes and possibly take your partner with you.
• Do keep in touch with your psychiatrist if you have suffered postnatal depression before.
• Do get enough nourishment – salads, fruits, milk, cereals and fruit juices.
• Do find time to have fun with your partner. Try to find a baby sitter, get out together for a meal or to see friends. This however does not mean you don’t breastfeed exclusively for the first 6 months.
• Do NOT be afraid to ask for help when you notice any danger signals – visit a psychiatrist or your nearest healthcare provider.

How can one prevent postnatal depression?

• DO keep your baby close. This is very important especially during the first few days post delivery. This helps the patient understand and manage the baby
• DO breastfeed exclusively for the first 6 months. This however does not mean you don’t breastfeed exclusively for the first 6 months.

Thoughts of suicide sometimes do occur and often have thoughts of harming the baby. When does postnatal depression set in?

Most cases start within a month of delivery but can start up to six months later.

Who is more likely to have postnatal depression?

• Having suffered depression before especially postnatal depression.
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• Do NOT be afraid to ask for help when you notice any danger signals – visit a psychiatrist or your nearest healthcare provider.
Emergency contraception is the use of a drug or device to prevent pregnancy after unprotected sexual intercourse. One method is the Levonogestrel Alone Emergency Contraceptive Pill (LNG ECPs), the 'Morning After Pill' or the E-pill or P-2 Emergency Contraceptive Pill (LNG ECPs), One method is the Levonogestrel Alone after unprotected sexual intercourse. It is safer for a woman who is regularly sexually active and needs contraception repeatedly because it disrupts the menstrual cycle. It is not 100% effective and its failure rate gets higher when used more than once in a menstrual cycle.

The two issues key to reducing this high maternal mortality is increasing contraceptive use amongst women and reduction in the incidence of unsafe abortion. The higher the use of contraceptives amongst women, the lower the fertility rate and the lower the maternal mortality. Statistics have shown that family planning and contraception could prevent upto one third of maternal deaths in Kenya. By preventing unintended pregnancies, the E-pill can help in reducing the need for abortions that result in maternal morbidity and mortality in countries where women do not have legal access to safe abortion due to restrictive laws like here in Kenya.

Dr. Rosemary Olara Chairperson - KMWA Nyanza Branch.

The Nyanza Branch has just been revived a few months ago, with the realization of the enormous amount of work that needs to be done if the region is to catch up nationally in health statistics. The disparity seen in National statistics demonstrate the seriousness of the issues at hand.

Of priority is the improvement of Maternal, Adolescent and Child health indicators towards the achievement of the MDGs, Vision 2030 and the New Constitution of Kenya 2010. This is in line with the KMWA National Strategic Plan 2010-2014.

The branch has made several appeals for support and continues to seek partners for the same through the modest operational plan that the branch is using to conduct business.

The KMWA National Secretariat and the Chairperson have been very supportive in the revival and establishment of the branch and participated in the inaugural CME in 2010.

A. Teenagers And Reproductive Health (KDHS 2008-09)

The KDHS 2008-09 showed that the proportion of teenagers who had ever had childbearing increased dramatically from 2% at age 15 to 15% at age 19. As was also observed in the 2001 KDHS, there was not much of a difference in teenage fertility between urban and rural women. The levels of teenage childbearing were highest in Nyanza (27%) and Coast (26%) provinces and lowest in Central province (10%). The low in Central province. Infant mortality is also highest in Nyanza province (99 deaths per 1,000) and lowest in Eastern province (93 deaths per 1,000). However, it is important to note the considerable declines in child mortality rates in Nyanza province over the past five years. For example, under-five mortality has declined from 206 to 149 deaths per 1,000 live births since the 2003 KDHS. There also appears to have been a dramatic drop in child mortality rates for North Eastern province, though the rates are subject to rather large confidence intervals.

Childhood mortality rates from the 2008-09 KDHS for Eastern province are comparable with those from the 2007 Multiple Indicator Cluster Survey (MICS). The under-five mortality rate based on MICS was estimated at 54 deaths per 1,000 live births, which is comparable to the rate of 52 from the 2008-09 KDHS. Similarly, the infant mortality rate of 40 deaths per 1,000 live births based on the 2007 MICS in Eastern province is almost identical to the 2008-09 KDHS estimate of 39 deaths per 1,000 live births.

A mother’s education can exert a positive influence on children’s health and survival. Under five mortality is noticebly lower for children whose mothers either completed primary school (68 deaths per 1,000 live births) or attended secondary school (59 deaths per 1,000 live births) than among those whose mothers had no education (86 deaths per 1,000 live births). However, under-five mortality is highest among children whose mothers have incomplete primary education. Similar patterns are observed for infant mortality levels. Child mortality rates generally decline as the wealth quintile increases, though the pattern is not uniform.
Champion for the improved health and dignity of society

KMWA National Secretariat- Jessica, Dr. C. Odula with KMWA Nyanza Officials During The Launching CME On 20th August 2010 Topic- Cervical Cancer

Delegates at KMWA symposium

Dr. W. Gichuru the best female medical student finalist 2010 and Dr. J. Kitulu Chairperson-KMWA

Dr. L. Loru during KMWA KOGS CME

Pictorials

Prof. R. Nduati during KMWA symposium October 16, 2010

Delegates (Eldoret associates) at KMWA symposium

Participants - at the KMWA planning meeting

Dr. K. Kinagei – H.E.R. subcommittee planning meeting

Dr. J. Wambani and Prof. M. Were

Participants - at the KMWA planning meeting

ASRM subcommittee members in Kibera during International Women’s Day

Group discussion WWC Sub-Committee planning meeting

Participants – Business Advocacy Fund Workshop

Participants at the International Women’s Day in Kibera March 08, 2011

Cocktail - after KMWA symposium
EDUTAINMENT FOR HEALTH:

By: Dr. Ann Musuva

Beth, an agricultural officer in the rural town of “Majani” who is expecting her first child attends the antenatal Clinic at the local health center where she is informed about a healthy pregnancy and receives advice on how to stay healthy during her pregnancy and to have an HIV test together with her husband. Her husband, Tom, is reluctant to accompany her to the hospital for an HIV test because he is worried that his past behavior may have put him at risk for HIV infection.

Martha, a tea picker in “Shamba la Majani” is also expecting her fifth child. She has 4 daughters and her husband Isaiah has been praying for a son, to carry on the family name. Martha has never visited the antenatal clinic because her religion does not allow her to. She develops complications in her third trimester and goes into premature labor. There is drama as neighbors deliberate on what to do to help Martha, because they know Martha and her family do not seek health care in hospitals. Her husband Isaiah is furious when he learns that the neighbors have dashed her to the local health centre… unfortunately, Martha loses the baby – the son that Isaiah has always hoped to have.

The above 2 shows are part of an Entertainment Education drama series titled “Siri”, broadcast on a national television in Kenya. The goal of this series is to improve preventative behaviors of Kenyans related to HIV & family planning and also improve service utilization on the same.

Watched regularly by hundreds of thousands of viewers, Siri is among the top rated TV programs in Kenya. Episodes are followed up with discussions on various health themes on radio call in sessions and in the communities via facilitated group discussions.

by: Dr. Wambani Sidika J

Chief Radiologist KNH.

EDUTAINMENT FOR HEALTH: MISSING THE EARLY SIGNS OF CANCER AS A CLINICIAN IS A COMMON MISTAKE

By Dr. Ann Musuva

Implementing a media message to both entertain and educate in order to increase viewers knowledge about various issues (e.g. health), create favorable attitudes, shift social norms and change event behavior. During the development of edutainment messages, one has to be careful to have a balance between entertainment and education. A focus on entertainment, may lead to the health message being lost. A focus on education on the other hand may bore the viewers, who may stop watching the series altogether.

The effects of these Edutainment interventions vary depending on whether audiences experience a one time live street theater performance, versus an ongoing long running television Edutainment drama series, like Siri. Edutainment TV drama series have proved especially effective in changing knowledge, attitudes, behavior and norms because they evoke emotions, create role models, stimulate discussions among listeners and viewers on various health issues. They show the ultimate consequences of both healthy and unhealthy behavior to large attentive audiences, and therefore usually inculcates long term changes in health behavior.

Since edutainment in health has proved a more effective way of communicating health messages than documentaries and other similar channels, it may be time for Health Edutainment to move beyond the boundaries of its mainstay messages – HIV prevention, family planning – to include other pressing health issues such as cervical and breast cancer and lifestyle diseases such as diabetes and hypertension, which are increasingly common in developing countries today.

The three most common cancers in women, cervix, breast and colon exhibit non-specific or common symptoms and quite often clinicians find themselves in traumatic positions due to delay in diagnosis or referral to specialists. Some of the non-specific symptoms could follow a drastic event like loss of a loved one or loss of a job, for example having a low mood and feeling tired with poor appetite.

The common symptoms are

- Associated pain or fullness
- A change in breast size or shape
- A lump or thickening
- A swelling or a lump in the auxiliary region
- Dimpling of the skin
- Associated pain or fullness

These symptoms should all pass as normal findings in a lactating breast and would not be clearly distinct from cancer of the breast.

Cervical cancer is the second most common cancer in women in Kenya after cancer of the cervix.

The breast is the beauty of every woman and defines her. Self breast examination has proved to be a method of breast lump detection. A well carried out examination and inspection could lead to early detection of breast cancer. However, majority of breast cancers usually occur during lactation. This is a period when the breasts are lumpy and engorged. Detection of lumps is difficult.

The common symptoms are

- A change in breast size or shape
- A change in the nipple shape
- A lump or thickening
- A swelling or a lump in the auxiliary region
- Dimpling of the skin
- Associated pain or fullness

These symptoms could all pass as normal findings in a lactating breast and would not be clearly distinct from cancer of the breast.

Breast cancer is the second most common cancer in women in Kenya after cancer of the cervix.

Cervical cancer is the commonest female cancer in Kenya. Pap smear is a common screening test for cervical cancer but early detection of changes in the cervical mucosa on histopathology depends on the skill of the pathologist.

The common presenting symptoms of cervical cancer are

- Per vaginal bleeding during or after sexual intercourse
- Offensive vaginal discharge
- Dyspareunia
- Per vaginal bleeding in between periods

These could be due to other conditions in our set up like severe pelvic inflammatory disease. A pap smear that has been report as normal in this instance will definitely delay diagnosis.

Diagnostic reports and hence delayed diagnosis.

What can we as medical doctors and possible candidates of the above three common cancers do?

- We must be involved in data collection and research.
- We must set national guidelines on screening of female cancers.
- We must be involved at national level in developing policies in cancer management.
- We should advocate for good clinical practices in female health.

ENTERTAINMENT EDUCATION (Edutainment) is the process of purposely designing and diagnostic reports and hence delayed diagnosis.

The clinician faced with the challenge of advanced technology and diagnostic imaging modalities has since relegated the simple methods of clinical history and physical examination to imaging departments and clinical pathology laboratories hence a lot of missed diagnosis.

Scanty history and clinical information definitely leads to inadequate clinical
Childhood cancers are treatable, with cure rates of over 70% in developed countries. Unfortunately, less than 20% of the world’s children have access to and can afford these curative treatment services and therefore more than 80% of these children die because they live in developing countries.

In the developed world, leukaemias are the commonest childhood cancers followed by brain tumours. Locally, the commonest cancers seen in children are Burkitt’s lymphoma, followed by nephroblastoma and Hodgkin’s lymphoma.

### Risk Factors

There are various factors associated with each type of cancer. These may include:

- Physical carcinogens: ionizing radiation (X-ray and non-ionizing radiation (electromagnetic fields, ultra violet rays)) being associated with leukaemias and skin cancers
- Biological carcinogens: infections from viruses (Epstein Barr virus-Burkitt’s lymphoma and Hodgkin’s disease; Hepatitis B liver carcinoma, and HHV8 and HIV-Kaposi’s sarcoma)
- Chemical carcinogens: tobacco; pesticides; asbestos; aflatoxin; arsenic; drugs like diethylstilbestrol, alkylating agents
- Inherited factors: predisposition to particular familial diseases and genetically determined conditions eg association of Down syndrome with leukaemia

### Principles of Management

The standard approach to treatment of pediatric cancers includes protocol-based treatment. Generally, the basis for treatment of pediatric cancers includes surgery to remove the tumour (if possible). Radiation is given to decrease tumour size and allow for surgical resection, to treat residual disease or, occasionally, to provide definitive local therapy. Chemotherapy treats both the primary tumour and presumed sites of distant micrometastatic disease, even when overt macroscopically visible metastases are not present. Hematopoietic stem cell transplant (HSCT), allogeneic or autologous, is occasionally employed as well, either at the time of initial diagnosis for diseases of especially poor prognosis or at the time of disease recurrence.

### Challenges to Management of Childhood Cancers in Developing Countries

Most patients often present with advanced disease due to lack of awareness, poverty, lack of easy accessibility to hospitals and disease due to lack of awareness, poverty, lack of early diagnosis. It is usually misdiagnosed as a yeast infection and a multitude of anti-fungal agents will have been prescribed, none of which will have been effective. It is easy to see on examination and will appear as a raised red, white or pigmented patch. A simple biopsy will confirm the diagnosis. The primary treatment is surgical excision of the tumor and resection of affected lymph nodes.

### WHAT TO LOOK OUT FOR:

1. A lump or ulcer on the vulva
2. Itching
3. Bleeding
4. Pain when passing urine
5. Pain during intercourse
KMWA's 1st Symposium: Theme: Maternal Health: Yesterday, Today, Tomorrow

By: Dr. Anne Musuva and Dr. Mukuki Ng'ang'a

Introduction:

KMWA held its first ever Scientific Symposium on 16th October, 2010. The theme of the symposium was “Maternal Health”, with four sub-themes: Maternal Health, Ethics in Research, HIV Prevention and Reproductive Health Cancers. The symposium brought together KMWA members from all parts of the country, KMWA’s trustees as well as non-KMWA members. In attendance also were representatives from our Patron’s office Hon Ida Odinga, the Head of the Division of Reproductive Health- Dr. Shrippah Kuria, the head of IPM- Dr. Zeda Rosenberg, as well as representatives from research organizations, Universities, NGOs and Civil Society Organizations.

The presenters and session moderators were all experts in their particular fields. Below are the key highlights from each of the sessions:

Maternal Health Care:

- The maternal mortality rate in Kenya is very high, yet most maternal deaths are preventable. The factors determining maternal health outcomes are diverse, cutting across social as well as infrastructural factors. Three main delays lead to maternal mortality, a delay in deciding to seek care, a delay in reaching care, and a delay in receiving care.
- In order to achieve MDG 5, we need to scale up high impact interventions, which have been proven to reduce maternal morbidity and mortality, with a focus on the pillars of safe motherhood. These interventions include meeting the family planning needs, building caregivers’ capacity to offer emergency obstetric care, focused antenatal care as well as improving post partum and neonatal care.
- Other interventions include use of the MCH handbook by mothers and caregivers, as well as exploring alternative ways of financing maternal care such as output based financing.

HIV Prevention:

The KMWA symposium on Maternal Health was highly informative and key in highlighting the steps taken towards achieving MDG 5 and what was yet to be done. With the current global refocus on maternal health, opportunities exist in achieving MDG 5.

KMWA has a key role to play in safeguarding maternal health in Kenya through:

- Advocacy for increased resources to decrease maternal morbidity and mortality especially in access to services, health education and Emergency Obstetric Care
- Mentorship- to health care providers offering maternal health
- Advocacy for sufficient safe blood supplies for mothers.
- Involvement in research and development of guidelines for the screening and management of reproductive health cancers
- Advocacy for male and community involvement in maternal health.
- Influence policy by participating in National technical working groups and development of guidelines relevant to maternal health.
- Advocate for use of the Maternal & Child Health handbook

Millennium Development Goal 5: Target 5.A. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio Target 5.B. Achieve, by 2015, universal access to reproductive health

Ethics in Research:

- Ethics in research is crucial and should ensure that the three key principles are adhered to: Respect of Persons, Beneficence and Justice.
- Community input is key prior to research design as the community can articulate their own problems best.
- In conducting maternal health research, one needs to consider hindrances facing women such as stigma, ignorance, harmful cultural practices etc.

Reproductive Health Cancers:

- Cancer of the breast is the second cause of cancer mortalities among women in Kenya.
- Mammography is important in screening for cancer of the breast, though image quality and radiation dose is not well controlled and diagnostic reference levels are often above the recommended levels.
- Cervical cancer is the commonest cancer among women in Africa and an AIDS defining illness.
- A study carried out in Tigoni, Kenya revealed that cervical cancer was significantly higher among HIV+ women at 25.5%, vs the general population at 8.6%
- There is a need to mainstream screening and treatment of HIV+ women for cervical neoplasia in comprehensive care programs

KMWA’s role:

By Dr. Wanjiku Gichuru

Five and a half years is a relatively long time to spend in University; babies are born and start kindergarten in that time, other people finish their degrees and PhDs while one is still just another undergraduate. It is therefore understandable that when graduation day finally comes around, medical graduates throw the biggest parties to usher in a new phase of their life.

On October 24th, 2005, I stepped into Chiromo campus to register for my medical degree course. I felt ready for the infamous difficult course, little did I know that nothing could prepare me for the endless hours of dissection, numerous CATs and dozens of assignments that marked my first year of med school. It proved a herculean task to work out a balance between studies and recreation and the friends I often saw during my two-year hiatus after high school gradually faded into the background as more and more time was spent in the library. Despite the bleak situation, that was the year I met the four friends who would nurture me, support me and ultimately inspire me all through medical school. We were from different schools and different backgrounds but the pressure of medical school and our determination to weather it strengthened our friendship, like the proverbial weak carbon, it turned into a diamond.

Medics often say, better even then odd; referring to the years we spend at the University. As I had more time on my hands in my second year, I had a moment to step back and analyze my decision to study medicine. The grueling first year was over but was I ready to commit myself to four more similar years and a busy lifetime of being a doctor? It did not help matters that I shared a room with a BA (Bachelor of Arts) student who had a lighter schedule in a week than I did in a day. One notices the many activities and parties a medic never has time to attend. But as the year rolled by, I remembered what made me choose medicine in the first place. I have a curious mind and despite the many not-so-positive adjectives often used to describe our noble profession, one can never say it is boring. Every patient is unique, even the same disease in different patients is not the same. There is always more, a new study being done, a new disease process finally understood or an old physiological function explained. The books, as big and as heavy as they were, fascinated me. In the clinical years, the many books were replaced with many patients and even more books and the doctor within the student emerged and a new passion came to life.

I find that the beauty of medicine lies in the fact that it is both an art and a science; the art of healing the patient and the science of curing the ailment. Balancing care with compassion is not easy, especially when as a student you are faced with patients to clerk, blood to draw, textbooks to read and the never ending lectures to attend. But we made it, all 260 of us who graduated. This is a special group of people who could have joined any lucrative career and succeeded but instead they chose to be of service to humanity. This is why I firmly believe being a doctor is not a career; it’s a destiny to fulfill.

I am proud to be living my destiny.
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Kenya Medical Women's Association Scientific Symposium

Theme: CHILD AND ADOLESCENT HEALTH

Saturday: October 15th 2011

Venue: To be confirmed

Deadlines: Abstract submission 9th September 2011 at 1700hours

Call for abstracts categories: Oral, Poster and Video presentation

All abstracts must be submitted in soft copy via e-mail info@kmwa.or.ke OR kenamewa@gmail.com