

Report for Iolanthe Midwifery Trust from Lisa Common, Student Midwife

I was absolutely delighted when Elizabeth Duff notified me that the Iolanthe Midwifery Trust had granted me a student award to fund my negotiated placement in Zambia to work with a HIV/AIDS charity called SAPEP (Simalelo AIDS Peer Education Project). The award made it possible for me to enhance my midwifery education by experiencing care provided in a very different setting to the consultant-led, well-resourced and high-tech environment in which I train in Nottingham. This award made it possible on my limited student income to broaden my horizons and immerse myself in another country and culture.

I arrived in Lusaka, Zambia's capital city on 8 September 2007 with a midwife colleague. I was in Africa for the first time in my life and it felt like the start of an amazing adventure. Driving through the streets of Lusaka and the market they call 'Soweto' with completely unfamiliar sights, sounds and tastes was amazing. We headed to the bustling bus station where passengers 'negotiate' the price of their seat and then wait for the bus to fill to bursting before departing. Eventually we arrived at the little town of Monze, about three hours away, into the scorching 38°C midday heat. We had arranged with SAPEP to meet us from the bus, but there had been a mix up on times. This is where I first experienced the kindness and hospitality of Zambians. People at the bus stop saw that we were lost and immediately tried to help. They offered us their telephones to make a call, tried to figure out where we were heading and how we could get there and eventually a Catholic nun in a 4x4 truck, loaded up our backpacks and drove us in to town to find our hosts.

My time spent with SAPEP was extremely helpful in gaining an understanding of the challenges faced by Zambia. Zambia is working towards achieving something called Millennium Development Goals (MDGs), designed to free men, women and children from the dehumanising conditions of extreme poverty and give everyone the right to development by 2015.

The latest figures make stark reading:

- 16% of the adult population is HIV positive
- 46% are living in extreme poverty and 28% in extreme hunger
- Maternal mortality has climbed to 729:100,000
- Only 45:1000 births are attended by skilled health personnel
- Progress towards increasing gender equality and empowering women in education and work has faltered
- Literacy rates are falling and the drop out rate for girls from education beyond primary school are high
- Child mortality remains high with 95 out of every 1000 children dying before their 5th birthday

Zambia is rapidly losing its natural resources, and water and sanitation services are not improving fast enough. Trade is constrained by problems with transportation, storage and communication and needs more development aid and most importantly, access to markets where they can trade fairly. So in a nutshell, Zambia and its people are suffering terribly.

SAPEP arranged for us to travel out into the rural district on motorbikes to see the work of their charity and meet local people. Tarmac and road-signs are not a feature of the rural infrastructure, so we spent some of our time lost among the grass and trees hunting for the tracks that would lead to our destination. The pace of life is very different to the UK, and I became aware of how much my life is ruled by the clock. People would wait for us under a shady tree and not be cross with us if we arrived late. Quite the opposite, they welcomed us

with open arms and offered us comfort and food. I learnt how important it is to take time with greetings and to shake hands in Africa. The people were extremely generous with their time and we were never rushed to 'get on'. We learnt a few phrases in Tonga, the local language, which were always greeted with surprise and greatly appreciated. These are simple but important learning points from my time in Zambia that I will integrate into my professional practice in the UK.

SAPEP initiatives are delivered by volunteers who live in the rural communities, understand local needs and are accepted by local people. This support is often coordinated through an infrastructure of Anti-AIDS Clubs. The clubs organise activities such as home based care for vulnerable people, school outreach, support for orphans, income generating activities such as chicken or goat rearing, and planting gardens to grow crops. They organise and participate in educating their communities about HIV/AIDS, the importance of knowing your HIV status and the prevention of mother to child transmission (PMTCT) of HIV. This is done through organising events such as plays, puppet shows, sport and dance competitions that attract the community and a wide audience who can then be exposed to health promotion messages.

I saw an example of how this works when I was given an opportunity to help a midwife at her antenatal booking clinic in Nampeyo, a rural district about a one hour ride out of Monze. Most of the work is conducted outside the clinic under a tree as the interior is for people sick with AIDS related illnesses. The midwife never knows how many people will turn up to her clinic and when 12 arrived, we clearly had our work cut out. The care provided was very familiar; we took a history, measured BP, urine and weight, then took blood samples for the compulsory syphilis test. In addition, women were given a supply of iron and folic acid tablets and medication for tetanus, if it was indicated. The midwife will see women during their pregnancy on four occasions and refer any high risk cases to Monze Mission Hospital usually two weeks before their due date where they will be admitted and 'wait' until they go into labour. Everyone else in this area will give birth at home, usually with the support of their mothers, sisters or a traditional birth attendant who may be skilled or unskilled.

Once we completed all the bookings the SAPEP Anti-AIDS Club performed a play as part of an antenatal lesson. Simply, the play involved a woman whose husband forbade her from attending for antenatal care and she ended up having a difficult labour and a baby who was sick and had sores. Her friend was assertive with her husband and did attend for antenatal care and had a healthy baby in good condition. The club members then facilitated a discussion which involved asking the women watching whether they would take a test to find out their HIV status if their husband forbade it. Only two of twelve women raised their hands. The club then explained PMTCT and how their baby can have a future free from HIV with appropriate care. The midwife later counsels women about HIV testing and offers them the result within 20 minutes. By providing women with simple information, SAPEP is having a major impact on HIV transmission rates in the areas in which they operate. In 2002, SAPEP reported that sexually transmitted diseases reduced from 33 per zone to an average of 8 per zone in the two year period from January 1999 to December 2001. So their work is really making a difference to the lives and life chances of the next generation. We were told that as much of the communication in rural areas is by word of mouth, our presence as visitors from the UK would be helping to raise the status and importance of antenatal care and getting tested to protect the next generation from HIV.

I also learnt how traditions, customs and other factors influence the spread of HIV/AIDS. These include:

- **Stigma** – couples choose to remain ignorant about their HIV status and avoid testing for fear that they will be ostracised by their community or their marriage will dissolve. Women in particular fear that their husbands will leave them if they test positive during pregnancy and this can be a barrier to accessing antenatal care.
- **Adultery** – gender inequality is extremely problematic from a HIV/AIDS prevention perspective. Women and girls are expected to be submissive and traditionally, are not permitted to refuse to have sex with their husbands. If men fail to provide adequate material support for their families, women and girls are often forced into commercial sex arrangements with other men. Increased beer drinking can also lead to unfaithfulness.
- **Polygamy** – extramarital relationships pose a threat of sexually transmitted infections to everyone involved in a polygamous marriage.
- **Child rape** – men sometimes believe that there is a 'virgin-cure' to HIV. That is, having sex with a female baby or child will rid them of the virus. Despite child protection laws in Zambia, children who inform on their abusers risk abandonment and/or violent punishment.
- **Poverty** – with high poverty levels, some parents allow their girls into commercial or casual sex for material support for their survival. Unprotected sex is more lucrative than protected sex.
- **Sexual cleansing** – a ritual where a deceased man's relative has sex with his widow, in the belief that this will dispel evil spirits.

From a midwifery perspective, the maternal mortality rate in Zambia is shocking when compared with the UK- 7290 per million next to 3 per million. The crisis is fuelled by a shortage of skilled practitioners to attend births and undeniably, is implicated in nearly 1 in 10 children not reaching their 5th birthday. Life expectancy for a baby born in Zambia today is just 40 years. I saw a baby brought in to a clinic by a young mother whose birth had been attended by a local village woman two days previously. The umbilical cord had been severed completely and the woman had walked several kilometres to bring her sick and bleeding baby to the hospital.

The time I spent at Nampeyo brought home to me why women do not have their babies in hospital or with the assistance of trained assistants. People do not have cars and they are lucky if they have a bicycle. The tracks are rough, there are no street lights and they are very, very far from town and other settlements. I was happy that I was able to spend some time with the *Zambian White Ribbon Alliance for Safe Motherhood* in Lusaka and give them a copy of Gill Gordon's *Training Manual for Traditional Birth Attendants* and UNICEF's *Born Free From HIV* pamphlet, to help with the development of a training programme for TBA's.

I also had the opportunity to work alongside the midwifery and obstetric team at the Monze Mission Hospital with its School of Midwifery and excellent scheme to train Clinical Officers up to obtain medical licences. These training schemes provide much needed health staff to work in clinics around Zambia. In a clinic we visited near Lusaka, we met a qualified nurse who had sole responsibility for a population of up to 15,000 – this is typical and demonstrates how desperate Zambia is for, and to keep its trained staff. The standard of education is excellent, with their students and clinical staff using the same practical skills and terminology that I have been taught in the UK. Trainees also develop confidence in recognising and treating infectious and tropical diseases and responding to neonatal conditions.

However, the equipment is often in poor condition and short supply. A typical example of this is that while Monze Mission Hospital is one of the best - receiving referrals from across Zambia - even here clinical staff have just one, very old ultrasound scanner to work with and the probe is partially broken so that just two-thirds of an image can be projected onto the

screen. Bearing in mind that only at-risk women will receive care in hospital, this was very frustrating to see. Drugs and blood supplies are in short supply or non-existent and there is no pain relief for women unless they are having a caesarean section or perineal sutures. They lack much of the neonatal resuscitation equipment that we consider essential and take for granted in the UK.

But not once did I see the staff despair or moan about their facilities. They were always realistic but looked to the future with optimism about developing their health service. They said it would be great to have electric labour beds, automated blood pressure machines, infusion pumps, CTGs, incubators and so on, so that they could improve the comfort and care they provide to high-risk pregnant women. But what shone through during my time in Zambia, was that they had a passion and enthusiasm to provide care to the women and families that needed it, despite all the challenges they are facing.

Everyday I saw something that reminded me how fragile the balance between life and death can be. One day it was a dead baby wrapped and lying in a cot awaiting collection by relatives, on another it was fighting to save a HIV positive woman who was haemorrhaging after birthing her fourth child, and on another it was caring for a woman who was unconscious following six eclamptic seizures and then discovering her fetus had died. The future of Zambia rests on the health of its women and children, and I had an acute experience of what part midwifery knowledge and skills can play in keeping them alive and safe.

One significant difference between care provided in Zambia and the UK is the application of patient rights. While a sign in the labour ward highlights that patients have rights to information, privacy, dignity, choice, safety and comfort, it was difficult to think of an occasion when I saw this in practice. For example, I saw prostaglandins inserted *pv* without any explanation to the woman, and on ward rounds covers were pulled back and intimate examinations performed in view of everyone on the ward with a non-sterile glove with no evidence of hand-washing before or after. I asked the student midwives what they thought women feel about the ward round. They told me that the expectations of women in Zambia are very different to those in the UK as they are pleased and grateful when a doctor comes to examine them as he is an expert who is going to help them. It would be rude to complain or be modest and women might not get treatment if they made a fuss. When I asked the consultant about the concept of informed consent he laughed and said that everyone who visits from the UK asks him this. In his view, his hospital could not function at the pace required if it attended to the principles of informed consent. It could be argued that the health professionals work in a culture that is not risk-averse because there is no fear of litigation or prosecution.

However, I was in no doubt that the consultant was a caring and committed professional. One of the trainee clinical officers told me a story about an APH that occurred one night on the ward. The consultant was called from his home and arrived half-dressed in his pyjamas. He picked the woman up in his arms and carried her to scan. When he established her baby was still alive, he picked her up again and ran with her to theatre where he delivered a live infant and saved the woman's life. I cannot think that I have heard a similar story about a consultant in the UK and can therefore understand to some degree why he is trusted and respected by his clients and his commitment is unquestioned.

I am grateful to Elsevier Science who couriered a large box of brand new midwifery text books to Zambia in lieu of payment for some work I did for them reviewing textbooks. I was

able to give these to the School of Midwifery library at the Monze Mission Hospital and know that they will be a welcome and valuable resource to the staff and students based there.

Poverty, disease and corruption. Some people feel that there is no hope for Africa and no way to 'fix' it. However, Zambians do not think of themselves as poor, but as suffering. They are wonderful, gentle and generous people who want to live. With projects like those provided by SAPEP, the traditional beliefs and attitudes are being challenged and they are beginning to make changes at grass root level within their tribes. Gender equality issues are being addressed and women are being encouraged to access antenatal care and testing. With committed health professionals like the ones I met in Monze and Lusaka there is a future. However, until the developed world stop exploiting resource-poor countries like Zambia, their development and progress will remain stifled.

I will be eternally grateful to the Iolanthe Midwifery Trust for supporting me to undertake this placement. Look at me, I've backpacked around Africa, I've shared guest houses with cockroaches, I've eaten weird and wonderful food, I've helped to birth a baby in Zambia, I've helped to build a roof for an elderly woman, I've washed orphans clothes, I've watched boys play football and taught kids to play frisbee, I've taught pre-school children how to sing 'Incy Wincy Spider' and I've seen the Victoria Falls and camped in a National Park with elephants, lions and hyenas. I have just started my third year as a student midwife and I feel that my life is ahead of me with so many possibilities. This trip has helped me to believe in myself and recognise that I am strong and resourceful and can do almost anything. I feel connected to Zambia forever and am sure that I will return when I am qualified to help develop their health service, perhaps by helping to train TBA's to provide good, safe care to women.

What impact has this placement had on me? In practical terms, I am now President of the Zambian AIDS Society at the University of Nottingham, a fundraising society dedicated to supporting PEPAIDS, the UK charity that funds SAPEP. I'm involved in organizing Rag Raids, supermarket bag packs, club nights and much, much more as a result and have a £5,000 target to reach. I wrote an article about organizing my placement for the Autumn 2007 edition of *Midwifery Matters* and have submitted a further article which I hope might be published in the next edition about what it was like. I hope my writing will motivate and inspire other students to undertake visits which will enhance their university experience. I have also given a presentation at my local RCM branch, to fellow students from my course and midwives from the Trust where I train about Zambia. I feel passionate about the potential organizations like the White Ribbon Alliance for Safe Motherhood www.whiteribbonalliance.org can make to improving maternal and infant health and can see my future being connected in some way to international development.

If you would like to help SAPEP, you can donate to a British charity called PEPAIDS that was set up by a nursing graduate of the University of Nottingham, Helen Allen who ensures the money is sent directly to the people on the ground. You can also set up a direct debit from as little as £2. Visit their website at www.pepaids.org to find out more.