

A woman wearing a light-colored headscarf and a green shawl is holding a baby wrapped in a green cloth. The baby is wearing a small, light-colored knit hat. The woman is smiling and looking down at the baby. The background is blurred, showing other people in a similar setting.

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UniMagazine

Ideas, Impact, and *Innovation* in
Healthcare

About UniMagazine

We are thrilled to launch a monthly publication aimed at improving Health Science students' writing abilities and promoting health literacy in the community. In addition to being an essential tool for aspiring Health Science students and professionals, this magazine will act as a vibrant forum for information exchange, debate, and discussion on important health issues that appeal to Ethiopian and African readers.

Effective communication is crucial in today's quickly changing healthcare environment. By giving Health Science students the chance to hone their writing skills via real-world experience, our magazine seeks to empower them. We hope to develop a new generation of healthcare professionals who are not only informed but also articulate and involved by promoting students' expression of ideas and research.

This publication will also cover important health issues that impact our communities, including gender-based violence, mental health, reproductive health, medical innovations, and ancient medical histories. By drawing attention to these issues, we hope to increase knowledge and comprehension, which will ultimately improve health outcomes.

In a society where it can be difficult to find trustworthy health information, this magazine will act as a knowledge hub, filling gaps and encouraging thoughtful dialogue.

We hope to build a thriving community of readers and contributors, expanding the magazine's audience and influence together with different organizations and institutions.

By working together, we can create a culture of health literacy that improves the lives of many people by empowering them and fostering community strength.

I would like to extend my heartfelt thanks to our Public Relations and Communication Director, Menam Mikresilasse, and our talented Graphics Designer, Ruhamah Nathnael, for their significant contributions and magnificent work in bringing this publication to life. Their dedication and creativity have been invaluable in shaping the vision of UniHealth.

Additionally, I am grateful to all the authors who contributed their insightful content, enriching our magazine with diverse perspectives and knowledge. We encourage anyone interested in contributing to our magazine as an author to contact us. Together, we are laying the foundation for a meaningful dialogue that will resonate within our communities.

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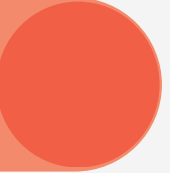
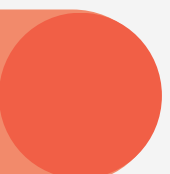
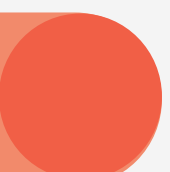
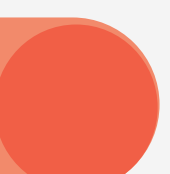
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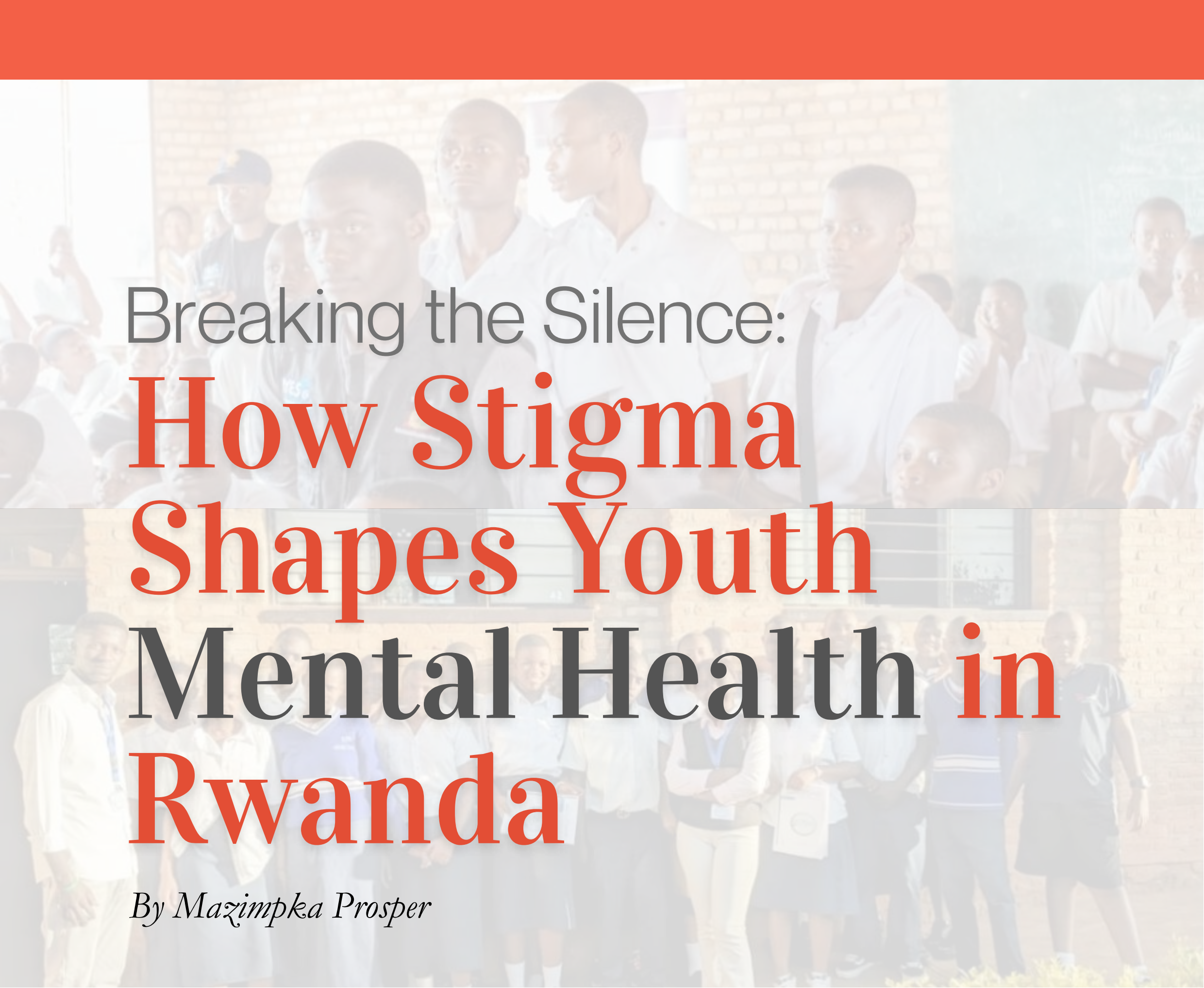
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Breaking the Silence: How Stigma Shapes Youth Mental Health **in** Rwanda

By Mazimpka Prosper

Mental health challenges affect thousands of young people in Rwanda, yet many continue to face them quietly. While awareness has improved over the years deep-rooted stigma and cultural misconceptions still prevent open conversations and timely support. For many years mental distress is not only a personal struggle but also a social burden shaped by fear judgment, misunderstanding, and exclusion.



When distress is treated as shame instead of pain, young people are left to suffer alone.

In some communities mental illness is still associated with witchcraft, spiritual punishment, curses, or moral weakness. These beliefs often influence how families and peers respond to emotional suffering. Instead of empathy and professional care, young people may be advised to pray in silence, seek traditional remedies, or hide their struggles to protect family reputation. As a result, symptoms of anxiety, depression, and trauma are frequently ignored or minimized until they become severe.

Through community outreach, school programs, and peer-led conversations, the Healing Hearts Initiative (HHI) has observed how stigma delays help-seeking and deepens isolation among youth. Many young people fear being labeled as 'weak' or 'unstable', which discourages them from accessing mental health services even when they are available. Gender expectations further complicate this reality with young men often pressured to suppress emotions and young women facing social blame for expressing distress.

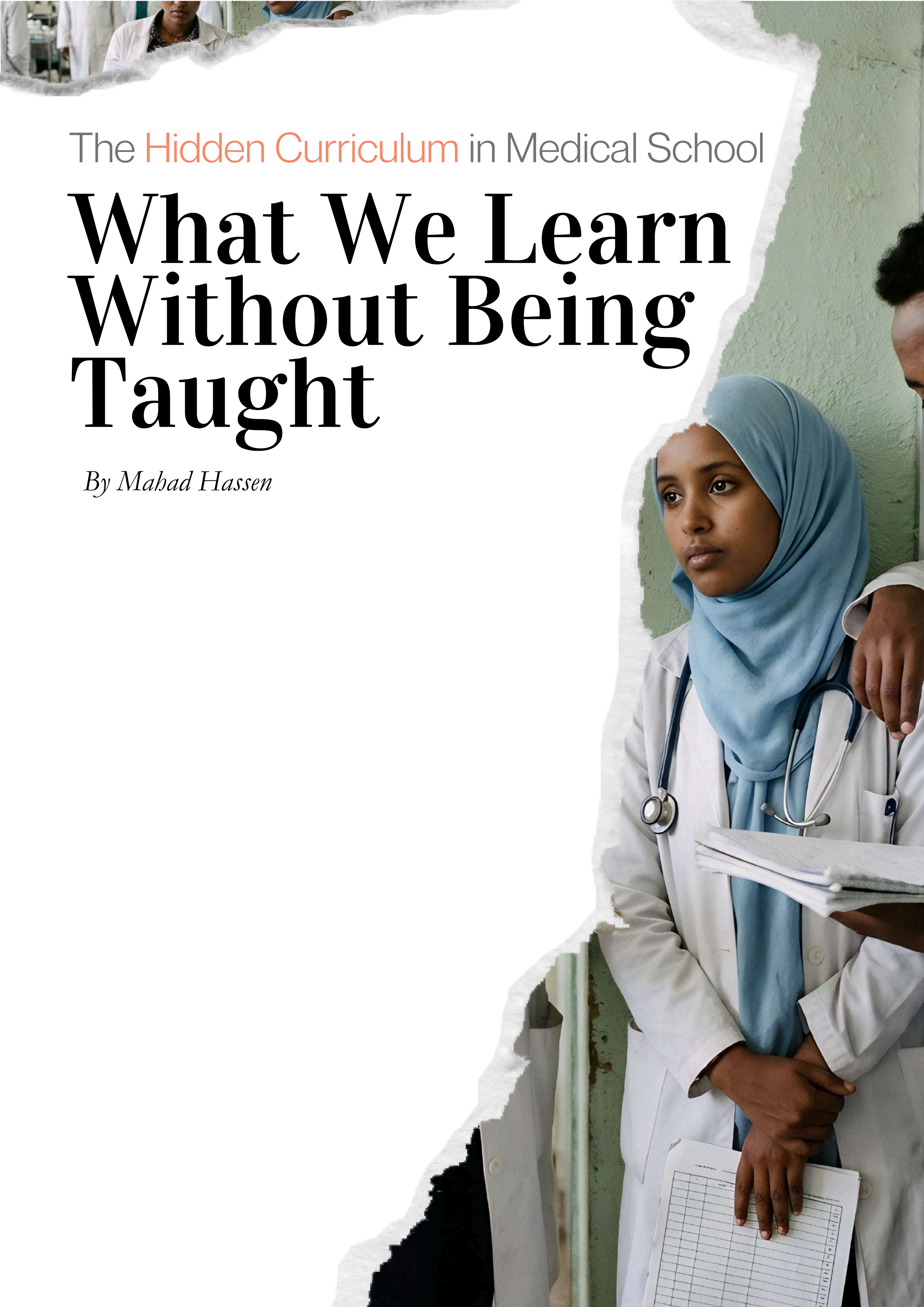


However, change is possible. Across Rwanda, there are growing examples of families, students, religious leaders, and health workers challenging harmful narratives and promoting understanding. Youth-led initiatives like HHI are creating safe spaces for dialogue, mental health literacy, and referral to appropriate care. By using culturally sensitive approaches and community language, these efforts help normalize mental health as part of overall well-being.



As Rwanda's youth shape its future, mental health must step into the light. Reducing stigma restores dignity, protects hope, and reminds young people that healing begins with understanding.

Reducing stigma is not only about correcting misconceptions it is about restoring dignity and hope. When young people feel understood and supported, they are more likely to seek help early, support one another, and thrive. As Rwanda continues to invest in youth development and health-care innovation, prioritizing mental health and breaking the silence around stigma is essential. Where understanding grows, healing truly begins.



The **Hidden Curriculum** in Medical School

What We Learn Without Being Taught

By Mahad Hassen

Medical education is often defined by structured curricula—lectures, examinations, clinical rotations, and competencies.

Alongside this formal training exists an unspoken system of values and behaviors known as the hidden curriculum. This hidden curriculum profoundly shapes medical students' experiences and has important implications for mental health.

The hidden curriculum includes lessons that are never written in course outlines but are learned through daily interactions. These lessons may include the normalization of exhaustion, silence in the face of hierarchy, competition over collaboration, and the belief that emotional distress reflects weakness. Over time, such messages become internalized as part of professional identity.

Research demonstrates that the hidden curriculum plays a critical role in shaping student well-being. Studies associate hierarchical learning environments and lack of psychological safety with increased stress, burnout, and reduced empathy among medical students. When resilience is assumed rather than nurtured, students are left vulnerable to emotional exhaustion.



Medicine is not only taught in lecture halls; it is absorbed in silence. Beyond the formal curriculum lies a hidden one where exhaustion is mistaken for dedication, silence for respect, and vulnerability for weakness. These unspoken lessons shape the doctor long before the degree does.

In low- and middle-income settings, including Ethiopia, these effects may be intensified.

Overcrowded classrooms, limited faculty resources, and heavy clinical workloads often prioritize endurance over reflection. As a result, medical students may learn to suppress emotions and normalize distress as an unavoidable aspect of training.

Silence is one of the most harmful lessons of the hidden curriculum. Students quickly learn when speaking up feels unsafe. Concerns related to mental health, workload, or mistreatment often remain unexpressed due to fear of stigma or negative evaluation, reinforcing isolation and discouraging help-seeking behavior.

Evidence links prolonged exposure to such environments with burnout, disengagement, and long-term dissatisfaction with the medical profession. Burnout among medical students affects not only academic performance but also empathy and professionalism, ultimately influencing patient care.

THE HIDDEN CURRICULUM

Recognizing the hidden curriculum is the first step toward transforming it.

Addressing the hidden curriculum requires deliberate institutional action. Creating psychologically safe learning environments, strengthening mentorship, and training faculty to model supportive behaviors are essential steps. Incorporating mental health education into formal curricula signals that well-being is a priority.

Medical students also have a role to play. Peer support initiatives, student-led advocacy, and open dialogue can challenge harmful norms and reshape learning culture. Recognizing the hidden curriculum is the first step toward transforming it.

Medical education should aim to produce not only clinically competent physicians but also resilient and compassionate professionals. By confronting the hidden curriculum and its impact on mental health, institutions can foster environments where students are supported, heard, and empowered.





Sleep as a Foundation of Physical and Cognitive Health

By Nesredin Hassen



Sleep is one of the most powerful tools we have for staying healthy and one of the first things we sacrifice.

In a culture that celebrates long hours, early mornings and constant productivity, sleep often feels like luxury. Staying up late to finish work or waking up before sunrise is worn like a badge of honor. But while we're chasing deadlines and to-do lists, our bodies are quietly running on a schedule of their own.

When we fall asleep, we're not "shutting off." We're handing control over to one of the most sophisticated repair systems in the human body.

WHAT REALLY HAPPENS WHEN YOU SLEEP

Sleep isn't empty time. It's an active, carefully organized process that affects nearly every system in the body — the brain, heart, immune system, hormones, and more.

Throughout the night, your body cycles through different stages of sleep. Each stage plays a specific role.

During deep sleep, your body goes into repair mode. Damaged tissues are restored, muscles recover, and your immune system strengthens. Hormones that regulate growth, appetite, and metabolism reset and rebalance.

When you don't get enough sleep, these essential processes are cut short. One bad night might leave you groggy and irritable. But when sleep deprivation becomes routine, the effects go much deeper .

Then there's the stage most of us associate with dreaming. During this time, your brain gets to work sorting through the day. It strengthens important memories, processes emotions, and clears away unnecessary information. In a sense, it's decluttering your mind.

THE POWER OF SEVEN TO EIGHT HOURS

Research consistently shows that most adults function best on about seven to eight hours of sleep per night. That window allows the body to complete full sleep cycles- not just rest, but true restoration.

Regularly sleeping fewer than six hours has been linked to higher risks of high blood pressure, heart disease, diabetes, obesity, and a weakened immune system. Over time, chronic sleep loss places the body under stress, increasing inflammation and making it harder to fight off illness.

At the same time, consistently sleeping far more than usual can also signal that something isn't right. Poor sleep quality, underlying health conditions, or mood disorders can all play a role.

Like nutrition, sleep works best when it's balanced.

SLEEP AND THE BRAIN: YOUR MENTAL RESET BUTTON

If you've ever noticed how much clearer your mind feels after a good night's rest, that's no coincidence. Sleep directly affects memory, focus, decision-making, and emotional regulation.

After quality sleep, learning feels easier. Reaction times are quicker. Problems feel manageable. Without enough rest, even simple tasks can feel overwhelming. Emotional control weakens, people often feel more anxious, more reactive, and less patient when they're tired.

Sleep gives your brain a chance to reset. It strengthens what matters, filters out what doesn't, and prepares you to think clearly again.



PHYSICAL HEALTH STARTS AT NIGHT

Sleep supports your body in ways you rarely notice until you're not getting enough of it.

It helps regulate blood pressure, protects heart health, balances hormones, and keeps your immune defenses strong. People who sleep well tend to recover more quickly from illness, maintain steadier energy levels, and manage their weight more effectively.

Long-term sleep deprivation, on the other hand, keeps the body in a state of stress. Inflammation rises. Immunity weakens. The body has to work harder just to maintain balance.

In many ways, sleep is the body's nightly maintenance system.

When we fall asleep, we're not "shutting off." We're handing control over to one of the most sophisticated repair systems in the human body.





WHY MODERN LIFE MAKES IT SO HARD

Despite its importance, sleep is often the first thing we trade away. Late-night scrolling, streaming shows, answering emails, and constantly staying "connected" make it difficult for the brain to slow down. The blue light from phones and computers interferes with melatonin, the hormone that signals it's time to sleep - tricking the body into staying alert.

Add in stress, packed schedules, and around-the-clock stimulation, and it's no surprise that quality sleep feels harder to achieve.

**But the truth is simple:
we can't outwork biology.**

Sleep isn't wasted time. It's preparation.
It's repair. It's protection.

**And in a world that
rewards hustle,
choosing to rest
may be one of the
healthiest decisions
we can make.**

The Psychology of Love: More Than a Feeling

By Dr. Eden Fanta



THE SEASON THAT AMPLIFIES EMOTION

Every February 14th, the world becomes louder about love. Flowers are delivered. Messages are drafted and redrafted. Restaurants are booked weeks in advance. Social media timelines turn red. And yet, for something we celebrate so publicly, love remains deeply private—and surprisingly complex.

As medical trainees and professionals, we are taught to understand the heart anatomically. We learn its chambers, its conduction system, and the physiology of circulation. But rarely are we invited to explore what happens psychologically when someone says, “I think I’m in love.”



Is love simply an emotion?

Is it biology?

Is it attachment?

**Is it something layered:
part instinct, part memory, part
meaning?**

Psychology has been attempting to answer this question for decades.

THE CHEMISTRY OF ATTRACTION WHEN THE BRAIN LEADS

Early romantic attraction is measurable. Functional imaging studies demonstrate that romantic love activates dopaminergic pathways within the brain’s reward system. These same circuits are involved in motivation and reinforcement. This activation explains the heightened focus, intrusive thinking, and emotional intensity that often characterize early infatuation.

Oxytocin and vasopressin further support bonding and trust, facilitating pair attachment. From an evolutionary perspective, these mechanisms promote relational stability and cooperative survival. Love, at least initially, reflects coordinated neurobiological design.



Yet chemistry alone does not explain why some relationships feel stabilizing while others feel destabilizing. For that, we must consider attachment.

ATTACHMENT: WHY LOVE FEELS DIFFERENT FOR DIFFERENT PEOPLE

If early attraction is driven by chemistry, attachment explains why that chemistry feels different for each of us.

Two people may experience the same rush of dopamine, the same intrusive thoughts, the same longing — and yet one feels exhilarated while the other feels destabilized.

Why?

Because love does not enter an empty system. It enters a nervous system shaped long before this relationship began.

When psychologists refer to “early caregiving experiences,” they are not speaking abstractly. They are referring to the emotional climate of childhood.

Was comfort consistent?

Did someone reliably respond when you cried?

Were emotions welcomed — or minimized?

Did love feel steady, or did it feel unpredictable?

Long before we understood romance, we were learning what closeness meant.

Attachment theory, introduced by John Bowlby and later studied extensively by Mary Ainsworth, suggests that these early patterns form internal templates. These templates do not disappear when we fall in love. They activate.

And when they activate, chemistry meets memory.

Let me invite you to consider your own reactions in love — not as labels, but as patterns:

Do you feel generally secure when someone grows close to you?

If conflict arises, do you assume it can be repaired?

If so, your nervous system may have learned that connection is safe. This is often associated with secure attachment—typically shaped in environments where caregivers were emotionally available and consistent. Love, for you, likely feels grounding.

Or perhaps you notice something different.

Do you feel intense anxiety when responses are delayed?

Do you need reassurance to calm your fears of abandonment?

Does uncertainty amplify your emotional state?

This may reflect anxious attachment—often shaped in caregiving environments that were loving but inconsistent. The child learns to heighten emotional signals to secure attention. In adulthood, love can feel urgent, consuming, sometimes overwhelming. Affection soothes; distance alarms.

Or maybe your reaction moves in another direction.

Do you instinctively withdraw when closeness deepens?

Do you pride yourself on independence, sometimes to the point of emotional isolation?

Does vulnerability feel uncomfortable?

This pattern, often described as avoidant attachment, may develop when emotional needs were dismissed or discouraged in childhood. The adaptation becomes self-reliance. Love may feel constricting—not because affection is absent, but because dependence feels unsafe.

What is powerful about understanding attachment is this:

It reframes romantic struggle.

Instead of asking,
“Why am I too much?”
“Why am I distant?”
“Why is love so hard for me?”

We begin asking,

“What did my nervous system learn about safety?”

Attachment is not destiny; it is adaptation.

And when awareness enters, adaptation can change.

BEYOND INFATUATION THE ARCHITECTURE OF MATURE LOVE

Psychological models describe love as consisting of three components: passion, intimacy, and commitment.

Passion is not merely physical attraction. It is physiological activation—the racing heart, the anticipation, the desire to merge, the longing that feels almost urgent. It thrives on novelty and uncertainty.

Intimacy is emotional exposure. It is the willingness to be known—fears, weaknesses, contradictions included. Intimacy requires psychological safety. Without safety, vulnerability collapses.



When love includes only passion, it burns brightly but often briefly.

When it includes passion and intimacy but lacks commitment, it may feel deep yet unstable.

When commitment exists without intimacy, relationships may feel dutiful but emotionally distant.

- Mature love integrates all three.



It regulates rather than destabilizes.

It allows disagreement without threatening the entire bond.

It replaces constant activation with steady presence.

Not all intensity is depth.

Not all calmness is boredom.

Sometimes, calm is security.

LOVE AND THE SELF

Our sense of self does not begin fully formed.

In childhood, identity is reflected back to us through caregivers. We learn who we are based on how others respond to us. “You are capable.” “You are difficult.” “You are sensitive.” These messages become internal narratives.

As we grow, identity becomes more autonomous. We form personal values, ambitions, and boundaries. Then romantic love enters.

During early infatuation, something fascinating happens psychologically: the boundaries of self temporarily soften. The other person's preferences feel like our own. Their happiness feels indistinguishable from ours. Neuroscientific research even suggests overlapping neural representation of self and partner during early attachment.

For someone unfamiliar with the concept, it may feel like this:

You do not just love the person—you experience them as an extension of you.

This can be beautiful, but it can also be destabilizing if individuality dissolves completely.

Healthy integration means this:

You remain you.

They remain them.

And together, you form a "we" that does not erase either identity.

In healthy love, growth is mutual. Differences are tolerated. Personal goals are encouraged rather than sacrificed.

Love expands the self.

It does not require its collapse.

CONCLUSION UNDERSTANDING BEFORE IDEALIZING

Valentine's Day invites celebration, but psychology invites reflection. Love is biological, developmental, emotional, and cognitive. For those in medicine, understanding these mechanisms deepens empathy and contextualizes relational experience within scientific frameworks.

But beyond theory, there is something more hopeful.

Love is not simply something that happens to us. It is something we participate in.

We bring our histories, our nervous systems, our attachment patterns, and our evolving identities into every connection. And with awareness, we gain choice.

**We can choose to respond rather
than react?**

**To communicate rather than
withdraw?**

To grow rather than repeat?

Perhaps the most inspiring aspect of understanding love psychologically is this:

We are not prisoners of our early patterns. We are capable of secure love: not because we were perfectly taught, but because we are capable of reflection, intention, and change. That may be the most powerful form of love of all.



Billy Milligan

When One Crime Had Many Minds

By Dr. Ruby G.



In 1977, a young man stood before an Ohio courtroom accused of rape, kidnapping, and armed robbery—crimes grave enough to guarantee decades behind bars. Yet Billy Milligan would not go to prison. Instead, he would walk into history, becoming the first person in the United States to be acquitted of serious crimes solely on the basis of a psychiatric diagnosis. His case forced an unsettling question onto the legal system and society at large: *What happens when one body houses many minds?*



Billy Milligan did not deny that the crimes occurred. What he denied—through his lawyers and psychiatrists—was that he committed them. According to psychiatric evaluations, Milligan suffered from what was then called Multiple Personality Disorder, now known as Dissociative Identity Disorder (DID). Within him, doctors claimed, lived twenty-four distinct personalities, each with its own voice, memories, mannerisms, and even physical traits. Some were gentle, some were frightened children, and at least one—named Ragen—was violent, aggressive, and allegedly responsible for the crimes.

This diagnosis transformed the courtroom into something closer to a psychiatric ward.

Psychiatrists testified that Milligan’s personalities took turns controlling his behavior, a process known as “switching.” The dominant personality, Arthur, was described as intellectual and morally rigid, while Allen handled social interactions. Billy himself—the core personality—was said to be unaware of what happened when others were “out.” In this framework, the prosecution’s argument began to fracture.



How could intent, guilt, or responsibility be assigned when the accused was not a single, unified self? The court ultimately accepted the defense’s argument. Milligan was found

“not guilty by reason of insanity”

and committed to a psychiatric hospital rather than prison. The decision sent shockwaves through the legal world.

To many, justice had failed. To others, justice had evolved. Public reaction was swift and unforgiving. Critics argued that the ruling opened the door for criminals to escape punishment by claiming fractured identities. Victims felt erased by a system that appeared to prioritize a diagnosis over their trauma. Even within psychiatry, the case ignited fierce debate.

Some experts believed Milligan's condition was genuine, shaped by severe childhood abuse. Others suspected malingering or unconscious exaggeration, possibly reinforced by therapeutic suggestion. The diagnosis itself came under scrutiny—was Dissociative Identity Disorder a real and distinct illness, or a dramatic construct shaped by culture and clinicians?

**... the fault line
between
medical truth
and moral
responsibility.**

What made the Milligan case uniquely troubling was that it sat at the fault line between medical truth and moral responsibility. Psychiatry could describe why a person acted, but the law demanded an answer to who acted. The legal system, built on the assumption of a singular, rational actor, was suddenly confronted with a mind that did not fit neatly into its categories. Over time, the legacy of Billy Milligan reshaped both fields. Courts grew more cautious, demanding stricter standards for insanity defenses and placing less emphasis on diagnostic labels alone. Modern legal evaluations focus less on how many personalities exist and more on whether the defendant could understand the wrongfulness of their actions or control their behavior.

In psychiatry, the case fueled more rigorous debate and research into trauma, dissociation, and the limits of diagnosis. Billy Milligan was eventually released after years in psychiatric institutions. He lived the rest of his life largely outside the public eye, but his case never faded. It remains a reference point in textbooks, courtrooms, and ethical discussions—a reminder that the human mind does not always obey the structures we build to judge it.

In the end, the Milligan case was never just about one man. It was about the uneasy intersection of science and law, compassion and accountability. It asked a question that still has no comfortable answer: when a crime is committed by a fractured mind, where does responsibility truly lie—in the body, the brain, or the society that must decide what justice means?



Kangaroo Mother Care From the “Poor Man’s Alternative” to Global Standard

By Lidiya Atnafu



KANGAROO MOTHER CARE - KMC

The year was 1978. Inside the walls of the Instituto Materno Infantil in Bogota, Colombia, the neonatal unit was facing a catastrophic crisis. The hospital suffered from a severe shortage of functioning incubators, extreme overcrowding (sometimes three babies to one incubator), and a staggering neonatal mortality rate of nearly 70%. Most babies were dying from cross-infections and abandonment.

Dr. Edgar Rey Sanabria, a professor of neonatology, proposed a solution that seemed backward to many of his peers. Inspired by how marsupials like kangaroos raise their underdeveloped young in a pouch, he suggested that mothers could serve as human incubators. He encouraged mothers to keep their low-birth-weight infants tied to their chests 24 hours a day. The results were immediate and staggering:

- Mortality rates plummeted.
- Infection rates dropped because babies were no longer sharing incubators.
- Abandonment decreased because mothers bonded deeply with their infants from day one.

Initially, the medical community in wealthier nations dismissed KMC as a "third-world solution" for countries that couldn't afford technology. However, when researchers began studying the Bogota babies, they found they were often healthier and more neurologically advanced than babies raised in high-tech incubators. Kangaroo Mother Care (KMC) is no longer just an alternative for resource-limited settings. It is the gold standard of care for every fragile infant.

By the late 1990s, the Kangaroo Mother Care International Network was formed, and the WHO released its first formal training manual in 2003. Previously, doctors waited for a baby to be "stable" before starting KMC. However, the 2023 WHO guidelines now recommend Immediate KMC.

“Kangaroo Mother Care should be initiated immediately after birth, even before the baby is considered stable, for all preterm or low-birth-weight infants.”

WHAT EXACTLY IS KMC?

The WHO has defined KMC as early, continuous, and prolonged skin-to-skin contact (SSC) between the mother and preterm babies; exclusive breastfeeding or breast milk feeding; early discharge after hospital initiated KMC with continuation at home; and adequate support and follow-up for mothers at home. KMC is a comprehensive intervention based on three inseparable pillars:

01

SKIN-TO-SKIN CONTACT

A mother's chest is thermally synchronized with her baby. Through a process called thermal synchrony, if the baby's temperature drops, the mother's breast temperature increases to warm the infant.

This is significantly more efficient than a mechanical incubator at preventing neonatal cold stress.

- For the Baby: Oxytocin reduces pain sensitivity (crucial for infants undergoing frequent blood draws) and stimulates the vagus nerve, improving digestion and nutrient absorption.
- For the Mother: It promotes milk "let-down" and reduces the risk of postpartum depression by lowering systemic cortisol levels.

In an incubator, a baby is colonized by hospital-acquired, often antibiotic-resistant bacteria. In KMC, the baby is colonized by the mother's skin flora. This friendly bacteria, combined with the antibodies in breastmilk, creates a powerful defense against sepsis, the leading killer of preterm infants.

02

EXCLUSIVE BREASTFEEDING

Studies have revealed that KMC results in increased breastfeeding rates as well as increased duration of breastfeeding.

03

EARLY DISCHARGE AND FOLLOW-UP

KMC cared LBW infants could be discharged from the hospital earlier than the conventionally managed babies. The babies gained more weight on KMC than on conventional care.

HOW CAN YOU PROVIDE A SUCCESSFUL KMC?

KMC can be provided by mothers, fathers and other adult family members.

Effective counseling- Effective KMC initiation relies on empathetic, family-inclusive counseling to build the mother's confidence and overcome socio-cultural barriers. By demonstrating techniques and encouraging peer support, providers ensure a smooth transition from hospital to home-based care.

KMC Positioning- The baby should be placed between the mother's breasts in an upright position. The head should be turned to one side, slightly extended to keep the airway open. The hips should be abducted in a frog position with arms flexed. The baby's abdomen at the mother's epigastrium and the baby's bottom is supported.

The Clothing: The baby should wear only a diaper and a cap. The mother should wear a front-opening shirt or a specialized KMC wrap to maximize skin contact.

The Duration: Aim for continuous, 24hr skin to skin contact or at least 8-24hrs per day. The infants in KMC need to be removed from skin-to-skin contact only for changing diapers and clinical assessment according to hospital schedules.

When the mother needs to bathe or eat, the father or a family member should take over. This ensures the baby never loses that vital heat source.

Feeding during KMC- The mother should be explained how to breastfeed while the baby is in KMC position. Holding the baby near the breast stimulates milk production.

Privacy- This should be maintained to avoid unnecessary exposure on the part of the mother which makes her nervous and uncomfortable.

Monitoring- Should be done checking the neck position, clear airway, regular breathing, color and temperature of skin, hands and feet for warmth. A mother should be trained to observe her baby for danger signs, like hypothermia, respiratory problems, feeding difficulty, change in color during KMC so that she herself can continue monitoring at home. KMC is now part of the Sustainable Development Goals (SDGs) aimed at reducing neonatal mortality to at least 12 per 1,000 live births by 2030.

WHEN SHOULD KMC BE DISCONTINUED?

When the mother and baby are comfortable, KMC is continued for as long as possible, at the institution and then at home. Often this is desirable until the baby's gestation reaches term or the weight is around 2500 g. She/he starts wriggling to show that she is uncomfortable, pulls her limbs out, cries and fusses every time the mother tries to put her back skin to skin. This is the time to wean the baby from KMC. Mothers can provide skin to skin contact occasionally after giving the baby a bath and during cold nights

KANGAROO FATHER CARE

While the name KMC implies mothers, the benefits extend to fathers and other family members. Kangaroo Father Care helps the father bond deeply with the infant and provides the mother with necessary breaks to sleep and eat. It reduces paternal postpartum anxiety and creates a family centered healing environment.

If KMC were implemented universally, we could save an estimated 450,000 lives every year. In an era of genomic medicine and robotic surgery, Kangaroo Mother Care reminds us that the most potent drug in the neonatal ward is human contact. It is a therapy that costs nothing but provides everything- warmth, safety, nutrition, and love for the little ones.



The Cut that February Refuses Each Year

Dr. Maramawit

Some dates pass quietly. Others demand that the world remember—and February 6 is one of those days. It was a bright Friday morning in 2026. Life was continuing as usual, and I was scrolling through my phone for news feeds and updates to begin my day. Suddenly, my eyes fell upon a poem written in 1988 by Somali poet Dahabo Musa titled "*The Three Feminine Sorrows*." The words were so intense that I couldn't move on without reading further.

They were all about three defining pains in the life of a woman subjected to one traditional act what comes naturally to her. Three torturous sufferings at different phases of her life: the day she is cut while still too young to defend herself; her wedding night, when the scar is forced open; and childbirth, when the same wound must yield again. Beyond this painful cycle, the wound is often stitched tightly after delivery—a practice known as reinfibulation—and the cycle resumes with each pregnancy and delivery, causing the sorrow to repeat across the milestones of her life. Reading her poem was not simply a literary experience; it was an awakening to a reality that millions of women still endure. It left me shocked and eager to learn more—to understand what could bring about such suffering. At the heart of these sufferings lies the cut that February refuses each year: Female Genital Mutilation.

According to the World Health Organization (WHO), female genital mutilation includes all procedures that involve the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. Although its exact origins remain unclear, historical accounts trace it back thousands of years, even in ancient civilizations. Over centuries, it has been justified through cultural narratives that frame it as a

safeguard of virginity, a marker of beauty, a religious obligation, or a sign of purity and fidelity. Yet no major religious scripture mandates it. Neither the Bible nor the Quran prescribes such a practice, and religious authorities across regions have increasingly spoken against it. Today, FGM is widely recognized as a violation of human rights and a manifestation of deeply rooted gender inequality — a cultural attempt to control a woman's right to full health and her decision over her own body.

“Three torturous sufferings... the day she is cut while still too young to defend herself; her wedding night, when the scar is forced open; and childbirth, when the same wound must yield again.”
— Dahabo Musa, Poet



THE REALITY OF THE PROCEDURE

The reality of the procedure is difficult to imagine unless one confronts it honestly. Usually performed by traditional cutters, elderly women, or a male barber in communities where barbers serve as traditional healers, the practice often takes place in the girl's home, without anesthesia and without sterile instruments.

The child may be forced to squat on a stool or mat, restrained by others, while the cutting is performed quickly. If the amount of tissue removed is considered insufficient, the cut may be repeated. She may scream, struggle, and bleed profusely — all done for no health purpose, but only for the promise of social acceptance, to be called pure, beautiful, or worthy of marriage, not under her consent but the mistaken assumption of love and protection from her family.

The wound is then stitched closed, leaving only a small opening for urine and menstrual blood to pass. Her legs may be tightly bound from hip to ankle for two to six weeks so that the tissue will fuse together.

She may scream, struggle, and bleed profusely — all done for no health purpose, but only for the promise of social acceptance.

IMMEDIATE & CHRONIC TOLL

What is promised as honor often leaves behind only pain — physical, psychological, and deeply personal — accompanied by serious complications.

Some begin immediately. Severe bleeding, intense pain lasting for days, infection that can lead to sepsis, difficulty passing urine, wound breakdown, shock, and even death may occur. The long-term consequences are equally devastating.

Women may suffer from chronic pelvic pain, slow urinary stream, repeated urinary tract infections, infertility due to scarring and narrowing of the vaginal opening, painful intercourse, and sexual dysfunction. Obstetric complications are particularly concerning.

Women with severe forms of FGM are at increased risk of obstructed labor, prolonged second stage of labor, cesarean delivery, postpartum hemorrhage, need for newborn resuscitation, and higher rates of stillbirth. Shared cutting instruments may also increase the risk of HIV and hepatitis transmission. The burden is not only physical but emotional and social. A girl once taught to see the practice as a symbol of beauty may later, especially when exposed to other cultural perspectives—particularly when living abroad—experience confusion, grief, or feelings of betrayal.

A GLOBAL CRISIS

FGM is not confined to one continent. It is a global health issue and a universal human rights concern. According to UNICEF, more than 230 million girls and women alive today have undergone FGM, and approximately 4 million girls remain at risk every year, particularly in 30 high-prevalence countries. Migration has carried its consequences across borders, meaning survivors now live in nearly every country, including high-income nations.

COUNTRY	PREVALENCE REDUCTION (AGES 15-49)
Sierra Leone	~ 50% Reduction
Ethiopia	~ 30% Reduction
Burkina Faso	~ 30% Reduction

PROGRESS AND THE PERIL OF MEDICALIZATION

The practice has been addressed in international treaties and national legislation, and measurable progress has been documented. Reports from the United Nations Development Programme (UNDP) and other UN bodies show significant reductions in prevalence among younger generations in several countries over the past three decades. For example, Sierra Leone, Ethiopia, and Burkina Faso have demonstrated that progress is possible, with estimated reductions in prevalence among women aged 15–49 of approximately 50%, 30%, and 30%, respectively. A girl today is considerably less likely to undergo FGM than she was in 1990. Yet the challenge remains persistent, and millions continue to face the risk.

An emerging concern is the medicalization of FGM in some countries—the performance of the procedure by healthcare providers in clinical settings under the false belief that this makes it safer. The World Health Organization and multiple UN agencies have clearly stated since 2008 that medicalization does not eliminate harm and violates medical ethics. Performing FGM under any circumstance is incompatible with the principles of "do no harm." Reinfibulation (narrowing the vaginal opening again through resuturing or tightening the FGM scar), typically after childbirth, is similarly condemned and, in many countries, illegal.

CLINICAL CARE AND SURGICAL REVERSAL

While prevention remains central, care for survivors is equally urgent. In 2016, the World Health Organization issued guidelines for the management of health complications from FGM, emphasizing the importance of respectful, evidence-based care.

Women with Type III FGM may benefit from a minor surgical procedure called deinfibulation, performed under anesthesia to open the scar and restore the natural anatomy of the vaginal opening.

Evidence summarized in WHO guidelines suggests that deinfibulation reduces cesarean section rates and postpartum hemorrhage and improves overall obstetric outcomes. It may be performed before marriage, before pregnancy, during the second trimester, or during labor, depending on clinical context and the woman's preference. Importantly, deinfibulation does not affect fetal growth but can reduce complications associated with obstructed labor and stillbirth.

The timing of deinfibulation should be individualized, taking into account contextual factors such as access to timely obstetric care, anticipated anatomical challenges during labor—including tissue edema or distortion—and the woman's informed preference

Antepartum deinfibulation, often performed during the second trimester, allows adequate healing before labor begins, provides better anatomical conditions, reduces technical difficulty during delivery, and may offer more optimal functional and aesthetic outcomes, particularly in settings where access to emergency obstetric care is limited.

Intrapartum deinfibulation, performed at the time of delivery, can also be effective, with evidence showing no significant differences in labor duration, perineal injury, or postpartum hemorrhage when carried out appropriately.

Regardless of timing, informed consent and thorough counseling are essential. Women should receive unbiased information about the procedure's risks and benefits, expected changes, and warning signs such as fever, foul-smelling discharge, heavy bleeding, or wound reopening.

THE PATHWAY TO HOLISTIC RECOVERY

Postoperative care includes maintaining hygiene, sitz baths, temporary abstinence from intercourse for one month, pain management as needed, and follow-up visits. Beyond surgical care, psychological support and sexual counseling are vital components of holistic recovery.

Research into long-term outcomes and comprehensive post-FGM care remains limited. Stronger collaboration among academic institutions, healthcare professionals, policymakers, and communities is needed to expand the evidence base and improve survivor-centered services. As highlighted in global campaigns for zero tolerance and WHO's updated recommendations against medicalized FGM, elimination efforts must continue while ensuring compassionate care for the millions already affected.

6 FEBRUARY

February 6 is not merely symbolic. It is a reminder of a girl who did not consent, a woman who labors with a scar she never chose. It is about a survivor who carries both silence and strength. Ending Female Genital Mutilation is not only about changing laws; it is about transforming beliefs, supporting communities, empowering girls, and upholding every woman's right to bodily autonomy, dignity, and full health. Zero tolerance is not just a slogan. It is an ethical obligation.

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