National Chairperson’s remarks

KMWA is 30! This is no mean achievement and it is with immense gratitude that we celebrate this milestone. From humble beginnings, KMWA grew in size and stature and currently commands a 400 strong membership. KMWA has a countrywide presence and a list of formidable partnerships.

We cherish our partnership with International Partnership for Microbicides (IPM) focusing on HIV prevention strategies and advocacy for microbicides. These include members’ attending International Conferences on Microbicides, CME’s and scientific symposia to gain more knowledge and disseminate the information.

KMWA’s partnership with Daktari Total Health Solutions (DHS) presents an IT solution to digitalise offices improving information and communication and enabling provision of better care for their clients while doctors become better managers of their enterprises.

Another landmark achievement that has made us proud is the endorsement of PUREIT a water purifier by Unilever which we believe will impact on the achievement of reduction of water borne diseases and the MDG 4 and 5 on Maternal and child health.

KMWA’s strong network at the Kenya Health Federation helps us play a crucial role in contributing towards the development Agenda in Kenya especially in Health Systems strengthening, the Health bill among others.

KMWA in partnership with KEPSA participates in the Kenya Youth Empowerment Project (KYEP) where in cycle 1, 2 and 4 interns in various fields are engaged at the KMWA programmes and later absorbed into other organisations.

KMWA has also partnered with Philips (Fabric of Africa Campaign in Kenya and Philips Cairo to Cape Town Road Show) to implement programmes that are in line with its core mission.

KMWA has also made significant contributions to the national government by creating a health manual for parliamentarians which was launched last year. Currently, we are in the process of developing a policy brief for parliamentarians on the Equal Opportunities Bill.

We are proud to host the Near East and Africa Secretariat of the Medical Women International Association (MWIA) following the 29th MWIA congress, 2013 Seoul Korea. This we hope shall go a long way in recognising and growing KMWA’s role regionally and internationally.

Although KMWA has changed and developed significantly over the past 30 years, some things remain exactly the same: Our desire to “Champion for Improved Health and Dignity of Society”.

As we take stock of our 30 years of being, indeed we thank all KMWA sub-committees who have worked tirelessly to see to the success of the celebration activities. Special mention to the Health Education and Research Committee, Finance & Administration Committee, Medical camps committee, Family Fun Day committee and all other Committees. To our partners we appreciate the generous support in all activities and we look forward to continued partnerships and pursuing improvement in KMWA through tapping into available funding opportunities and growing our membership.

We are truly thankful to God for preserving KMWA.

Long Live KMWA!!!

Dr. Praxy Okutoyi
National Chairperson

Editorial Team

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Dr. Praxy and Dr. Bonass during the Ecobank cancer caravan.
The secretariat congratulates all KMWA Council members led by the Chairperson, the trustees, members and above all, women and girls who have continued to develop this country, continent and the world with remarkable tireless commitment. Indeed the good results being observed in many sectors are because you are caring, loving, sweet, beautiful, God fearing and blessed.

This year, the International Women’s Day was marked on March 8 as has been done annually for more than a decade now. This day is recognised by the United Nations through dedication of various relevant themes to benefit the plight of women. The focus of the celebrations range from general celebration of respect, appreciation and love towards women to a celebration for women’s economic, political, and social achievements. In some regions, the human rights theme as designated by the United Nations runs strong, and political and social awareness of the struggles of women worldwide are brought out and examined in a hopeful manner. Most people celebrate it by wearing purple ribbons.

This year KMWA has had a full calendar with CMEs on HIV, Skin Care, Research, ICT amongst others. The climax being the build up to the 30th anniversary celebrations through the multiple activities conducted to commemorate the same. These are medical camps in Kisumu, Machakos counties, charity visits to children’s homes, talk to girls’ schools, Cancer Caravan in conjunction with Ecobank, Family Fun Day, Golf Tournament and finally the Symposium and Gala Dinner.

All information and activities can now be obtained from our revamped website www.kmwa.or.ke and interactions can be channeled through our email, Facebook and twitter accounts.

Through your overwhelming support we managed to publish a newsletter last August with the theme ‘Focus on MDGs’ and this one has the special befitting theme of celebrating women and children.

It is my hope that as Kenya establishes its devolved government, the plight of women and girls will be highlighted in all sectors for us to progress as expected. The areas of focus include ending violence against women and girls, affording equal opportunities for them and investing even more in them. Indeed the theme for this year is ‘A promise is a promise’ and we need to keep all the previous promises during celebration.

We are grateful to all our partners and members who have helped us achieve what we didn’t in 2013 and in the 30 years of our existence. Now that KMWA has grown even stronger, we hope to achieve even more in the years ahead.

Happy 30th Anniversary to all KMWA members !!!

Dr. Rosemary Obaya Okeyo
Frm CEO

It is with great joy that I write on behalf of the KMWA Trustees on this momentous occasion of KMWA celebrating 30 years of existence. It is no mean feat.

So what is the role of a trustee, one may ask. One of our key responsibilities is to ensure the successful future of KMWA. The main object of the Trust is to hold and invest property (movable and immovable) on behalf of the Association and its members. It is expected that the trustees would set aside personal feelings and goals and instead do what is in the best interest of the trust beneficiaries. For the legal minded this is called the ‘fiduciary duty’. Trustees are recruited for their demonstrated commitment to the values and mission of the organisation. Those of integrity and high-standing in the community are likely to be helpful in establishing the credibility of the organisation for fundraising and public relations purposes. In all this the trustees work very closely with the Chair and Council of KMWA, and I must report that we have had excellent relations with the current and previous KMWA councils. KMWA has nine trustees from diverse backgrounds which make for a rich mix of professions. Here, I would like to pause and fondly remember one of our dedicated late trustees, Mrs. Abigail Kidero, who passed on several years ago.

As I peer into my crystal ball, what do I want to see for KMWA in the future? A strong organisation at the forefront of championing the health and rights of women, children and men. We would like to see more KMWA members, and especially the younger generation, spearheading this noble goal. I am proud of what we have achieved in recent years and confident in our vision for the future.

Happy celebrations…

Dr. Jessie Githanga
Chair, Board of Trustees
The KMWA Chair 2008 - 2012

My two terms as chair of KMWA definitely go down as one of the most exciting and challenging periods in my life. As KMWA we had an intense period of introspection as we put our house in order.

Governance issues were top of the agenda as we set up an active Council, Board of Trustees and appointed a Patron. Launching and starting to implement our strategic plan 2010-2014 then directed KMWA’s energies into our key areas of operation and directing some of our subsequent partnerships. As an institution, streamlining of the Secretariat was done and activating of our branches so that North Rift, Nyanza, and Machakos branches became active again participating in medical camps, C.M.E’s and so on.

Continuous Medical Education (C.M.E) forums also became an exciting place to be for us to continue being active in our medical training camps, C.M.E’s and so on. Forums became active again participating in medical camps, C.M.E’s and so on.

Our partnerships grew locally with like-minded organisations as an example in partnership with Business Advocacy Fund, (B.A.F) we were able to work with other female B.M.Os to produce a document on Discrimination of Women in the work place.

Internationally, we partnered with International Partnership for Microbicides (I.P.M) enabling us to share information on Microbicides widely in the country and also played a key role in resumption of the KMWA Annual Symposium and the KMWA Bi-annual Newsletter.

We were also able to link up with our sister Medical Women’s Associations in the Africa and Near East Regional Congress of MWIA Newsletter.

KMWA’s participation in the National Health Agenda was apparent in our sitting on the National Economic and Social Council, our participation in the Consortium for the Constitution and the Health Sector finally producing a Health Budget Toolkit, Policy Brief and Constitution and Health Guide and in our continuous participation in the Kenya Health Federation.

My special thanks go to my predecessor Dr. Jeska Wambani for giving me this grand opportunity to lead KMWA.

Dr. Praxy Okutuyi who is moving KMWA to greater heights, both Councils in my terms, the KMWA Trustees and the whole KMWA fraternity for their support.

Dr. Jacqueline Kitulu
Chair 2008 – 2012

As we mark 30 years, KMWA should strive to be a policy development organ in health. Initiate an institute that focuses in the crafting of policies that focuses on maternal, child and adolescent health. Through this, doctors’ contribution would be core in enriching policies that will make the health system efficient.

With the promulgation of the Constitution 2010, KMWA should be engaged in the devolution of the health services through facilitating the restructuring and setting of standards. Through this, KMWA would be promoting our vision by providing excellent leadership in all matters of health.

Lastly, I urge all the members to be pro-active and be sensitive on health issues. Members should be involved in health Research in their respective medical disciplines to develop policy supporting data. Think of the vulnerable – the woman – who makes approximately 53% of the Kenyan population. Her gift is beyond procreating. She is the first physician. Keep her healthy.

Dr. Wambani Sidika Jeska
MBChB, MMed (rad) Pead (rad) Chief Medical Specialist, Pediatric Radiologist.
Kenyatta National Hospital, Nairobi, Kenya.

The KMWA Chair 2005-2008

I thank God for creating me as a woman, furnishing my knowledge, endowing me with skills, nourishing my heart, and giving me this grand opportunity to participate in the ministry of healing the sick and nurturing a healthy people.

I am currently the Chief Medical Specialist (Radiology) at the National Apex institution, the Kenyatta National Hospital and consulting Pediatric Radiologist at the only children’s hospital in East and Central Africa, the Gertrude’s Garden Children Hospital. I am involved in Radiation Dosimetry Research (Radiological Protection of Patients and Medical Exposure Control) and Honorary Lecturer in Radiation Medicine at the University of Nairobi and Kenya Medical Training College.

Being a girl child, girl student, a female in a male dominated profession and a mother makes me significantly unique. We well understand issues that the males, females and children grapple with, and remain committed to resolving them.

Being a member of Kenya Medical Women Association (KMWA) gives me great joy. As a group of medical professionals from different disciplines, we complement each other and have continuously upheld the mission of the organisation by championing improved health and dignity of the vulnerable persons in our society.

My participation in KMWA is as follows:-

1. Created awareness and embarked on recruiting member to execute KMWA’s mandate.
2. Created committees and developed a stable financial strategy for the association. For instance, we have leased out the KMWA Secretariat in Nairobi West to Gertrude’s Garden Children’s Hospital in order to get funds to run some of our activities.
3. Developed a strategic plan draft which was passed on to the next chair for refining and implementation.

As a past KMWA official, chairperson and now a trustee, I see our distinctive position as an association to completely revolutionise the health care system in our country having in mind that women form the majority of those that require quality and timely services.

As we mark 30 years, KMWA should strive to be a policy development organ in health. Initiate an institute that focuses in the crafting of policies that focuses on maternal, child and adolescent health. Through this, doctors’ contribution would be core in enriching policies that will make the health system efficient.

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Dr. Wambani Sidika Jeska
MBChB, MMed (rad) Pead (rad) Chief Medical Specialist, Pediatric Radiologist.
Kenyatta National Hospital, Nairobi, Kenya.

I wish to dedicate the two awards I received in this period OWTP Woman of the year 2010 awarded by The Organisation of Women in International Trade and The African Most Astounding Female Professional Award 2012 awarded by The Centre for Economic Leadership and Development to KMWA.
The strategy spells out the following as key areas where action is needed to accelerate progress towards achieving MDG 4 & 5 which have been noted to be the two MDGs out of 10 that are lagging far behind and developing countries to provide funds and other support for the substantial commitment from development partners, the private sector and other neglected diseases…"

In a number of discussions in Kenya and some other African countries with respect to this Global Strategy for Women’s and Children’s Health, there seems to be a tendency for professionals to appear like there is a lack of guidance on how to go about addressing the strategy or how to monitor performance on the strategy in our countries. The main purpose of this article is to make it clear that guidance is available, particularly from the two commissions that were specifically established in the context of this global strategy! These commissions were established as the basis for supporting acceleration of actions establishing frameworks through which monitoring of progress could be carried out. The first of the two commissions to be established was the Commission for Information and Accountability (CoIA). The second one was the UN Commission on Life-Saving Commodities for Women and Children. The contents from the reports of these commissions provide guidance on what needs to be done and therefore provides a basis on how to go about monitoring progress with respect to implementation of the Global Strategy. Getting a grasp of the recommendations from these two commissions and putting them into action would greatly contribute to countries’ acceleration of progress towards achieving MDG 4 & 5. Furthermore, implementing these recommendations would establish a basis for achievements that are sustainable.

In launching the Global Strategy in 2010, the UN Secretary General, Ban Ki-Moon has a growing global impact. Let us celebrate by being part of that. Launching was accompanied by substantial commitment from development partners, the private sector and other support for the implementation of the strategy. The strategy specifically addresses the need to accelerate progress towards achieving MDG 4 & 5 which have been noted to be the two MDGs out of 10 that are lagging far behind the others.

In launching the Global Strategy in 2010, the UN Secretary General stated, "Each year, millions of women and children die from preventable causes. These are not mere statistics. They are people with names and faces. Their suffering is unacceptable in the 21st century. We must, therefore, do more for the newborn who succumbs to infection for want of a simple injection, and for the young boy who will never reach his full potential because of malnutrition. We must do more for the teenage girl facing an unwanted pregnancy; and for the married woman who has found she is infected with the HIV; and for the mother who faces complications in childbirth…Together we must make a decisive move, now, to improve the health of women and children around the world. We know what works. We have achieved excellent progress in a short time in some countries. The answers lie in building our collective resolve to ensure universal access to essential health services and proven, life-saving interventions as we work to strengthen health systems. These range from family planning and making childbirth safe, to increasing access to vaccines and treatment for HIV and AIDS, malaria, tuberculosis, pneumonia and other neglected diseases…”

The strategy spells out the following as key areas where action is urgently required to enhance financing, strengthen policy and improve service delivery:

- Support for country-led health plans, supported by increased, predictable and sustainable investment.
- Integrated delivery of health services and life-saving interventions – so women and their children can access prevention, treatment and care when and where they need it.
- Stronger health systems, with sufficient skilled health workers at their core.
- Innovative approaches to financing, product development and the efficient delivery of health services.
- Improved monitoring and evaluation to ensure the accountability of all actors for results.

In a number of discussions in Kenya and some other African countries with respect to this Global Strategy for Women’s and Children’s Health, there seems to be a tendency for professionals to appear like there is a lack of guidance on how to go about addressing the strategy or how to monitor performance on the strategy in our countries. The main purpose of this article is to make it clear that guidance is available, particularly from the two commissions that were specifically established in the context of this global strategy! These commissions were established as the basis for supporting acceleration of actions establishing frameworks through which monitoring of progress could be carried out. The first of the two commissions to be established was the Commission for Information and Accountability (CoIA). The second one was the UN Commission on Life-Saving Commodities for Women and Children. The contents from the reports of these commissions provide guidance on what needs to be done and therefore provides a basis on how to go about monitoring progress with respect to implementation of the Global Strategy. Getting a grasp of the recommendations from these two commissions and putting them into action would greatly contribute to countries’ acceleration of progress towards achieving MDG 4 & 5. Furthermore, implementing these recommendations would establish a basis for achievements that are sustainable.

The Commissioners in the Commission for Information and Accountability (CoIA) produced their report in May, 2011 which is summarised in 10 recommendations.

The 10 Recommendations from the Commission for Information and Accountability

The reports states, “The 10 recommendations focus on ambitious, but practical actions that can be taken by all countries and all partners. Wherever possible, the recommendations build on and strengthen existing mechanisms…”

Better information for better results

1. Vital events: By 2015, all countries have taken significant steps to establish a global system for registration of births, deaths and causes of death, and have well-functioning health information systems that combine data from facilities, administrative sources and surveys.

2. Health indicators: By 2012, the same 11 indicators on reproductive, maternal and child health, disaggregated for gender and other equity considerations, are being used for the purpose of monitoring progress towards the goals of the Global Strategy.

3. Innovation: By 2015, all countries have integrated the use of Information and Communication Technologies in their national health information systems and health infrastructure.
Improved tracking of resources for women’s and children’s health

4. Resource tracking: By 2015, all 74 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: (i) total health expenditure by financing source, per capita; and (ii) total reproductive, maternal, newborn and child health expenditure by financing source, per capita;

5. Country compacts: By 2012, in order to facilitate resource tracking, “compacts” between country governments and all major development partners are in place that require reporting, based on a format to be agreed in each country, on externally funded expenditures and predictable commitments;

6. Reaching women and children: By 2015, all governments have the capacity to regularly review health spending (including spending on reproductive, maternal, newborn and child health) and to relate spending to commitments, human rights, gender and other equity goals and results.

Better oversight of results and resources: nationally and globally

7. National oversight: By 2012, all countries have established national accountability mechanisms that are transparent, that are inclusive of all stakeholders, and that recommend remedial action, as required.

8. Transparency: By 2013, all stakeholders are publicly sharing information on commitments, resources provided and results achieved annually, at both national and international levels.

9. Reporting aid for women’s and children’s health: By 2012, development partners request the OECD-DAC to agree on how to improve the Creditor Reporting System so that it can capture, in a timely manner, all reproductive, maternal, newborn and child health spending by development partners. In the interim, development partners and the OECD implement a simple method for reporting such expenditure.

10. Global oversight: Starting in 2012 and ending in 2015, an independent “Expert Review Group” is reporting regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission’s recommendations.

The Independent Expert Review Group was established during 2011 by the Director General consisting of seven experts globally selected whose tasks include pursuing matters of accountability in the implementation of the Global Strategy with particular reference to recommendation 1 to 9 and to the TOR that guides their work.

The 10 Recommendations from UN Commission on Life-Saving Commodities for Women and Children.

Improved markets for life-saving commodities

1. Shaping global markets: By 2013, effective global mechanisms such as pooled procurement and aggregated demand are in place to increase the availability of quality, life-saving commodities at an optimal price and volume.

2. Shaping local delivery markets: By 2014, local health providers and private sector actors in all EWEC countries are incentivised to increase production, distribution and appropriate promotion of the 13 commodities.

3. Innovative financing: By the end of 2013, innovative, results-based financing is in place to rapidly increase access to the 13 commodities by those most in need and foster innovations.

4. Quality strengthening: By 2015, at least three manufacturers per commodity are manufacturing and marketing quality-certified and affordable products.

5. Regulatory efficiency: By 2015, all EWEC countries have standardised and streamlined their registration requirements and assessment processes for the 13 life-saving commodities with support from stringent regulatory authorities, the World Health Organization and regional collaboration.

Improved national delivery of life-saving commodities

6. Supply and awareness: By 2015, all EWEC countries have improved the supply of Life-saving commodities and build on information and communication technology (ICT) best practices for making these improvements.

7. Demand and utilisation: By 2014, all EWEC countries in conjunction with the private sector and civil society have developed plans to implement at scale appropriate interventions to increase demand for and utilisation of health services and products, particularly among under-served populations.

8. Reaching women and children By 2014, all EWEC countries are addressing financial barriers to ensure the poorest members of society have access to the life-saving commodities.

9. Performance and accountability: By end 2013, all EWEC countries have proven mechanisms such as checklists in place to ensure that healthcare providers are knowledgeable about the latest national guidelines.

Improved integration of private sector and consumer needs

10. Product innovation: By 2014, research and development for improved life-saving commodities has been prioritised, funded and commenced.
Table: Snapshot per commodity of barriers, recommendations and impact.

The table provides estimates of how many lives could be saved if common barriers were overcome and equitable access achieved for 13 life-saving commodities. The Commission’s recommendations are in section V.

<table>
<thead>
<tr>
<th>Commodity by life stage</th>
<th>Examples of key barriers</th>
<th>Recommendations</th>
<th>Potential 5-year impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MATERNAL HEALTH COMMODITIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Oxytocin - post-partum haemorrhage (PPH)</td>
<td>Often poor quality</td>
<td>1, 4, 5</td>
<td>15,000 maternal lives saved</td>
</tr>
<tr>
<td>2. Misoprostol - post-partum haemorrhage</td>
<td>Not included in national essential medicine lists</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3. Magnesium sulfate - eclampsia and severe pre-eclampsia</td>
<td>Lack of demand by health workers</td>
<td>1, 9, 10</td>
<td>55,000 maternal lives saved</td>
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<tr>
<td><strong>NEWBORN HEALTH COMMODITIES</strong></td>
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<td></td>
<td></td>
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<tr>
<td>4. Injectable antibiotics - newborn sepsis</td>
<td>Poor compliance by health workers (PPH)</td>
<td>1, 9, 10</td>
<td>1.22 million neonatal lives saved</td>
</tr>
<tr>
<td>5. Antenatal corticosteroids (ANCs) - preterm respiratory distress syndrome</td>
<td>Low awareness of product and impact</td>
<td>9</td>
<td>460,000 neonatal lives saved</td>
</tr>
<tr>
<td>6. Chlorhexidine - newborn cord care</td>
<td>Limited awareness and demand</td>
<td>2, 5</td>
<td>422,000 neonatal lives saved</td>
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<tr>
<td>7. Resuscitation devices - newborn asphyxia</td>
<td>Requires trained health workers</td>
<td>1, 9, 10</td>
<td>336,000 neonatal lives saved</td>
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<tr>
<td><strong>CHILD HEALTH COMMODITIES</strong></td>
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<tr>
<td>8. Amoxicillin - pneumonia</td>
<td>Limited availability of child-friendly product</td>
<td>2, 7, 9, 10</td>
<td>1.56 million lives saved</td>
</tr>
<tr>
<td>9. Oral rehydration salts (ORS) - diarrhea</td>
<td>Poor understanding of products by mothers / caregivers</td>
<td>2, 5, 7, 9, 10</td>
<td>1.89 million lives saved</td>
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<tr>
<td>10. Zinc – diarrhoea</td>
<td></td>
<td></td>
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<tr>
<td><strong>REPRODUCTIVE HEALTH COMMODITIES</strong></td>
<td></td>
<td></td>
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<tr>
<td>11. Female condoms</td>
<td>Low awareness among women and health workers</td>
<td>1, 7</td>
<td>Almost 230,000 maternal deaths averted</td>
</tr>
<tr>
<td>12. Contraceptive implants - family planning / contraception</td>
<td>High cost</td>
<td>1, 7</td>
<td></td>
</tr>
<tr>
<td>13. Emergency contraception - family planning / contraception</td>
<td>Low awareness among women</td>
<td>2, 7</td>
<td></td>
</tr>
</tbody>
</table>

DISCLAIMER: the numbers presented here are draft estimates meant to give a general overview of the barriers certain commodities face and the potential impact if these barriers were surmounted. These draft estimates are based on a systematic analysis approach explained in the Annex.

The independent Expert Review Group (iERG) that monitors accountability with respect to the performances related to the recommendation of the Commission for Information and Accountability (CoIA) has also been asked to also monitor accountability with respect to the UN Commission on Life-Saving Commodities for Women and Children. Each year, this independent Expert Review Group produces a report for the UN Secretary General. So far they have presented reports for 2012 and 2013. Both reports can be obtained through a Google search. Therefore as adventurous 30-year-olds, let us move with the world in pushing for achievement of MDG 4 ands 5 with the help of the recommendation from the two commissions and the reports of the iERG.

I acknowledge with thanks the reports of the Commission for Information and Accountability (CoIA) and the UN Commission on Life-Saving commodities for Women’s and Children’s health.

Laureate, Hideyo Noguchi Africa Prize;  
Goodwill Ambassador, Community Health Strategy, Kenya;  
Chancellor, Moi University;  
Member, Independent Expert Review Group on the Global Strategy for women’s & Children’s Health
New Frontiers in HIV Prevention Technologies

S. Njuguna, S. Gitome, E. Ombati, B. Njoroge, E. Bukusi
(Kenya Medical Research Institute)

Worldwide, approximately 40% (80 million) of all pregnancies are unintended, with one-half of these pregnancies ending in abortion. Four out of five unintended pregnancies in the developing world occur among women who want to use contraceptives but do not have access to them. Each year there are approximately 44 million abortions, of which 38 million occur in developing countries. Many of these abortions occur under unsafe conditions, leading to tens of thousands of maternal deaths and millions of women suffering temporary or permanent disabilities each year. Furthermore, Africa accounts for more than half of all cases of maternal deaths worldwide. African women have a one in 42 lifetime risk of dying during childbirth [1].

The leading causes include: hemorrhage and hypertension which together account for more than half of the maternal deaths.

Maternal health is equally ravaged by HIV/AIDS. According to WHO, HIV is the leading cause of illness and death among all women, particularly women in their reproductive years (15–44), with 19% of all female mortality being attributable to HIV. This is a matter of grave concern. Over the years, the prevalence of HIV infection in women has increased and this trend is particularly high in sub-Saharan Africa where women account for 60% of people living with the virus [2].

Therefore, development of new HIV prevention technologies that are tailored to suit women’s reproductive health needs are critical.

This is a unique opportunity to participate in the evolution of women’s reproductive health programmes and in the development of new health technologies for women. The global health community has recognised the need for an integrated approach to women’s sexual and reproductive health (SRH) to meet women’s multiple and diverse needs. Current health programmes have embraced the integration of family planning, reproductive health, and HIV services. This is the time to embrace the development of new health technologies that could provide simultaneous protection for the multiple health risks many women face [3].

Imagine a product that could prevent pregnancy, HIV and STIs at the same time. A product that would ensure a woman’s privacy and safety, which is affordable and easily available and is designed to meet a diverse range of women’s needs and preferences. One potential strategy is the development of multi-purpose prevention technologies (MPTs). MPTs for sexual and reproductive health, also called combination or dual technologies may include vaccines, microbicides and devices like intravaginal rings or diaphragms, designed to address multiple sexual and reproductive health needs. These would include prevention of unintended pregnancies, sexually transmitted diseases including HIV [4].

MPTs promise to be among the most innovative health products under development. Furthermore, MPTs would expand the range of women’s needs and preferences. They may potentially make pregnancy, HIV and STIs at the same time. A product that would ensure a woman’s privacy and safety, which is affordable and easily available and is designed to meet a diverse range of women’s needs and preferences. One potential strategy is the development of multi-purpose prevention technologies (MPTs). MPTs for sexual and reproductive health, also called combination or dual technologies may include vaccines, microbicides and devices like intravaginal rings or diaphragms, designed to address multiple sexual and reproductive health needs. These would include prevention of unintended pregnancies, sexually transmitted diseases including HIV [4].

MPTs promise to be among the most innovative health products under development. Furthermore, MPTs would expand the range of effective prevention options for women, and allow women to take responsibility for their reproductive health. From a socio-economic perspective, because MPTs address more than one reproductive health need, it may make them potentially more cost effective compared to products intended for only one health need. These new technologies could contribute substantially to the health of women and girls around the globe.

It is clear that many women want and need technologies that prevent both pregnancy and STIs, including HIV. But finding the right delivery system is crucial. To design effective products that women can use, product developers must understand the challenges women face in accessing and using new technologies. The role that gender norms and power asymmetry play in women’s ability to access and use technologies cannot be underestimated. In addition, preferences for specific MPT product characteristics (such as formulation, duration of action, and presence and magnitude of side effects) must be taken into account early on in the product-development process [6].

For example, a long-acting product may be easier for some women to use than one that must be taken or used on a daily basis or around the time of sex.

While the existing MPTs (male and female condoms) are effective when used correctly and consistently, many women simply are not able to negotiate condom use with their partners. Furthermore, in Kenya, 44% of married/cohabiting HIV infected persons have an HIV uninfected partner. Most of these couples are young and desire to have children. Therefore, these couples will continue to expose themselves by engaging in unprotected sex and ultimately increase their risk of HIV.
infection. Once developed and approved, MPTs will be a major advance for global public health and will provide millions of women with new means to protect them.

MPTs, when available may not only have an impact on maternal health, but also child health, particularly in Sub-Saharan Africa where 98 deaths occur per 1,000 live births.

A child born in sub-Saharan Africa faces more than 16 times the risk of dying before his or her fifth birthday compared to a child born in a developed country. The leading causes of death among children under five years old are largely preventable and include under-nutrition, pneumonia, prematurity, birth asphyxia, diarrhoea and malaria [7].

Empowering women to prevent unintended pregnancies and protect themselves against HIV acquisition allows them to have families that they can afford to take care of. In resource-limited settings where women have to dig deep into their pockets to cater for their children’s basic needs including healthcare, MPTs will play a frontline role in improving maternal and child health outcomes, thus achieving the first, fourth and fifth millennium development goals.

REFERENCES
The Girl with Many Dreams

Dr. Betty Gikonyo

Dr. Betty Gikonyo is known to many as a paediatric cardiologist and Chief Executive of The Karen Hospital. However, what people do not know about her is that she is a girl of many dreams. For 10 years she jotted down the story of her life and on July 31st 2013 at a hotel in Nairobi she launched her autobiography “The Girl who Dared to Dream.” Her autobiography tells of her pilgrimage from a seven-year old with the dream of becoming a doctor to the woman who is a specialist doctor and founder of The Karen Hospital, a hospital that she and her husband Dr. Dan Gikonyo dreamed of setting up two decades ago as they were pursuing their fellowship programme in the USA.

Dr. Betty Gikonyo tells the story of a girl from humble origins and station in life and informs us that even people with humble stations have their stories to tell. Born and raised at the slopes of Mt. Kenya, Dr. Betty Gikonyo goes to a village school and through sheer tenacity and encouragement from her dotting mother she is able to attain the grades that see her admitted to the prestigious Alliance Girls High School and later on to The University of Nairobi where her dream of becoming a doctor is actualised. The rest as they say is history.

However, as you read her autobiography one gets to learn and understand that the circumstances under which you are brought up does not in any way determine who you become later on in life. Nobody is defined by their background. It is up to an individual to decide what it is that they want for themselves in life and work towards that goal. Dare to dream and when you are done dreaming wake up and work on attaining your dream.

Dr. Gikonyo’s story is laced with struggles such as watching her mother waste away and coming to terms with her departure at the tender age of 14, adversity and unce tainty in trying to discover and understand life, looking for an education, making a family and at times doing all these things concurrently. Challenges in the work place, challenges in raising children and trying in a difficult environment, to build a hospital for specialised care.

However, her story has not all been gloom. There are lots of happy moments in her life which tells us that life is a composite of the smooth and rough at the same time. Hers is a story that gives meaning to ordinary people as they go through the challenges of life. When all is said and done we are all ordinary people who have the same fears hopes and aspirations and we all have our stories to tell.

Dr. Gikonyo dispels the myth that a professional woman has to forfeit the pleasure of being a wife and mother. She tells the story of her serving as the chair of the Nairobi Health Management Board, Chair and founder of the University of Nairobi Alumni Association and member of Council of the University of Nairobi Council. She is also a co-founder of the Heart to Heart Foundation a not for profit charity organisation that helps children from needy backgrounds who have heart ailments get the much needed open heart surgeries.

An avid reader, Dr. Gikonyo quotes on one of her favourite authors Paulo Coelho in The Alchemist who urges us to awaken ourselves to the power of our minds. He argues that if we want something with all our mind the whole universe will conspire to give it to us.

When one is done reading Dr. Gikonyo’s autobiography you are convinced that you have the ability to conceive and to live your dreams because you are the only one who determines the ambition and final value of your dream.

Dr. Betty Gikonyo the girl who dared to dream and continues to dream to date.

Dr. Betty Gikonyo
I grew up in a rural area in Murang’a and went through the usual challenges of rural life. These included working in our shamba, where my parents grew coffee, as a cash crop and subsistence foods that included maize, beans, potatoes, bananas, vegetables, and fruits. I also had to help in the household chores as well as assist in drawing water and fetching firewood. Murang’a being hilly, it was always an uphill task to go up with either a load of food staffs, or a gerrican of water, or firewood.

My grandfather had embraced Christianity and education and therefore not going to school was not an option even when one was physically tired. In 1964 I was admitted to Kahuhia Girls High School after passing my primary school exam. It was when I was in high school that I realised that to achieve anything in life one needed to be committed to the author of life for guidance. I therefore committed my life to God in 1965. With time I developed a desire to help those with special needs in the society. When studying for my A-Levels at Kenya High School from 1968 I was involved in teaching Sunday School at the Jacaranda School, a school for children suffering physical challenges such as Cerebral Palsy.

After A-Levels I joined University of Nairobi to study medicine from 1970. When it came to specialisation I felt drawn to Obstetrics and Gynaecology for two reasons, the first was the joy a new baby gave to their mothers after suffering severe labour pains. The second was the amount of suffering women and girls underwent when they got unplanned pregnancies. The number of women who came for post abortion care and the tears they shed overwhelmed me. These tears were a culmination of devastating effects of rejection. What was more upsetting was the fact that those who made them pregnant went scot free. I therefore purposed to be involved in helping them by mobilising the church because it is the biggest constituency and because it is against abortion.

In 2000 while the Chairperson of Medical Fellowship, (A registered fellowship for Christian doctors and dentist), together with churches and para-church organisations we formed an organisation called Protecting Life Movement. This organisation has been educating the churches and the rest of Kenyan community on causes, complications, alternatives and prevention of abortion. It was also involved in advocating against its legalisation. Protecting Life Movement became registered as a Trust and is now involved in establishment of Rescue Kiotas, (Kiotas means a nest) in partnership with churches. The Kiotas admit girls and women in crisis pregnancy who are rejected by family, guardians and the men who impregnated them. In such a crisis the only options are either to go for an abortion or commit suicide.

At the kiota they are offered accommodation, counselling, ante-natal care and safe delivery, life skills as well as Bible teachings and prayers. The first home was opened in April 2011 and so far 43 girls from all over Kenya have been admitted. They have come from Kisumu, South Nyanza, Kisii, Mumias, Busia, Kakamega, Kitui, Kangundo, Machakos, Meru, Lamu, Muranga and DR Congo. Thirty seven have given birth and only 2 have given up their babies for adoption. Most of them have gone back to school while their parents and guardians look after the babies.

My hope and prayer is that Rescue Kiota will be established in each county by 2020. I also hope that the male community will start taking responsibility and look after their offspring as the girls go on with their education or career.

I thank God that I can contribute my knowledge and skills to alleviate the suffering of the vulnerable part of our society-women carrying crisis pregnancies. Let us remember that these pregnancies are a social problem not a medical one. I challenge KMWA to partner with us in this project.

Dr. Jean W. Kagia
Consultant Obstetrician/Gynaecologist
KMWA Trustee

A Dream and a Passion

Dr. Jean W. Kagia

Philips believes that women are the fabric of Africa, and that a healthy Africa begins with healthy women.

Championing for the Improved Health and Dignity of Society
Desire to Improve Lives
Hon. Dr. Susan Mbinya Musyoka

I was born and brought up in Matungulu District of Machakos County, the third born in a family of five siblings. My father was a pastor and became the Secretary General of the AIC church in 1962. This gave the family a short-lived opportunity to live in Nairobi before he died of a car crash in 1965. We travelled back to the village and lived under the care of our mother who was a primary school teacher. It was not easy for her. I saw her struggling to raise four girls and one boy singlehandedly and I thank God that with her inspiration, guidance and strict discipline, we managed to attain high levels of education.

I joined the medical school in Nairobi in 1975, and qualified in 1980. I then went to work in Machakos and got married to a businessman - Tito Musyoka. We were blessed with three lovely girls who are all now grown, (Liz Beth Wayua, Tamika Mwongeli and Nakita Ndunge). As a young doctor it was quite a challenge managing seriously ill patients and trying to raise a family at the same time.

I worked with the government for six years then started my own private practice and later went to UK for my MPH (Leeds University 1990). As soon as I came back from UK I continued with my practice as well as embarking on church based healthcare programs. I initiated Community Based Healthcare (CBHC) projects with the Africa Brotherhood Church where we trained Community Health Workers (CHW’S) and helped establish some dispensaries.

I joined KMWA as a founder member and became the Eastern region representative until I got more involved in other activities which demanded a greater deal of my time. I have been a member of Rotary international, Machakos club, a member in several institutional boards, some as chairperson and also involved in church leadership.

As soon as I joined KMWA in 1983 I immediately started a “mothers fight against hunger” project. The women in my ward who had malnourished children made baskets (kiondo) which my friend Trizar and I sold in Israel. Unfortunately, the vicious cycle of poverty did not allow this project to go far. The baskets they made were far below acceptable standards for sale abroad. We therefore ended up just giving them food while we treated their malnourished children. I felt I had not done enough and the desire to impact people’s lives remained persistent and stronger.

I had to deal with people from very poor backgrounds. I was moved to see children dying of malnutrition right from the beginning of my career. To me, it was very disturbing to imagine that the little amount of food required to feed each of these children to grow as healthy babies was not available. On many occasions, I helplessly watched people suffer from all kinds of afflictions and gradually, I developed the desire to advocate for improved healthcare. I believed that if I was in a decision-making position, I could make a significant difference in empowering our women and children by improving the health of the community.

I have been involved in politics since the 1990’s and vied twice without success for the Machakos constituency seat due to the insurmountable challenges faced by women in politics. However, with the new constitution, I saw an opportunity and successfully vied for the affirmative action seat on a platform of women empowerment and healthcare improvement.

I now know that as a leader in Machakos County, I have a very heavy task. Aside from my parliamentary duties, I am involved in advocacy activities within the county. I am also working with the county government of Machakos to embark on various activities such as water provision, improved agriculture and marketing of farm produce and of course ensuring improvement in healthcare delivery.

I am in the health committee in parliament and I hope through my contribution, no matter how small, will help shape the health of our people. I hold medical camps in various parts of the County of Machakos. During which I interact directly with the people and encourage healthy living. One of the most successful medical camps was done in Matuu town in August 2013 in collaboration with KMWA.

In closing, I want to appreciate the work done by KMWA in advocacy of healthcare particularly for the marginalised people in society who include women and children. My desire is to work closely with KMWA and other agencies especially the Machakos County Government to improve lives.

HAPPY 30TH ANNIVERSARY AND LONG LIVE KMWA!
A Transformational Leader and a Mentor

Prof. Olive Mugenda

Competing with male counterparts in higher education especially in positions of leadership can be very daunting and challenging.

But for Prof Olive Mugenda, who was appointed Kenyatta University Vice-Chancellor seven years ago, the experience is normal and worth being pursued by women.

Before becoming Vice-Chancellor, Prof Mugenda had had a long and eventful career in education. The journey began in 1979, when she graduated with a first class honours degree in education from the University of Nairobi. She later did a Master of Science in Family and Consumer Sciences and a PhD at Iowa State University (USA). She is also a holder of an Executive Master of Business Administration from the Eastern and Southern Africa Management Institute. She has taught at Kenyatta University for many years, rising to various leadership positions including Deputy Vice-Chancellor (Finance, Planning & Development). She entered the history books as not only the first woman Vice-Chancellor of a public university in Kenya but also in the East African region.

Since taking over the mantle in 2006, Prof Mugenda has transformed Kenyatta University by consistently aligning most activities to its vision: To be a dynamic, an inclusive and a competitive centre of excellence in teaching, learning, research and service to humanity. She calls this ‘transformative leadership’, which is aimed at making KU a globally competitive university and a centre of academic excellence. “This was a dream I set forth from the onset and put in place measures to actualise it,” she says. “We identified new visions, new strategies and new structures.” Prof Mugenda then identified a team of champions, including management and board of directors, and got them to embrace the university’s new strategic and vision plan. The plan, the first ever for the University, outlined priority areas and flagship projects. Among the projects is the university’s hospital which will be the first referral hospital in East and Central Africa to be owned by a university. The hospital is already under construction and will have a bed capacity of 600.

Apart from being an inspiring role model for most women, Prof. Mugenda is a great mentor. She pioneered the establishment of the Kenyatta University Mentorship Programme, which has been very instrumental in supporting many students and even young members of staff to develop their careers as well as nurture personal growth and leadership. Prof. Mugenda is never short of ideas to mentor women to venture into science and technology programmes. In collaboration with the Ford Foundation and Rockefeller, Prof. Mugenda initiated two major projects to enhance female participation and performance in mathematics, sciences and information technology in schools in Kenya. The projects’ intervention strategies have resulted to greater women participation in these hitherto male dominated disciplines.

In addition to publishing several award-winning scholarly papers and books, Prof Mugenda also sits on the board of regional and global bodies. Notable among them is the International Association of Universities and Association of African Universities. She is also a board member of Nation Media Group.

To her, these extra responsibilities give her a chance to make a difference in those organisations by contributing her leadership and management skills. Professor is able to balance the roles through prudent time management.

Professor Mugenda is a strong champion of Equity as demonstrated through her innovative projects which have been instrumental in enhancing access and equity for marginalised populations and groups. In 2009 for instance, she established an Orphans and Vulnerable Students Fund which has gone to support many young and vulnerable people to join the University.

In 2008, Professor Mugenda also pioneered the establishment of the Marsabit Open Distance and e-Learning Centre for Women. The project aims to increase the number of female teachers in secondary schools in marginal areas in the country. In 2013, in an effort to promote talent among young Kenyans, she established scholarships for students who have excelled in sports or performing arts to join the University and sharpen their talents. The initiative supports students who have attained a C+ in KCSE but have failed to join the University through the Joint Admissions Board.

The don says universities are realigning themselves to the new Constitution and Kenya Vision 2030. KU, for instance, revised its strategic and vision plan in 2010 in line with the new dispensation. Her target is to build KU into a globally competitive university. Given the chance to revamp the education sector, Prof Mugenda says she would focus on three things. First, she would introduce a course on diversity and good citizenship at all levels, from primary to university. “This will change the mindset of our children and slowly unify them and eventually eliminate tribalism,” she notes. Secondly, she would introduce a scholarship and bank loan programme at university level to ensure no student who qualifies to join university is left out.

Third, she would compel universities to focus more on research and innovation. These would transform the nation’s economy by translating research results into the production of goods and services and innovation.

The record setting mentor has a word of advice to Kenyans: “As a country we must inculcate the culture of diversity among the youth to eliminate tribalism through the educational system. We need to develop a culture of working hard and patriotism among the youth and develop a spirit of wanting to make a difference.”
Drs. Kachumbo and Praxy distributing sanitary towels at KMWA Medical Camp in Machakos.

Dr. Praxy and Hon. Susan Musyoka- Women’s Representative Machakos County.

Ecobank cancer caravan held on 4th and 5th October 2013.

Hon. Susan Musyoka and Dr. Odula in Maituu, Machakos.

KMWA visit to Noon-Kopor Girls High School.

Dr. Praxy and Dr. Bonass at Ecobank/ KMWA cancer caravan.

Dr. Lore presenting a gift from KMWA to the Principle of Noon-Kopor Girls High School.
A Voice in the Wilderness
Asunta Wagura

I have always termed myself as a voice in the wilderness helping women living with HIV become drivers of their lives, take charge of their destiny and that of their children. I adopted this approach not because of my professionalism but because in 1988 I tested HIV positive. I was young and beautiful and my family and the society was quick to judge my morals. Before long, I was an outcast in the society I had been brought up.

I thought I needed to tell the world through whatever platform that I didn’t choose to be infected. It was unfortunate that things turned out this way for me. I however need to emphasise that despite my being HIV infected, this didn’t affect my humanity. I was still a human being of worth. I was still a sister, an aunt, a cousin a daughter and today I am proud to say I am a mother. May be the greatest and sweetest title to my name is that of ‘mom’ which my five handsome boys call me every day. I refused to give up when it was the obvious next step in order to maintain my sanity.

Without false modesty, I feel that other sojourners in the Kenya Network of Women with AIDS-KENWA are also worth celebrating. I celebrate my motherhood also on behalf of women who live in the slums of Korogocho who never tire of showing care and love to their loved ones when it would be easier to give up on them. They have taught me never to give up. I celebrate my community health workers who have ensured that hundreds received treatment in time even if it meant carrying them on their backs. I accept this honour on behalf of community volunteers who refused to give up when donors said the priorities have changed. I accept on behalf of those that stood with their sick until they breathed their last and ensured they died in dignity.

So on their behalf again I want to express my gratitude to you. I am very pleased to receive this nomination. I am very pleased also because it would have been incomprehensible to me 26 years back when I tested HIV positive. I remember at that point, my plans and hopes were all crashed by one statement: "Asunta I am sorry you have AIDS." When the principal realised her statement had wrecked me she offered as an afterthought. “I don’t mean you will die immediately you can live for up to six months from now”. That was the last time I saw the inside of my medical school and I was sent home to wait for my six months to die. How I wish this Principal were here today to witness that it was not all over for me. Rather, the HIV positive serostatus was the magic key to a door. A door of hope to tens of thousands that I have reached with the message that all is not over, that they too can pull out from hopelessness, mend their broken lives and dreams and move on. They can take it one day at a time and it doesn’t matter for how long, lead quality, positive constructive lives and offer hope to others in similar situations. This is the backbone of KENWA.

Asunta Wagura
Executive Director KENWA

The Nairobi West Comprehensive Reproductive Health Centre

Worldwide, socio-cultural and medical research studies have demonstrated that the performance of any society, in terms of education, industry, economic achievements, sports and even recreation, are all influenced by the overall health status of the members of that society, particularly so, the working and or parenting age group and the youth.

Health is therefore central and crucial to the success of all societies which comprise the world’s people. What is health? Medically, health is the complete wellness of an individual’s physical, psychological, physiological, emotional and possibly economic state. In this regard therefore, for an individual to be healthy, they must have access to quality health care, amongst other requirements for complete wellness.

The Nairobi West Comprehensive Reproductive Health Clinic, an initiative by the Kenya Medical Women’s Association is geared towards promoting health for all, and towards this goal, offers highly professional, affordable, acceptable quality health care services in the field of obstetrics and gynaecology in a most friendly atmosphere for all age groups.

Towards this very noble objective we shall have a symposium on ‘Health For All’ on November 9th 2013, to highlight ways and means of enhancing our country’s overall health as a strategy for a better Kenya tomorrow.

All are welcome.

Dr. Maryanne Nyamogo
Resident Consultant Obstetrician/Gynaecologist
Nairobi West Reproductive Health Clinic
Gertrude’s Nairobi West Satellite Clinic

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Gertrude’s Nairobi West Satellite Clinic
Wings of Compassion Organization
NGO Registration no. OP.218/051/12-038/803

WHO WE ARE
Thank you very much for choosing to include wings of compassion org to celebrate with KMWA during your 30th anniversary. We are looking forward to walking with you and we believe that your partnership with us will improve the lives of these young mothers and their babies.

Wing of Compassion is a rescue home for expectant orphans and most vulnerable teenage mothers.

It was founded on 1st May 2011, after carrying the burden for many years and out of a deep desire and commitment to alleviate the dire situation of teenage mothers.

These young mothers are typically a products of broken family units. Many of them were chased away from their homes and forced into the streets after they became pregnant. They have experienced absolute poverty, sexual abuse and exploitation, early sexual relationships, drug abuse and prostitution. These experiences have served to erode their self-confidence and left them with a feeling of hopelessness.

Our objective is to bring hope back into the lives of these mothers, through spiritual guidance, offering counselling and parenting skills, food and a home, education through primary, secondary, college and vocational training, thereby empowering them to become self-reliant and to provide their children with a bright future.

The home opened, with 18 mothers. At present, we have successfully supported 54 mothers who have since left our home and are now completely self-reliant.

OUR AIMS AND OBJECTIVES
Our key objective is to offer a positive and supportive home and provide the right environment for our young mothers to recover from their past trauma and take the first steps towards a brighter future. We provide immediate relief in the form of food, shelter and clothing. We strongly believe in adopting a holistic approach and therefore provide support in the form of:

• Education
We work tirelessly to ensure that all the girls enrol in school and complete their education. We believe this is an essential element in helping them secure a successful future. Our girls are enrolled in various institutions, including primary school, secondary school, and further education institutions for courses such as catering and secretarial

• Vocational courses such as tailoring and bead-work
We also ensure our young mothers engage in vocational courses such as beauty, hairdressing, tailoring and beadwork. These are invaluable skills as they provide the young mothers with useful, income-generating skills which help them achieve and maintain financial independence.

• Counselling to help heal the pain from their traumatic past experiences
Most of our young mothers have lived through very traumatic experiences in their past, and we acknowledge that in order for them to rebuild their lives, we need to ensure that they are able to heal from within. Thus, we provide counselling to help them recover from the trauma, and also to rebuild their sense of self-worth, self-confidence and hope for the future.

• Parenting skills
In preparation for their babies, we provide the girls with practical parenting skills, ranging from breastfeeding, infant nutrition, health and hygiene.

PARTNERSHIP WORKING WITH LOCAL AUTHORITIES
We work closely with the local authorities, including the Area Chiefs and the District Children’s Offices.

BUILDING COMMUNITY LINKS
A significant part of our mission is to engage the wider community in providing support for our young mothers. This not only helps to sensitize the community on the ongoing plight, but also helps to build strong relationships and promote social cohesion. It also helps to eliminate the stigma that surrounds teenage mothers and promotes positive support.

We hereby encourage more people to take this initiative to ensure that the teenage mothers in their communities are well supported to be able to build their self esteem and fulfil their dreams.

Our contacts are:
Wings of Compassion Rescue Home
Located in Kasarani, Roysambu in Maruru / Thome.
P.O BOX 234 - 00618, Nairobi, Kenya
EMAIL: wingsof2011@yahoo.com
FB Page: wings of compassion
TEL: +254 722 169 994/+254 735 411 509
Dr. Praxy and Dr. Pheney donate sanitary towels at Matus medical camp

Dr. Angie Dawa welcoming members to CME - Living smart as a doctor

KMWA and Nigerian delegates at the 29th MWIA congress held in Seoul Korea

KMWA Drs. Lore, Mary Hayego, Sheila Macharia, Njambi Nyaguna and Lucy at an outreach visit to Noon-Kopir Girls High School.
Information Technology in Health Care

Dr. Emily Obwaka

The role of information Technology (IT) has grown from its use primarily within the context of computer science in the late 1970s to today where it has permeated various disciplines including health. What role does or could it play in the health sector?

The first and most compelling answer is that IT in healthcare adds value to the health sector by contributing to systems strengthening. This technology presents itself through health management systems, electronic or digitalised health records, m-health, e-learning and teledermatology that all result in increased efficiency in day-to-day processes. A more efficient system leads to several desirable outcomes including optimising of resources and ultimately better patient care and satisfaction. Over the years mistrust in the quality and efficiency of the health sector has kept many away from health services and ultimately contributed to poorer health for the nation as whole. Utilising IT solutions that strengthen the core of the health sector could be the way to encourage and reaffirm trust in public and other health services.

Another significant impact IT can afford to the health sector is in availing a centralised database of health records that could be used to inform and direct national health policy. A centralised database of health records could provide critical information that could help direct policy makers in creation, implementation and disbursement of policy and funding. Availing more information to decision makers could help the health sector overcome some of the barriers that have previously restricted development and responsiveness to emerging trends and emergencies.

IT in health care can improve health coverage for a population. Telemedicine is an advanced Telecare solution that is aimed at building remote connectivity between doctor and rural patients to improve emergency response care and ensure continuous care for chronic or post-operation cases. Through e-health and m-health, populations can also be helped to know about disease risks, available services and be reminded about essential health practices for better health. Health workers can use this same technology to track information, report emergencies, disease outbreaks, and drug outages among other information.

As KMWA we are conscious of the effort our country is making toward achieving the MDG 4 and 5 which focus on improving maternal and child health as well as minimising the escalation of HIV/AIDS. Although great strides have been made to pursue these goals, it is unlikely that we will meet these goals by 2015. Taking advantage of IT in healthcare could propel us toward achieving these goals. For instance, Rwanda and Mongolia (both rated as developing countries) are countries that embraced technology and have seen a drastic improvement of several health indicators. In the case of Mongolia, health practitioners have used teledermatology to reach mothers and newborns in the remote recesses of their nation and have seen a dramatic reduction in maternal and child mortality as a result. Rwanda adopted a nationalised health management system that helped drive health policy that has ultimately seen an overall improvement in health services and increased access to healthcare for all citizens at levels close to ninety percent. Though these two cases come from countries situated thousands of miles apart, they offer proof that when applied, IT has the power to drastically improve the health sector.

At a micro-level for health practitioners, IT provides easy access to multiple sources of information about diseases, investigation and treatment protocols, drug indications, options and interactions, and so on. Electronic records for a patients means that the patient’s medical history can be referenced in future consultation anywhere and for referrals. Sharing medical information between practitioners leads to a reducing in medical errors and increases health care quality, effectiveness, productivity and efficiency. Through IT, a practitioner can also monitor operations in every aspect of their practice thus managing the facility better.

While IT in health care is not the answer to all shortcomings to achieving universal health for all, it can contribute significantly to increasing access to healthcare for the majority in Kenya. The Government of Kenya through the Ministry of Health is spearheading the realisation of a digitalised healthcare system spelt out in its E-Health Strategic Plan which contains five pillars, namely: Telemedicine, Information Systems, Information for citizens, m-health and e-learning. With the open space the Government has created for IT and the commensurate effort it is making to install the requisite infrastructure, Kenya is likely going to see a revolutionised health care landscape going forward toward meeting its Vision 2030.

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Dr. Emily Obwaka
Chief Strategy Officer,
Daktari Total Health Solutions
Struck Down But not Destroyed
Ann Ndimu’s story

What do you do when you wake up one day only to realise that life as you knew it just ended? You realise that you will have to re-adjust your dreams, re-strategise on how to achieve your goals or try to dream afresh. For me, one thing was certain, as long as I had breath in me, life had to move on as best as I could no matter how hard the circumstances were.

As I lay on that hospital bed, I assessed all that had happened. I thanked God for the life I had had and prayed that He would strengthen me for what lay ahead as it would not be easy. With time I learnt that I had been involved in a tragic road accident where I had lost two friends, one of whom was my closest friend in university and a lab technician who had kindly offered us a lift from school to Nakuru town. I had been in ICU and hospitalised for about two months. I could not leave the hospital just yet as I had not paid the hospital bill. Of course all these details came to light with time as my state of mind was considered fragile. Most people around me were walking on eggshells. They were very careful about what they said and how they said it. I knew that I was treated differently. Life felt surreal. I always got my way and was even asked what I wanted! This was not how real life went. Everyone was usually too busy to indulge me this much. I deduced that I must have been at a very bad place to be eligible for the treatment I was receiving. At the end of the day, I knew that this would not last. I was on my own and only I would be able to pick up the pieces. I felt reassured that I would get all the support I needed but it would be a long road to recovery. I needed to be strong.

With time I learnt that though I had regained most of my memory back, it was not business as usual. I re-learnt how to read, write and do the normal day to day activities. It was not difficult as it was like taking a refresher course but it was very frustrating. I had also broken my collar bone, a few ribs and both legs. In the process I had lost the ankle bone in my right leg and now had a fixed joint. I definitely did not understand what I had done to deserve all this. It felt like a punishment. Many people doubted my ability to continue pursuing a degree in medicine and surgery at the university. They said that everyone would understand that I had gone through a lot of trauma if I chose to change to an easier course. I felt misunderstood. Of course my life would have to change radically. My mobility was now compromised and I was now wheezing. The doctors said the wheezing would pass with time and had resulted from prolonged ICU stay where the intubation had led to narrowing of the trachea. That was 2011, the accident having occurred on 4th February 2011.

Since then, I have been back in school where I am continuing with medical school and I am now in my third year. I have met many amazing people who have encouraged me through the hard times, even total strangers. My lecturers have been very understanding and have helped a lot with my school work. Even the non-teaching school staff have done their bit to make life easier for me. I count myself loved by God and lucky to have the life I live.

I had laryngotracheal reconstruction surgery in January 2013 and therefore do not wheeze any more. God has opened doors and allowed me to be under the care of Prof. Macharia, an ENT surgeon, and one of the best in the region, I might add. After the surgery, the trachea restenosed (reconstricted) so I am now breathing through a tracheostomy tube. It was initially cumbersome due to the unnatural nature it works but I am now used to it. It’s definitely better than wheezing. If I walk long distances, my ‘ankle-less’ leg hurts so I walk with the aid of a crutch. The orthopaedic surgeons, who happen to double as my lecturers, say that the fusion of the tibia and fibula with the calcaneus (heel bone) has not yet occurred and they need to re-examine the screws in theatre.

As things stand now, I am still on my way to becoming an awesome doctor. I am due for two more surgeries; laser surgery for my trachea and the other for my fixed ‘ankle joint’. Looking back, I thank God for His care since the accident, where He preserved my life through the ordeal. I am also thankful for the fundraising that was held, enabling me to leave hospital after the accident. Since the laryngotracheal reconstruction surgery, which ended up being pro bono for the surgeon and anaesthetist, I had to have a number of dilatations in theatre. By this point all my insurance policies had been depleted and my case was presented to KMWA, who offered to cover the hospital fees. Prof. Macharia and the anaesthetist, who was either Dr.Kabutu or Dr.Kabetu accepted to waive their fees.

Through it all, I thank God for giving me access to the best medical care, better than I could have even imagined. He allowed me to be under the care of amazing doctors who have set the bar quite high regarding the kind of doctor I want to become. I am most grateful to Dr.Kabutu who presented my case to KMWA giving me access to so many amazing doctors and Prof.Macharia who keeps me hopeful that soon I will be able to breathe well on my own and encourages me in my studies. I am also grateful to my lecturers who have been very supportive and understanding through it all. They have been more than lecturers who just impart knowledge in their students. Not forgetting all my friends and strangers who gave me the time of day and supported me, be it financially, emotionally or stood with me in prayer.

Last and not least I am more than grateful to my family who have stood by me every step of the way, especially my mother who has done everything in her power to ensure I do not have to take on the world unequipped and my younger brother who still sees me as a hero. Thanks be to God for all these.

Ann Ndimu
3rd year student MBChB Egerton University
A Second Shot at Life

Penninah Kabethi’s story

When things happen, they happen for good to ones who love God. It was in Kenyatta University where I was studying medical laboratory science that I started experiencing discomfort in my body. Upon going to KU’s Health Centre, the journey to my diagnosis began. I had throbbing persistent headaches, was given medication and was compliant to the letter. Unfortunately the headaches persisted; I went back, my medication was changed and I was advised to get enough rest after reading which I did. The headaches still persisted, I went back, my diet was changed and I complied.

With headaches still persisting, the question that was now disturbing was, what was wrong with me… was I reading too much, was I not eating well or was I not resting enough?

End of term exam came and I revised well for one paper. I could not remember anything except my name and registration number. I started seeing two similar questions and some darkness, and I realised that my headache was more than headache.

On closing that semester, I went to my aunt in Nairobi determined to seek more attention at Kenyatta Hospital. All my vital signs were okay. Malarial, Widal, hemoglobin, bacterial, viral, Parasitic and even HIV tests were negative. The headache only got worse. I was sent to the eye clinic, my vision, acuity, color interpretation, near and far-sightedness were okay. The headache was becoming intense and I developed double vision and was so often dizzy.

I was sent for a CT scan and there, they found something in my brain. I was referred to a neurosurgeon who needed me to get an MRI scan from Agakhan hospital, my family was getting drained financially by now and my friends assisted us. The machine broke down while I was undergoing the procedure and had to wait for two weeks to complete it. After the machine was repaired, I completed the scan.

On interpretation I had a brain tumor on cerebro-pontine angle and emergency surgery was needed. I was scheduled for theatre a month later. This was one dark, trying and a month full of fear of the unknown. I developed photophobia, could not stay in light, couldn’t read, couldn’t watch TV. the pressure in my head increased massively upon performing a small task and I was suffering emotional trauma.

My family supported me, prayed with and for me and encouraged me. On 6th February 2006 at 11am, I went to theatre. The operation lasted nine hours and I was in a coma for four days. I awakened and could recognise everyone except my best friend. Soon after, I had a stroke on my right side including my face. I started physiotherapy immediately to revive my muscles, I was discharged a month later, and on going home worked extra hard, going for physiotherapy every day together with my dad who had a hip dislocation and was recapitulating. Love and care from relatives and friends facilitated my quick healing. I went back to school after one year.

I faced rejection from many including close friends, due to my new looks and imbalance. I was very dependent many things had to be done for me, I became depressed and had low self-esteem. Despite this, I completed my degree, volunteered in Kenyatta hospital and looked for a job for one year. Eventually I was employed at Bristol park hospital. Working in hospital, the ambition I had harboured since my youth took a different turn.

I took a major step of faith, as being a doctor was a calling. I applied to the University of Nairobi for admission to pursue a medicine degree in 2010. Due to financial constraints and my dad passing away, I could not join then. Where there’s a will God makes a way. I talked to many people on how I could go about it, I wrote to many companies, organisations and foundations to no avail. In 2011 I joined Kenya Medical Women Association and they came to my aid. They took me as one of their own, mentored me and gave me hope to dream more.

This has given me a second shot at life.

Thanks KMWA, LONG LIVE KMWA AND GOD BLESS.

Penninah Kabethi

2nd year student University of Nairobi

Plight of children with HIV not as grim as it used to be

Sister Owen

This September, I begin my 45th year in Kenya. From High School education in the first half, to starting Nyumbani (Children of God Relief Institute) with Fr. Angelo D’Agostino SI, MD 21 years ago. The empowering of girls and children has been both my mission and joy. Celebrating life achievements with my former students from Loreto High School, Limuru, many of whom are now in leadership positions in society, are moments of great pride that are becoming more and more frequent.

The call to reach out in 1991 to abandoned children who had inherited HIV invited a right turn in my life. Compassion informed by justice for children abandoned on the side of the street, left behind in hospital, rejected by extended family after parents passed away grabbed my heart. I started by participating in a seminar which helped me begin to overcome ignorance, fear and stigma, so easily communicated non-verbally. Once, we were told by a funding agency where we had gone for support: ‘These children are going to die anyway; get into prevention’ - every little step to ensure the rights of these children was a moment of celebration. From 2000, through lobbying authorities, we gradually began
to access antiretroviral treatment for the more compromised
children, first AZT mono-therapy, later dual-therapy and
finally the triple cocktail – HAART. Finally we gained access
for all our children needing antiretroviral treatment. From
grieving and laying to rest two, sometimes three children
every month, celebration as we witnessed each special child
growing up healthily became the order of the day.

A wake-up call came in 2004, when we realised that our
children were now reaching adolescence. That year too
our children, who were being denied access to free primary
education, won a landmark discrimination case against the
Government of Kenya. The Ministry of Education officers
were given 10 days to place over 40 of our children in
Government schools. What a great celebration followed!
Then, in 2006, our first young person completed Form 4
and, following training, graduated from Nyumbani and was
employed – the first of now over 30 young adults happily
re-integrated back into the wider community.

One final celebration: A message from our nurse matron
in 2010: ‘Sister, if we do not get access to Third Line
ART, two of our children are going to die.’ There followed
frenzied lobbying of all possible sources, finally getting
compassionate access pending availability in Kenya. From
successive opportunistic infections and frequent missing
of school attendance, what great joy it was to see our two
children put on weight again and come alive!

Today we care for more than 4,200 children infected and
affected by HIV through three programmes: Nyumbani
Home, Lea Toto community-based programme and
Nyumbani Village. We continue to celebrate as our children
grow up healthily, secure, and confident, dream their dreams
and, finally realise their God-given potential. But we have one
celebration still to happen: As our young adults re-integrate
into the wider community, they come face to face with the
stigma that still surrounds HIV which locks them in secrecy
and vulnerability. The fact that HIV is a medical condition
which can be contained with medical treatment has still to be
understood and integrated into our attitudes and behaviour I
hope and pray to celebrate the full claiming in Kenyan society
of the dignity and respect due to persons living with HIV.

Sister Owen
Director Nyumbani Children’ Home
KMWA Profile

It was established in 1983 as a membership organization for Kenyan female Medical Doctors and Dentists in practice. It is an independent Non-Governmental and non-profit making organization registered under the laws of Kenya. It seeks to uplift the health status of women, adolescents and children in Kenya by enhancing the capacity and potential of medical women to respond through determined action involving advocacy, information and service provision, to meet their special needs and whose main agenda is voluntary in nature. Currently we have over 400 members, which includes up country branches in North Rift, Nyanza and Eastern Provinces.

Vision
An association of excellence providing leadership in all matters of health.

Mission
To champion for the improved health and dignity of society, particularly vulnerable groups through a cohesive, professional membership committed to our core values of excellence, integrity and compassion.

Core Values
The Kenya Medical Women’s Association (KMWA) will promote and operate within a clear and consistent set of ethics, reflecting its core values of:

- Integrity
- Commitment
- Excellence
- Compassion
- Cohesion

Strategic Program Issues

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

Objectives

1. Contribute to the betterment of health services in Kenya (see Kenyan Health Situation on the next page).
2. Afford opportunities for Medical Women to meet at stated times to confer and take necessary action on matters relating to the health and wellbeing of the various communities they serve.
3. Provide a means of communication between Medical Women in different parts of the country and the rest of the world.
4. Promote the general interest of medical women and foster friendship and understanding amongst them.
5. Afford opportunities for Medical Women to have a voice in professional and related bodies.
6. Hold meetings for discussions and interchange of ideas of problems particularly relating to women and secure cooperation at all times in matters connected with National and International health.
7. Offer mentorship to young girls as they enter into medical and related professions.
8. Encourage, commission and conduct research into health problems relating to maternal and child health.
9. Afford opportunities for Medical Women to meet and to confer with non Medical Women and share each other’s expertise.
10. Participate in the National arena thro various initiatives with the focus on the health budget monitoring tool kit at the National Assembly level.

KMWA Achievements

Since its inception in 1983 KMWA has been involved in a lot of activities, and has had several achievements of note.

The KMWA Strategic Plan (2010 – 2014) was launched in November 2009 with partners and stakeholders in attendance.

- The Strategy developed here builds upon our belief on the strengths of our proven and unique identity as an organization, able to make a distinct contribution to healthcare in this country. KMWA’s strategic niche is in its proven capability to credibly contribute to the relevant organizations that play a role in the promotion of gender equality and empowerment (MDG 3); reduction of child mortality (MDG 4); and maternal health (MDG 5), those that relate to the improved health status of the people by 2015.

- Our “Well Woman Clinic” situated on Kodi Road II, Nairobi West at the KMWA premises provides improved and affordable reproductive health care to expanded populations in the greater Nairobi area. It is staffed by upwardly mobile gynecologists who are KMWA members. The clinic also runs medical out-patient clinics once a week at Deep Sea Suswa Slum in collaboration with the Consolata Fathers.

- KMWA in partnership with GlaxoSmithKline Kenya (GSK) has been able to promote the use of Cerverix Vaccine in the prevention of the spread of cervical cancer among women. This information is also being disseminated in the Continuous Medical Education sessions carried out. KMWA has been involved in research on cervical cancer, breast cancer and the environmental relationship, genetic factors and HIV/AIDS.
• KMWA is an accredited Continuous Professional Development (CPD) provider by the Medical Dentists and Practitioners Board (MPDB). Members have also been participating in international and national forums in relation to health issues affecting women and children.

• KMWA in partnership with the Business Advocacy Fund shall be developing a policy paper focusing on equal opportunity at the workplace for women. This shall be developed in partnership with other stakeholders through use of different research methodologies.

• KMWA in partnership with the International Partnership for Microbicides (IPM). This is a project supported by the International partnership for Microbicides mainly focusing on HIV Prevention strategies and advocacy for Microbicides. KMWA members attend International Conferences on Microbicides to gain more knowledge and disseminate to other members and the society at large. KMWA holds annual scientific Symposium for its members and the corporate world on health issues, health talks through Media, Schools, Medical Camps etc.

• KMWA in partnership with KEPSA is participating in Kenya Youth Empowerment Project (KYEP) where in cycle 1(2012) we admitted one intern within our organization and she was exposed on financial operations and in cycle 2(2013) we have two interns (Bachelor of Commerce and Sociology & Communication) whereby KMWA gets Ksh. 6000/- and the interns also get 6000/- stipend each per month.

• KMWA is also continuously growing the partnerships and stakeholders as we aim at championing for the improved health and dignity of society through use of the newly launched Strategic Plan. The members constitute professional women who are empowered and advocate for a cause that has been clearly identified.

KMWA on the health situation and health needs in Kenya

Kenya’s Vision 2030 recognises health as part of its social pillar and aims to provide an efficient, integrated, high-quality, affordable health care system. Together with the new Constitution of Kenya 2010, it is currently under progressive implementation and a legislators’ (HBM) toolkit has been launched. We in KMWA have re-positioned ourselves to participate in monitoring and/or tracking the fulfilment of these expectations to Kenyans. Multiple interventions have been introduced, particularly focused on addressing the burden of communicable diseases and preventable diseases such as HIV/AIDS and malaria.

A review of the health situation shows that the health status of the people in Kenya has only marginally improved in the last 20 years. Age-specific health impact indicators have shown stagnation or worsening of the health situation in some instances.

KMWA seeks to be at the frontline in policy making, education and implementation of the health sector programmes as pertaining to vision 2030. We endeavour to roll out countrywide campaigns in all media networks which will address the following:

• Accessibility of health care to all Kenyans
• Affordability of quality and specialised health care.
• Procurement of essential drugs and equipment in all counties.
• Training and personnel development in the health sector.
• Improvement of the health infrastructure.

Benefits of being a KMWA Member

• Member Professional Growth.
• Capacity building – experience and training including CMEs.
• Scholarships, Job opportunities; Information resources.

Shared Identity – Sense of belonging (Family Sense)

• Responsibility including indemnity & advocacy for entitlements.
• Social Empowerment & Development – Unity/Solidarity and strength in numbers towards a common cause e.g. at a time of need. Expanding to reliable countrywide errands execution for members.
• National positioning/ recognition & credibility in gender issues – as an organized group & Economic Empowerment.

KMWA wishes to acknowledge the support of all our esteemed partners: