

# AMREF News

Issue No. 1

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## Ebola International scare local nightmare

As you drive into Gulu, life seems so normal that it is impossible to understand the fear the rest of Uganda, and indeed the rest of East Africa, seems to have at the mention of Gulu



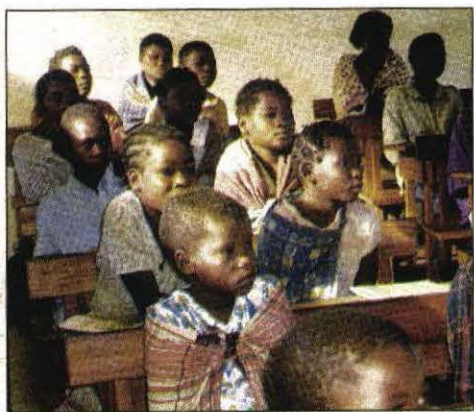
A burial team lowers the casket of the late Dr Mathew Lukwiya, the Medical Superintendent at St Mary's Lacor Hospital in Gulu who contracted the disease as he treated Ebola patients.

The people of Gulu, northern Uganda, go about their daily life as if oblivious of the fact that they are in the centre of an international health crisis that has claimed 173 lives and affected thousands of families. By the roadside, people chew sugar cane as they walk, others ride their bicycles and the occasional moped. Roadside cafes and markets sell food as is normal in most rural townships in Africa.

However, all is not right in Gulu. Ebola, the devastating viral disease has left behind a path of death, orphans, poverty, 'untouchables' and a lot of misery in the area. People no longer shake hands, go to church or funerals. A whole community is in great fear of this disease.

The death of Mathew Lukwiya, the Medical Superintendent at St Mary's hospital in Lacor, Gulu, sent shock waves

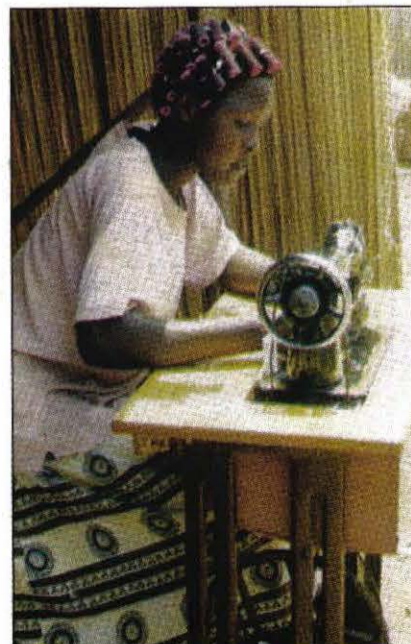
C o n t i n u



Boys and girls in Mozambique struggle with adolescent pressures

• Pg 11

"I HAVE  
HEARD OF  
CONDOMS,  
BUT..."



Commercial  
sex workers

How AMREF is helping young women off the streets of Kampala

• Pg 8 and 9

## Letter from Africa

I come out of the theatre and notice everyone is acting as though life is "normal". People are sitting around talking, laughing and drinking tea as though nothing has happened. Me... well I am in shock.

Only metres from all this "normality", I have just witnessed my first live operation and no amount of watching "E.R" or "General Hospital" on television has prepared me. In the room back there they are grappling with life and death — out here they're drinking tea.

I am in Kagando Hospital, a stunningly beautiful spot on the borders of Uganda and The Congo. The hospital overlooks the mythical "Mountains of the Moon", the Ruwenzori mountains. I am dressed up in green surgical robes with white surgical boots. I look the part right down to the facemask, but I do wonder about how sterile I really am. The boots are splashed with some blue antiseptic but there is some chocolate sauce on the front of this gown. Or something... I won't think about it. Whatever, it is not quite "Dr Kildare".

I am here to watch Dr Marlene Long, one of the AMREF outreach surgeons perform a cleft palate operation on a boy, Peter, seven years old. Peter's mouth is so deformed that the brace used to assist in the operation won't fit. "We'll just have to make do," says Marlene.

Adrenaline is normally used to stem the flow of blood. But for some reason this batch of Adrenaline is not right and the blood loss is

extreme. Surprising myself, I don't faint or feel sick. Rather I am fascinated by the procedure. I am filled with admiration at the skill shown. But most of all I am filled with a transferred fear, a fear of how much this will hurt poor Peter in the morning. I find myself feeling the top of my palate with my tongue. I need to check that everything is O.K. It's fear. I worry about pain.

Peter is lucky the hospital has just got new supplies of morphine. Often in this hospital the only pain killers available is aspirin or paracetamol. I think of my last dentist visit, a minor, but in my mind, very painful experience. The thought of going through that with only an aspirin is bad enough. The thought of having my face go through what Peter's is undergoing has me checking the roof of my mouth once again.

The operation lasts for over three hours. Marlene is unable to complete the whole procedure. Peter has lost too much blood and been under anaesthesia for too long. It is too dangerous to go on. Peter will need more surgery in a few months. I hope that they have painkillers then too.

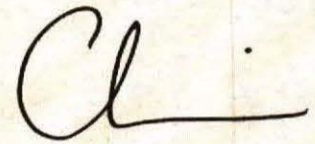
Peter is one of the nine patients Marlene will operate on over two days. All are reconstructive surgery cases. In each operation the training role for the local doctors is just as important as the help given to the individual patient. Local doctors learn techniques and procedures from Marlene, which mean that in future they will be able to perform the same operations without

AMREF assistance.

Peter has travelled a long way to get the operation. It is important to him and to his parents that he looks 'normal'. People can be very unforgiving about the unusual. For the victim it can be hateful. Peter has been bullied in school because of the way he looks.

There are many like Peter and local doctors need training in how to perform this simple but life-changing procedure. I realise suddenly that it is not AMREF but Peter who is the star of this story. Without him Marlene could not teach. Without him the doctors would not learn and many more others would not be helped. Of course he is benefiting but it is he and not AMREF who had their mouth taken apart and put back together again. It is he who will feel like he was hit by a bus in the morning.

Not even Marlene (who will operate on two more patients that day and only finish working at three in the morning) will sacrifice as much as Peter. In fact she comes out of the theatre laughing and joking with one of her students. She merely needs a cup of tea. For her too, it has been a "normal" day.



Chris Williams is the AMREF Director of Fundraising and Communication



AMREF News is the quarterly newsletter of the African Medical and Research Foundation (AMREF).

AMREF is an international health care NGO whose mission is to empower disadvantaged people in Africa to enjoy better health. AMREF is headquartered in Kenya, and has country offices in Tanzania, Uganda, South Africa and Kenya. There are field offices in Mozambique, Ethiopia, southern Sudan and Somalia. AMREF also has fundraising offices in Europe and North America.

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## Ebola in Gulu, Uganda

in the country, and immensely affected already demoralized health workers. The Minister of Health, Crispus Kiyonga, described Mathew Lukwiya, as "a giant in this episode". The feeling among most people in Gulu was that the death of Dr Lukwiya was equivalent to losing a key commander in a war - the war against Ebola - which often requires rallying of troops. And rallying the troops is what the Minister had come to do, besides attending Lukwiya's hurried burial on the grounds of the mission hospital.

Lukwiya was the fourteenth medical worker and the 156th person to die of Ebola since it broke out in September. A total of 22 health workers have caught the disease from their patients.

The Uganda Ministry of Health launched an appeal to medical workers from other parts of the country to volunteer for training and deployment in Gulu and Masindi to help in the management of Ebola patients.

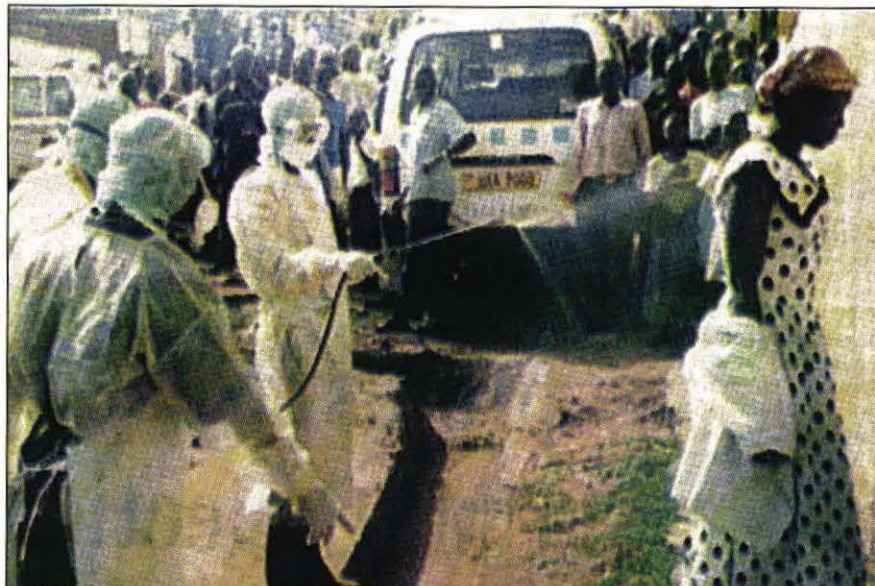
"Ebola is a very intense condition which needs 100 per cent

concentration. To remain alert for three hours is very difficult. We should get support from outside the district so that the nurses work for only four hours instead of eight", said the minister.

The minister promised that higher institutions would strengthen their support to health workers in Gulu through continued provision of protective wear and other supplies, logistics such as transport and national mobilisation of other health workers to come to Gulu to support their colleagues.

Dr Alex Opio, assistant commissioner in charge of national disease control, said even though the situation was now under control, people could still catch Ebola from contact with patients or dead bodies.

Since the Ebola outbreak in Uganda, 286 people have been discharged and are recovering. Many others have been contacts and have been declared free of the virus after the mandatory 21 days of follow-up by community monitors. The disease has left behind orphans, widows, widowers and 'untouchables'. Below are the stories of people in Gulu who survived the deadly virus, or lost relatives from the disease.



Ebola scouts attached to Gulu hospital spray an Ebola suspect

More stories on pg3,4 and 5



*Ebola orphans who were evicted from their hut following the death of their mother, now under the care of their unemployed brother and sister.*

# Ebola survivors and victims tell their stories

## Josephine Apoko, an Ebola survivor

Josephine Apoko is a 40-year-old trained traditional birth attendant at Koro Lajwatek, in the outskirts of Gulu town. When her daughter-in-law was due to deliver, Josephine escorted her to Gulu Hospital, as is recommended for all first births. The young woman had a normal delivery, but soon started ailing. She started bleeding, vomiting, had diarrhoea and a very high fever. When her condition worsened Josephine decided to take her home. She died the next day. As arrangements for her burial were going on, the baby girl developed a very high fever and three days later she too died at Lacor Hospital where she was on IV transfusion. By this time two health workers had died from what now everyone knew to be Ebola. Josephine realised that her daughter-in-law and granddaughter must have died from the same disease. Three days following the death of the baby, Josephine herself developed a high fever, headache and joint pains.

"I was sure I was going to die. My daughter-in-law and my granddaughter had died from the disease and I knew for me it was a matter of time. I did not even want to waste time and money going to the hospital and my



*Josephine Apoko, an Ebola survivor whose daughter-in-law and granddaughter died from the disease*

husband and my son took time to convince me".

Her son took her to Gulu hospital. She was admitted into the medical ward where she was initially treated for malaria. A week later it was realised she had Ebola, and not malaria. She was transferred to the Ebola ward where she was to remain for three weeks. In this ward people died each day, and this made it even more certain to Josephine that she too would die.

"I must have been unconscious, and when I came to there were some white doctors round my bed. They called me, 'Apoko, Apoko,' and I answered. They then asked me to count up to five on both hands, and one asked me what is five plus five. When I answered their questions they continued talking amongst themselves.

"I was soon transferred to the conversion ward, and the white doctors kept coming and talking to us about the disease and what they were doing to treat us.

"They joked with me a lot, saying they would take me to America. But I told them now that I had survived I would stay with my children".

This mother of eight went home three weeks after, very weak but with a certificate that stated she was free of Ebola.

"For the first two weeks I could not even sit up. I hardly recognised people, not even by their voices, and I had to be supported to get out of bed. I have also lost sense of taste and I cannot tell you what food is what. I



*Harriet Achan with her brother*

was supposed to go back to the hospital for a check up one week after? but I have not done this. My sons say the bicycle is not in good condition and there is no other means of transport. I buy panadol for my severe chest pain". From her tone, Josephine knows why her sons don't fix the bicycle - fear.

At the hospital Josephine was advised to eat well, which she understands to mean eating beans, fruits and vegetables besides the standard Acholi diet of sweet potatoes, silver fish and eggplant. But money is a constraint.

"When my daughter-in-law and her child died, we did not know it was Ebola. So we had a big funeral, as is normal here, and we spent a lot of money on the 100 or so relatives who came for the burial. This

and my having the disease has affected our family a lot."

Josephine would really like to go back to Gulu hospital for her appointment.

"I am not afraid of the hospital. It was in that hospital that I got treated," she says.

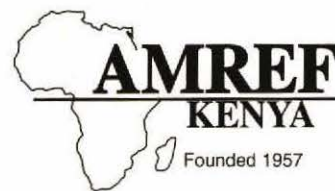
## Harriet Achan: I lost my mother

Harriet Achan is barely 14 years and she really misses her mother. She is especially worried about the future of her and her three brothers' education now that her mother, who was the breadwinner, is dead. Harriet's mother, 38-year-old Beatrice Atera, died after caring for her mother, whom the hospital had mistakenly declared free of Ebola.

"My mother was a fish monger at the Gulu market. She had also built these nine rental huts and she supported the family because my father is unemployed," explains the shy Harriet in halting English.

As far as Harriet knows an uncle came from Kampala, capital city of Uganda, sick with tuberculosis and was admitted at Lacor hospital. Her grandmother went to the hospital to take care of him. When the grandmother started ailing she was tested for the virus, and when her test was negative Harriet's mother brought her to her home. Since the grandmother was weak Harriet's mother slept in the same hut with her.

"One night my mother-in-law tried to get out to go to the latrine, and she fell. Beatrice lifted her and supported her to the latrine. We suspect this is how she got the virus. Soon afterwards my mother-in-law



## Pan African Training of Facilitators (TOF) Course Year 2001

As primary health care has continued to take root in Africa, AMREF has been in the forefront in training PHC managers and trainers of community based health care workers. The training of trainers course is designed to strengthen the capability of managers of PHC/CBHC programmes. Course participants also visit CBHC projects for practical sessions and learning experiences.

The four-week training covers:

- Health and development concepts
- Project management
- Training and learning methods
- Contemporary challenges in community based development and sharing of some of the proven and documented best practices.

The course is coordinated by AMREF CBHC Support Office and facilitated by highly qualified and experienced trainers.

### Course Fee

Residents: Ksh 60,000 per person  
Non-residents (includes Kenyans working abroad): US\$ 2,000 per person

The cost includes tuition, full board accommodation, training materials, field visits and workshop report. Course participants must meet their medical care, travel and other personal expenses.

Training is always held away from the City Centre in conducive learning environments (preferably a training institution). Venue is always confirmed one month before the training.

### Training Calendar Year 2001

26th Pan African TOF: 4-31 March 2001  
27th Pan African TOF: 3-30 June 2001  
28th Pan African TOF: 2-29 September 2001

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was taken back to hospital where Ebola was confirmed. She died after a few days," explained Harriet's father, 42-year-old Benson Lamtoo, now widowed.

During her mother's hospitalisation Beatrice did not take care of her and therefore did not suspect she had contracted Ebola. After her mother's burial she went back to selling fish at the market. She fell sick while at the market, was taken to Gulu Hospital and died soon after.

"When my mother-in-law stayed with us, the children and I did not have any contact with her, and we have all lived through the 21 days health workers said are necessary before we can be declared safe from Ebola".

Harriet is however not happy with this 21-day Ebola 'pass'.

"My mother is dead and it is going to be very hard for us", she says.

It has been hard since her burial, especially since almost all the tenants moved out, cutting down the family's income.

"The tenants seemed to think that the virus would escape from my wife's grave, and they moved out", explains Benson.



Far left, Minister of Health Crispus Kiyonga, with Dr Lukwiya's wife and children during his burial in Gulu

**"Untouchable" Ebola orphans**

Gift Oyela is 12 years old. Before the Ebola outbreak she was an ordinary class six schoolgirl at the Gulu Public School. She lived in a single room at Peche with her mother, Alice Alek, and three younger brothers. When Gift's auntie Grace fell sick

Alice went to take care of her, and caught Ebola. Both sisters are now dead. Gift and her brothers aged 11, six and five years, are now orphans, and none of her mother's immediate family is willing to take care of them. They have remained in the rented single room, under the care of Dorine Anyom, the landlady.

"We are still hoping some relative will come and take us away, otherwise I do not know how we will survive", says Gift.

On her part Mrs Anyom says she cannot blame the children for what happened, but she cannot promise to take care of them.

"I do not know what to do. Good Samaritans have been making

contributions towards rent and food but this is not enough. These children need to be taken to the village, but their mother's family needs to make that decision. So far none of them has been here since Alice was buried".

Gift would like to continue with her education, and train to be a nurse.

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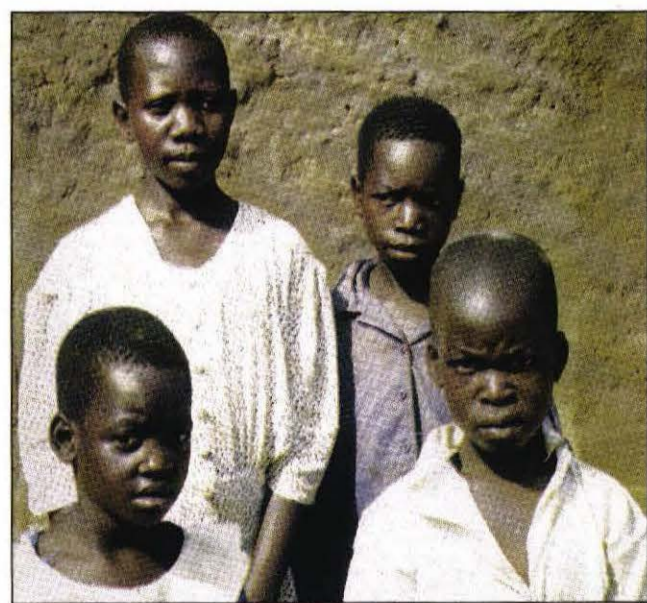
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# AMREF spearheads fight against Ebola

When Ebola broke out early October, it was simply referred to as a 'mysterious disease'. Within a few days many NGO workers fled Gulu in fear. Soon samples sent to South Africa confirmed the worst: the mysterious disease was the highly contagious Ebola.

"Containment of the disease was paramount. A district task force and a technical committee were set up immediately. AMREF sits on both of these. The containment strategy addressed community mobilisation, case management, surveillance, logistics, supplies and coordination. With our primary health care orientation, AMREF took responsibility for mobilising communities and has been leading in training hundreds of health workers and local leaders in and around Gulu Municipality. Members of the health sub-district committee were also trained and they went on to train other health workers outside the municipality", says Dr Ernest Munaaba, the AMREF Gulu PHC project manager whose water and sanitation activities had to be put on hold.

AMREF also trained about 50 religious leaders. These have a ready audience every



Gift Oyela with her three brothers still live in their rented room after their mother died. No relative had come forward to claim them.

week. There were requests for training from the judiciary and the police, and some people came with their spouses.

Training focused on prevention, what to do with a suspected Ebola patient, procedures for handling the dead, household hygiene, and demonstration of how to use Jik, a disinfectant, or protective clothing.

"We used the media a lot. The committee developed a video in a question - and - answer format. Speakers were on radio answering similar questions and others that the public was anxious about," Dr Munaaba adds.

"As members of the two committees we get to know the urgent requirements and provide

what we can. For example when there was a shortage of protective wear and intravenous fluids, AMREF was able to acquire these quickly," says Dr Munaaba.

AMREF also supervised the mobile teams, ensuring that the volunteer scouts went from house to house, finding possible Ebola patients and bringing them to hospital, as well as visiting the Ebola contacts each day for the mandatory 21-day period before these were declared free of the disease.

Dr Munaaba regrets initial miscommunication that has resulted into discrimination against Ebola survivors and relatives of Ebola victims. And this is where now the mobile teams are now concentrating - getting the message right and making re-integration less traumatic.

"Over-emphasis on how to avoid transmission resulted into some health workers advising family members to burn all clothing and bedding that had been used by a survivor or a victim. In other cases as soon as a person was taken away in an ambulance, all their personal belongings, including their huts, went up in smoke. When survivors came back, family and relatives were afraid of them. The community therefore rejected these people, and they were ostracised - they could not leave their huts, cannot use communal water sources, or even buy food, as their money was also rejected.

Also discriminated against were people whose close relative had died of Ebola.

All the Ebola dead are buried in a public cemetery, and by a hospital burial team. Relatives are not involved. This is contrary to local culture, where people normally want to touch the dead, wash and oil the body, dress it, close their mouth and eyes and bury them as near their house as possible. Yet at death the viral load is at its highest, and therefore handling the very sick or touching the dead is a sure way of contracting the disease.

However community sensitisation helped a great deal and reduced panic in the community.

The death of 22 health workers, including the doctor who was in charge of case management, was demoralising to staff and alarming to the population.

"Barrier nursing is not routine - it is possible to make a mistake when overworked and under stress, and one small mistake is equivalent to death. Most of the health workers in Gulu were working six-hour shifts and under such circumstances it is

hard to maintain a rigorous procedure. In addition, all workers in a hospital, and not just those working in the isolation ward, should be trained in barrier nursing," says Dr Munaaba.

William Odur, a nursing officer in Gulu, and also the chairperson of the Gulu CBHC association, worked closely with the Ebola mobile teams of local volunteers whose daily routine was to visit homes, find out if there are any people with signs of the disease, and visits survivors and contacts.

"We advised them on how the disease is spread. We especially made them understand the need to stay in their homes within those 21 days because should they move to another town or village before they are declared free of the disease, they would spread it even further. Majority of contacts remained healthy, and the

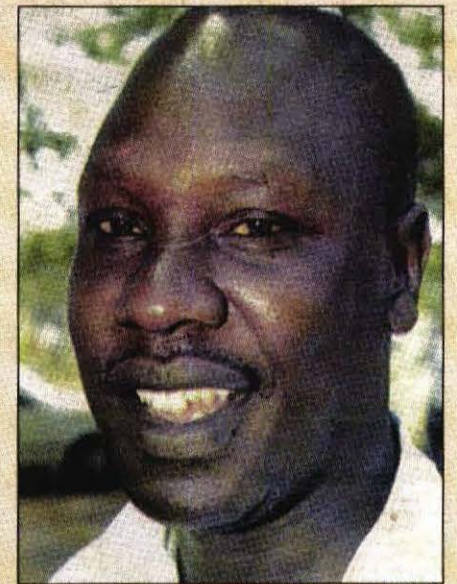
## Mathew Lukwiya, the Gulu Ebola martyr

"Dear God, we ask you to stop this scourge sooner or later. We suggest that it be sooner, not later". Amidst loud wailing, these were the words of anguish from a speaker at the St Mary's Hospital, Lacor, Gulu, where hundreds of health workers, missionaries and high ranking Ministry of Health officials from Kampala, including Minister Cripus Kiyonga, gathered briefly before Dr Mathew Lukwiya was buried in an equally hurried ceremony on the hospital grounds. His wife Margaret, his five children and his mother listened as the Minister appealed to the other health workers to honour Dr Lukwiya by "making sure we achieve what he wanted to achieve - the elimination for Ebola from Gulu."

It was Dr Lukwiya who first reported that he suspected the "strange illness" that people in Gulu were coming to hospital with was Ebola. After tests confirmed his suspicions, he worked tirelessly to treat those infected. When nurses died after contracting the disease from their patients, other health workers went on strike, demanding better working conditions and compensation. Dr Lukwiya did not join the strike, and instead put in more hours as he tried to boost the morale of those working alongside him.

Mathew Lukwiya has been hailed as a rare breed of African professional. With his postgraduate qualifications from Liverpool Institute of Tropical Hygiene and, just before his death, another postgraduate qualification from Makerere Institute of Public Health, Dr Lukwiya could have had his pick of international jobs. But he always worked in Lacor, ever since graduating from Makerere in 1984.

Following his death, most radio



Mathew Lukwiya

stations in Kampala played Elton John's Candle in the Wind, the song dedicated to Princess Diana after her death. The whole of Uganda was devastated by his death.

But as sweet-smelling wreaths were laid on his grave, his wife Margaret prayed not just for her husband's soul but for peace and the unity of the Acholi people. Gulu is a war-torn region where thousands of people live in camps, displaced by the Lords Resistance Army rebels who have inflicted untold suffering on the local community as they fight the government. Gulu's economic potential through agriculture is immense, but it remains one of the poorest regions in Uganda, thanks to rebel activities. One can only hope that the postgraduate scholarships offered in Dr Lukwiya's honour by the Italian government, Makerere University and the US Centres for Disease Control will produce more health care professionals who will emulate the dedication he showed in his selfless service to the people of Gulu.

few who developed symptoms were taken to hospital for screening and treatment. Treatment meant taking care of the opportunistic infections which would otherwise make the body unable to fight the disease.

Most of those affected by the epidemic were women of 20 to 45 years as well as very old women.

"Women take care of sick family members, at home and in hospitals. Old women often sit with bodies of the dead for long periods, sometimes spending nights oiling and dressing the body. This exposes the women to the virus", explained William.

Family members are not allowed to see

the patients or view their bodies. Often people have only been informed that a relative has died and is buried. Hence a lot of sick people are discouraged from coming to hospital if they will die anyway. Better to die in the community and be buried among your people, has been a common argument. The high levels of illiteracy and superstition have also been a hindrance to community mobilisation.

For William it is disappointing that the disease has taken so long to erase. The longer it remains here the more lives will be lost. However community mobilisation has not been in vain. The toll would have been much higher otherwise.

# AMREF holds AIDS consultative meeting

AMREF should use its international and regional clout to push for a more appropriate and effective HIV/AIDS agenda.

The organization should work closely with employers, trade unions and professional associates in order to promote effective work place HIV/AIDS guidelines and

stronger political support. AMREF should also strengthen the capacity of appropriate institutions.

These were some of the conclusions at the end of the AMREF intercountry consultation on HIV/AIDS held in September. This consultation is the first in a series of meetings aimed at enabling AMREF establish effective partnerships with governments and other organizations in the fight against priority health problems in sub-Saharan Africa.

The consultation was attended by 42 participants from Tanzania, Uganda, South Africa, Mozambique, Ethiopia and Kenya.

Some of the key issues discussed at the three day meeting were the effectiveness



The Ethiopian participants at the AMREF AIDS consultative meeting in Nyeri



Participants at the AMREF AIDS consultative meeting

of peer educators, adolescent sexuality, voluntary counseling and testing, access to and affordability of antiretroviral treatment, policies, people living with, and people affected by HIV/AIDS.

The star of the three-day meeting was Lillian Mworeko, a Ugandan woman living with AIDS and a very active member of the Uganda Network of AIDS Service Organisations. While the story of living with AIDS was sobering to her listeners, it was her grasp of a wide cross section of issues in HIV/AIDS that was most riveting. She is an authoritative advocate for voluntary counseling and testing, psychological, spiritual, medical, nursing and general care for persons living with HIV/AIDS and access to anti retroviral treatment.

(Lillian's story on facing page)

***This consultation is the first in a series of meetings aimed at enabling AMREF establish effective partnerships with governments and other organizations in the fight against priority health problems in sub-Saharan Africa.***

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# Lillian Mworeko

## A woman of courage

“My husband died two years after testing positive. I nursed him as well as I could, but towards the end it was depressing and I almost gave up. I am a mother of one beautiful daughter. I decided to get tested after my husband died. Failure to test means not getting the support and services than can make you live longer.

HIV/AIDS is associated with sex and immoral behaviour, unfortunately. Yet people living with AIDS need regular and continuous acceptance and support. The attitude of some religious leaders has been wanting. Imagine how shocking and stigmatizing it is when a pastor preaches against us in church, yet in the congregation there will be some who are positive. We need emotional support.

People living with AIDS need quality medical, nursing and general care. Quality home care will help them to die in dignity, which they have a right to.

When the virus affects your friend, relative or neighbour it is very sad. But when it affects you, it is in your body, it is devastating.

When my husband died my in-laws did not even want to bury him. After the funeral I was confused and depressed. I am very grateful to my colleagues in my former work place. I was scared of their reaction but when I went back to the office after the funeral they were very supportive. But I still did not know how to carry on. I sought out Major Rurunga, a well-known person living with AIDS who travels across Uganda and the rest of East Africa

promoting voluntary counseling and testing. He changed my life. After relating my story, he advised me on how to live my life. I had hospital bills to take care of, I had a baby who needed my care, and my rent was four months in arrears.

Major Rurunga made me realize that what you cannot change you have to learn to live with. You must adjust your life to your financial ability. If for example you cannot afford a curly kit hairstyle, cut it short like me. People living with HIV/AIDS live from day to day. We do not make long-term plans.

We are very grateful for support from organizations like AMREF and TASO. At least we are not

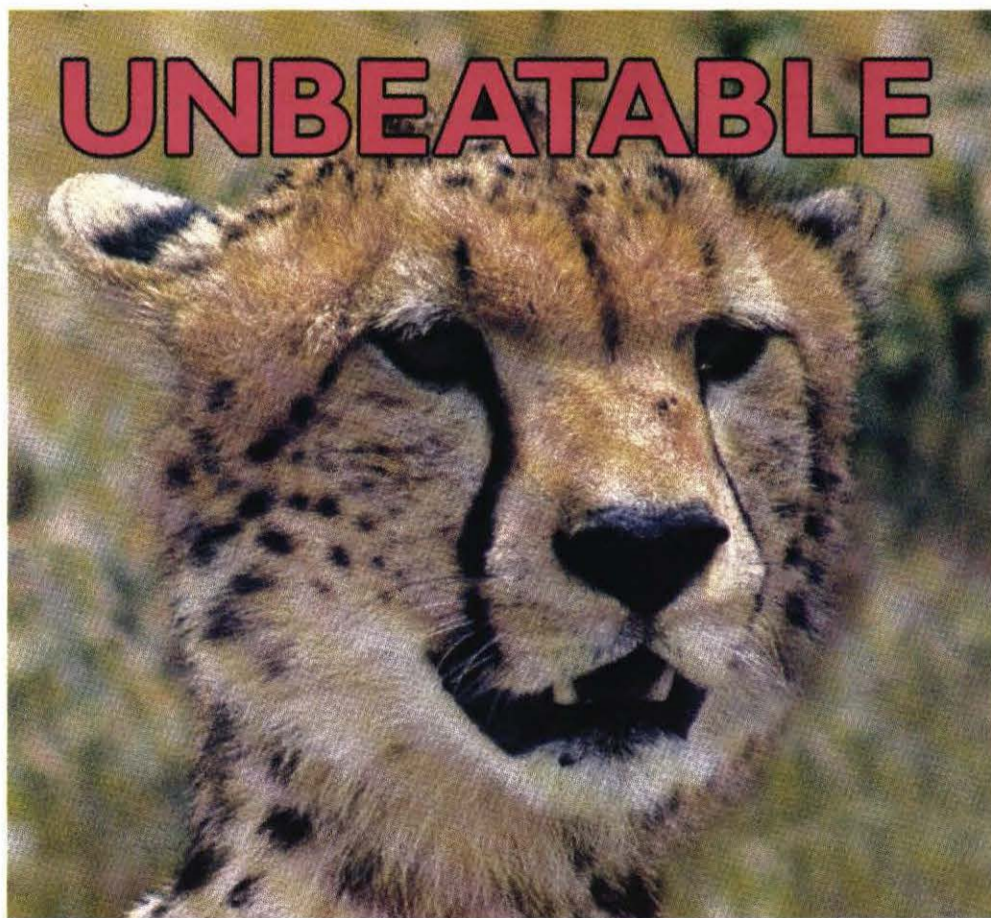
isolated. My coming out has saved many people. I believe I am beautiful, and many men want a relationship with me, but I tell them the truth. A former boyfriend has remained a good friend, but we both know our limits.

I would like to see more constructive engagement between organizations and people living with AIDS. We should not just be paraded. In most HIV/AIDS forums people living with AIDS are asked to stage dramas and recite poetry while the politicians make the speeches and policy statements. We do not want to be left out of policy issues.

Let us not forget the levels of poverty people living with AIDS have to contend with. Is there anything AMREF can do to start antiretroviral centers?"

**When my husband died my in-laws did not even want to bury him. After the funeral I was confused and depressed.**

**I would like to see more constructive engagement between organizations and people living with AIDS. We should not just be paraded.**



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# Walking away from

Reprinted from *The New Vision*

**A**nne Tugume (not her real name) left her home in Ibanda western Uganda and went to live with her aunt, after her parents disowned her for getting pregnant. Unfortunately, her auntie did not look after her, even though she was working for her as a househelp. One day a friend told her that there was a way to make quick money. She took her advice and before long she was pregnant again. Her aunt kicked her out. Now on her own, she got herself a room where she embarked on prostitution full-time to earn a living. She now has three children.

Tugume is one of the reformed sex workers in Kibe Zone, Kalerwe, a Kampala suburb on Gayaza Road, who has decided to turn to something more respectable after AMREF offered them something better to do. Nineteen former prostitutes received certificates in small-scale business skills like making tea and hairdressing. These girls live in the poorest parts of Kalerwe. Most of them claim they were forced into prostitution in the first

## AMREF has given former sex workers in Kibe zone, Kalerwe, a meaningful alternative to earn a living

place, mostly because of poverty. Their stories are similar. They ran away from home because of pregnancy. A few claim they lost both parents and had to look after their younger siblings.

Did they not have anything else to do apart from prostitution? Could they not at least have become housegirls? "Housegirls suffer much more than prostitutes. They are always controlled, overworked and underpaid", says Tugume. But it was not smooth sailing even in prostitution. Halima Namubiru (not her real name) said that her happiest moment was when a man she thinks was a Kenyan promised to pay her Kshs 500 (about 6 dollars). But

her happiness was short-lived because the man ended up sodomising her. "It was painful," she said.

"Nze nali ndowooza ebyo bya musajja ku musajja" (I used to think such things were done by men to men) she said, almost in tears. Worse still, she did not get all her money. He gave her Ush 5000 (36 US

cents), and it was much later that she learnt it should have been twice as much.

Nakitto, another girl, was approached by two men who asked if she could take on two customers at a go. She agreed when

they said they would pay her Shs 20,000 (one and a half dollars). "They took turns with me throughout the night, and in the morning they told me prostitution was illegal, and they left without paying," she said.

Prostitution is a fact that cannot be denied.

"But some girls are as young as 14 years. They don't know how to protect themselves from diseases and they know next to nothing about family planning", says Joyce Kintu, the project manager.

AMREF decided to give them help especially in the health area. The project staff explain about AIDS and other sexually transmitted diseases to the girls, and provide them with contraceptive

**"Housegirls suffer**

**much more than prostitutes.**

**They are always controlled,**

**overworked and underpaid"**

**says Tugume**



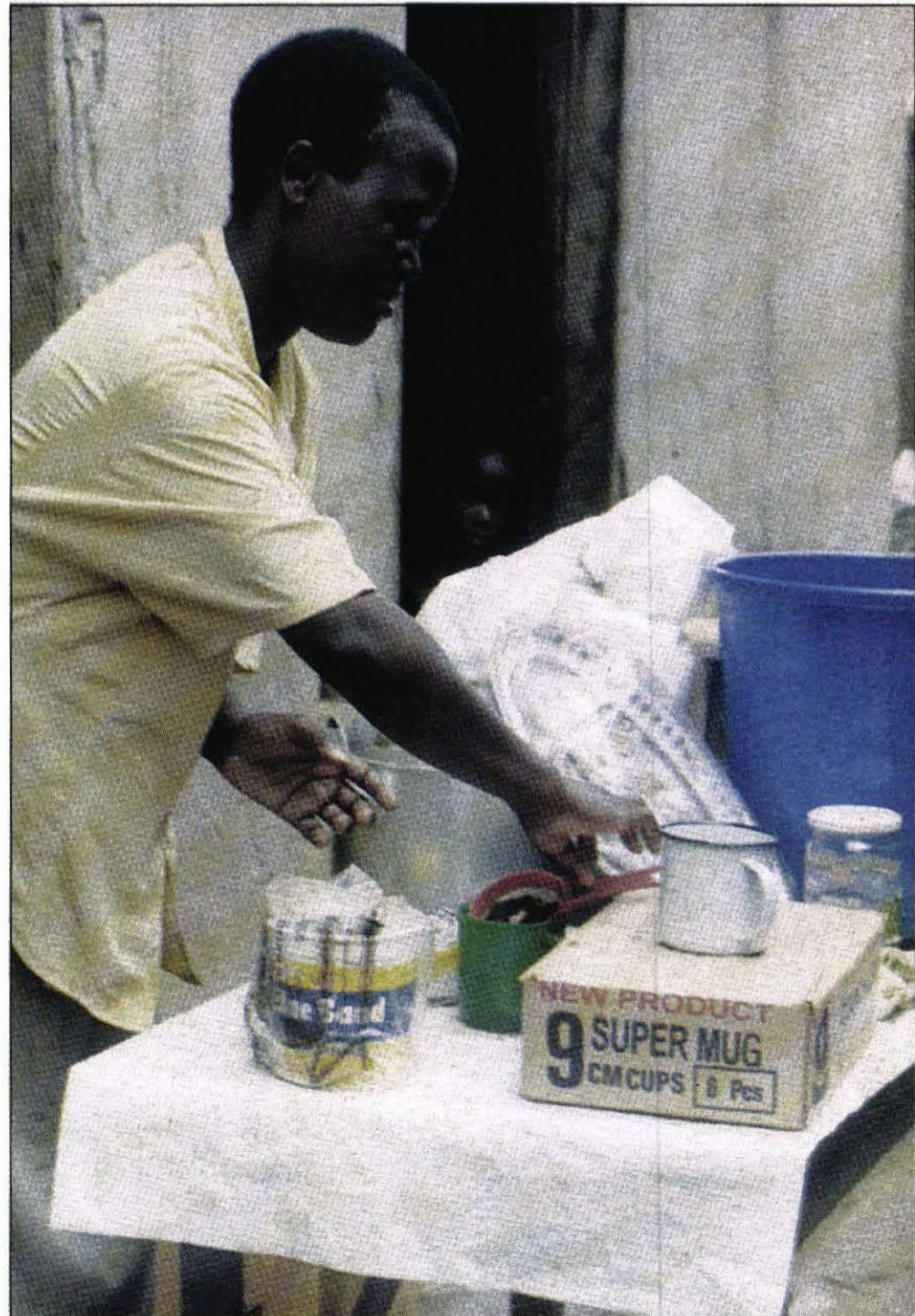
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Selling tea and snacks at a street corner is a more meaningful alternative to commercial sex for this woman

# prostitution

**Fact File**  
 People. Most Ugandans are black Africans. Nearly all of the more than 20 ethnic groups have their own language. Uganda has no language that is understood by everyone. The Ganda, also called the Baganda, are the largest and wealthiest group. They live in central and southern Uganda. Their political and social organization is one of the most highly developed in central Africa. Until 1967, the Ganda had their own kabaka (king) and Lukiko (parliament).



services. It was also decided that the girls be given some training to help them find alternative employment. Milly Iga, secretary for Information Education and Mobilization, Sebina Zone, a neighbourhood near Makerere University, says the project is a godsend.

"These girls were indulging in prostitution because of lack of employment. Although most of them refused the training, we hope that when they see their colleagues' change of lifestyle they will follow suit."

Of the 19 girls interviewed, only three were not mothers. The others had between one to five children. Iga says the girls charge between sh 500 (4US cents) to sh 1000 (7 US cents) for their services.

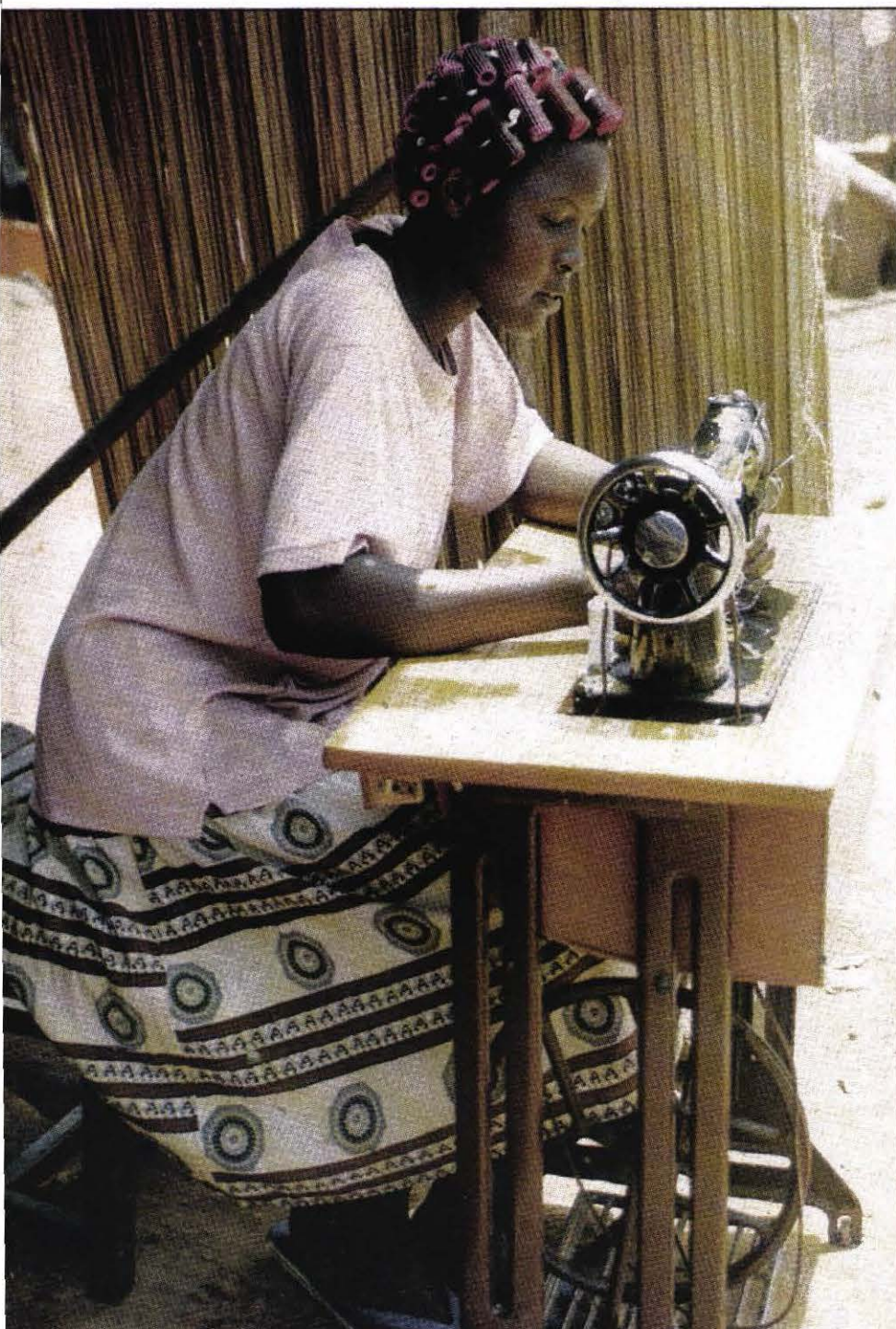
In August the girls who were trained in hairdressing graduated, receiving

certificates, after months of training. Others are still being trained in tailoring and tea making. On completion of the courses, they will each receive sh 30,000 (about 2 dollars) from AMREF, as rent for working premises. In Kalerwe, premises can be rented for 10,000 (just under a dollar) shillings per month.

In addition, the tailors will get sewing machines and tea-makers will get utensils at half-price, to be paid for in instalments. Tailoring trainees appeared in smart blue uniforms to shake hands with the guest of honour. They also had a present for the project manager Joyce Kintu, which they gave her kneeling down in respect and gratitude.

Kintu is optimistic that the project will improve the lives of these girls, most of whom are aged 14-22 years.

**"These girls were indulging in prostitution because of lack of employment."**



For this young woman learning a new trade means goodbye to commercial sex work

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AMREF is worth funding long term - five to 10 years of programme funds instead of the two-year project financing.

This is the verdict of an evaluation carried out on behalf of Sida and CIDA, the two donors who have provided programme funds to the organisation for several years. At a donors meeting chaired by World Bank Kenya resident representative Harold Wackman, the evaluators presented their preliminary findings and recommended continued Sida/CIDA support, 'particularly in this challenging time in AMREF's history'.

According to the evaluators, "There are few, if any NGOs active in Africa that have the same professional stamina, the organisational reach or the credibility to provide quality support to the on-going sector-wide transformation of public health care systems."

The evaluators however recommended that AMREF develop a sharper concept of its role in the region, demonstrate a more progressive gender practice, institute a stronger evaluation and monitoring culture, utilising results-based management. They also recommended the use of time-bound and verifiable indicators in programme work as well as in organisational management.

Diana Chaplin from CIDA, Ottawa, said that CIDA was very happy with the review and with the fact that AMREF had been extremely open during the evaluation.

"CIDA would like to see AMREF using programme funds to initiate strategic activities, and not to fill gaps. This will

# AMREF evaluated

require careful prioritising so as not to lose the stamina, concentration and focus that is necessary", she said.

The Sida head of Development Cooperation said that Sida would like to

see the results from studies by AMREF being put to more use.

The meeting was attended by representatives from DFID, DANIDA, Sida, FINNIDA, EU, GTZ, Norwegian Church

AID, USAID, WHO and CIDA. The senior management team and a few board members represented AMREF.

In his closing remarks, AMREF chairman Bethuel Kiplagat thanked both Sida and CIDA "for trusting us, and coming along with us. I hope this is an educational process for other donors."

Mr Kiplagat promised that the AMREF board would work out a mechanism for implementing the recommendations in "this very important document."



Pictured, from left to right : Gordon Tamm, Sida consultant, Diana Chaplin, CIDA Ottawa, Gerry Cooney, CIDA consultant, V.S. Thygarajan, AMREF and Naftali Oirere, UNICEF.

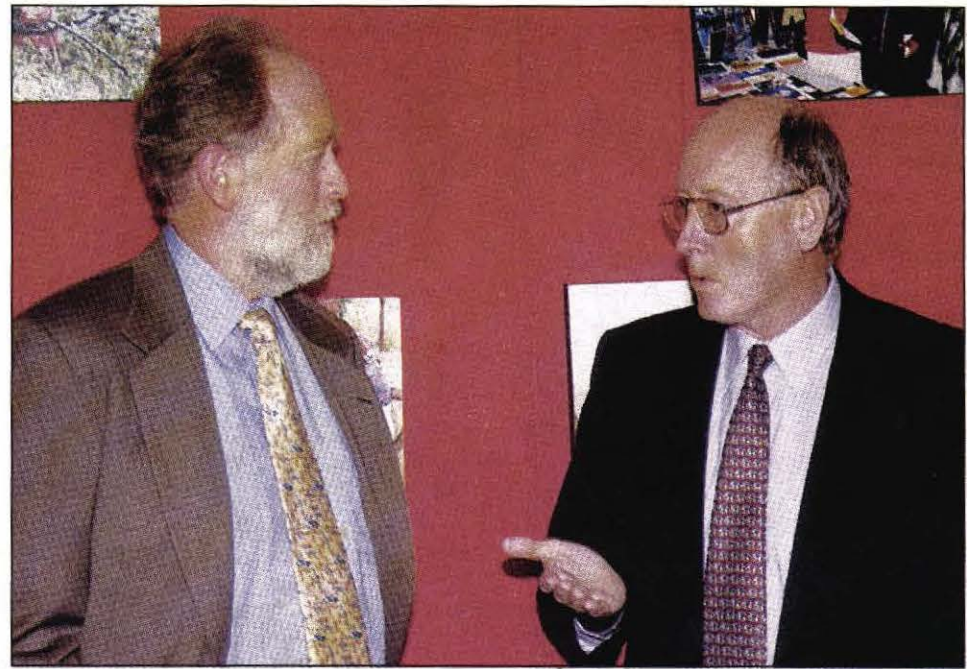
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Harold Wackman with Robert Bird, an AMREF board member, at the meeting

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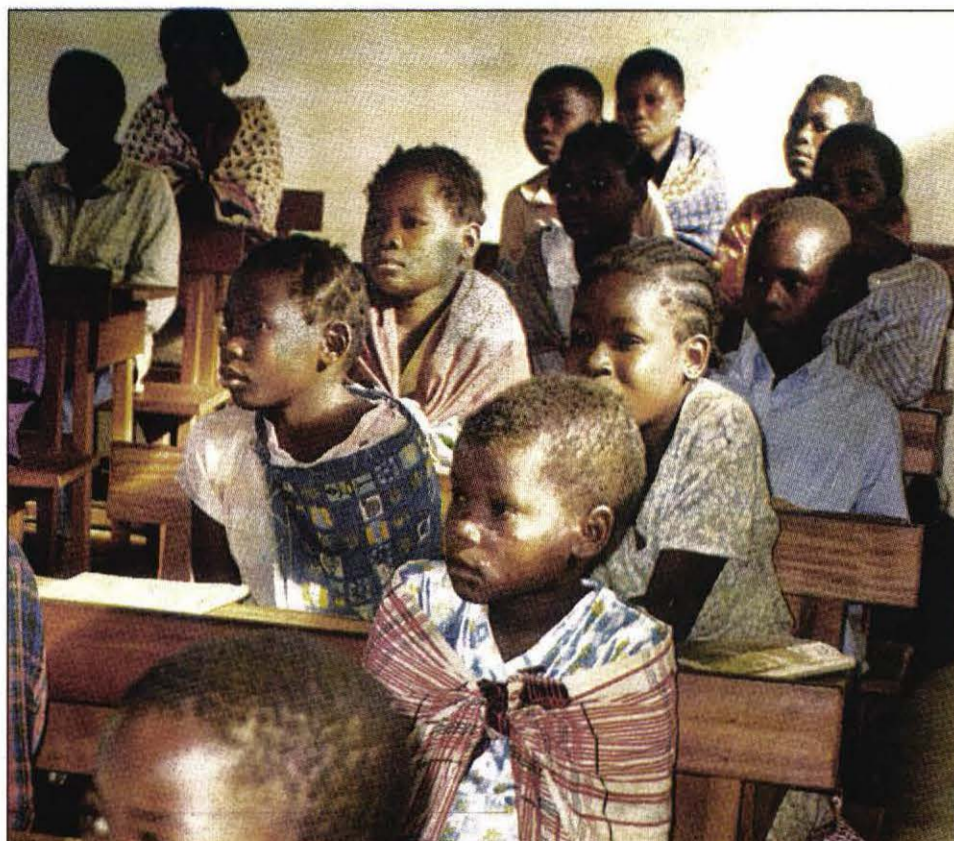
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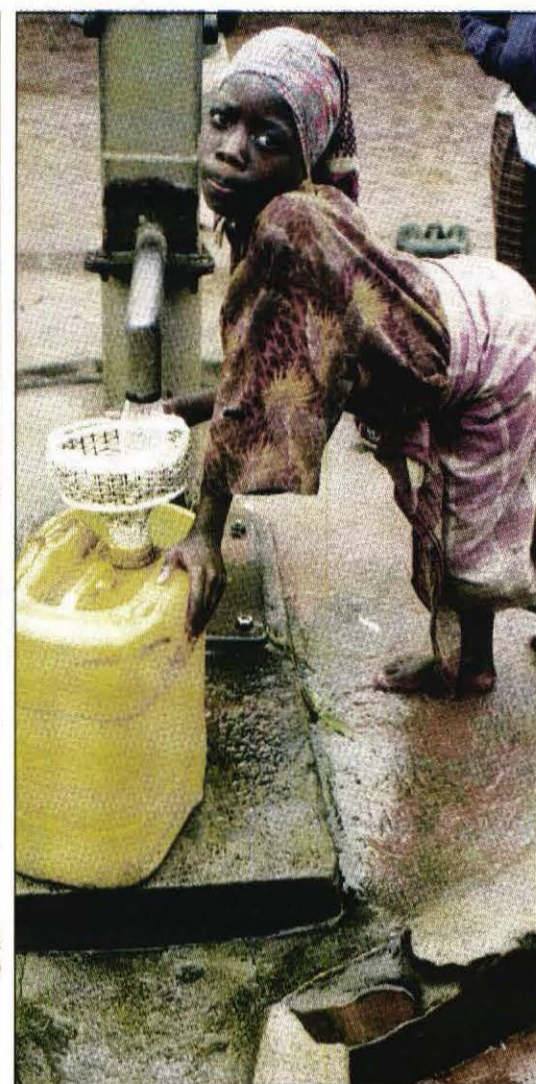
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# Understanding adolescent health

Young people, teachers and community leaders participated in a baseline survey whose aim was to identify the key issue for adolescents in Maxixe City in Inhambane, Mozambique



Top: Boys and girls in a classroom in Dongane, central Mozambique.



Right: This girl could benefit from evening classes if they were available in her village.

Sergio Joaquim and Cristina Matias are members of the local AMREF Maxixe adolescent reproductive health project committee. Young people, teachers and community leaders participated in a baseline survey whose aim was to identify key issues affecting adolescents in Maxixe City, Inhambane district of Mozambique.

The local team used the findings to write a plan of action which they sent to AMREF in Maputo. They have recently received comments and are sharing these with the local teachers and other committee members.

Meanwhile, in partnership with Population Services International, AMREF has supported the local health centre where Cristina is also a nurse, in setting up an STD clinic which provides treatment, health education, family planning and condoms. Cristina feels the clinic is having an impact because women who come for STD treatment are bringing in their partners. In addition, a lot of young people are coming in freely for condoms and contraceptive pills.

After initial resistance by some religious leaders, the main churches are today venues for workshops and video shows on reproductive health.

Cristina and Joaquim feel that the major problems facing young people in Maxixe are unemployment, drug abuse and crime. School girl pregnancy is not an obvious problem here because many girls are on contraceptives and a return-to-school policy camouflages school girl pregnancy.

"Many of the girls who become pregnant can go back to school as long as they can find someone to take care of the baby during the day. If not they can attend night school," says Cristina.

The back-to-school policy is a result of a government/UNICEF initiative supported by a United Nations Fund for Population Activities media campaign through radio and newspapers in favour of the girl child and her education.

## Where premature sex leads to 14-year-old couples

Jose Severiano Guambe is the headmaster of Dongane Primary School, Inhambane district. He has just been through an AMREF workshop where participants selected the priority health issues they wanted to deal with in their schools. Mr Guambe has chosen to work with young people so that when they leave school they can take with them some knowledge that will help their health and that of their families. He is currently preparing to start a campaign on AIDS, other sexually transmitted diseases as well as other common health problems.

School girl pregnancy and drop-out of both boys and girls is a big problem in this

poor rural district. Many girls get pregnant from as early as 13 years. And the girl leaves school, not alone, but with the boy responsible.

The reasoning here is that if a girl and a boy feel they are grown enough to have sex that leads to pregnancy, they are equally ready to start married life together.

Mr Guambe is aware of the back-to-school campaign but in a rural setting it is not easy to put into practice. First the girl and the boy would never face their classmates, out of shame. Secondly many parents in rural areas undervalue the girl child, her health and her education. Bride



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price also plays a part, since the girl's parents, often poor, get an opportunity to make demands on the parents of the boy.

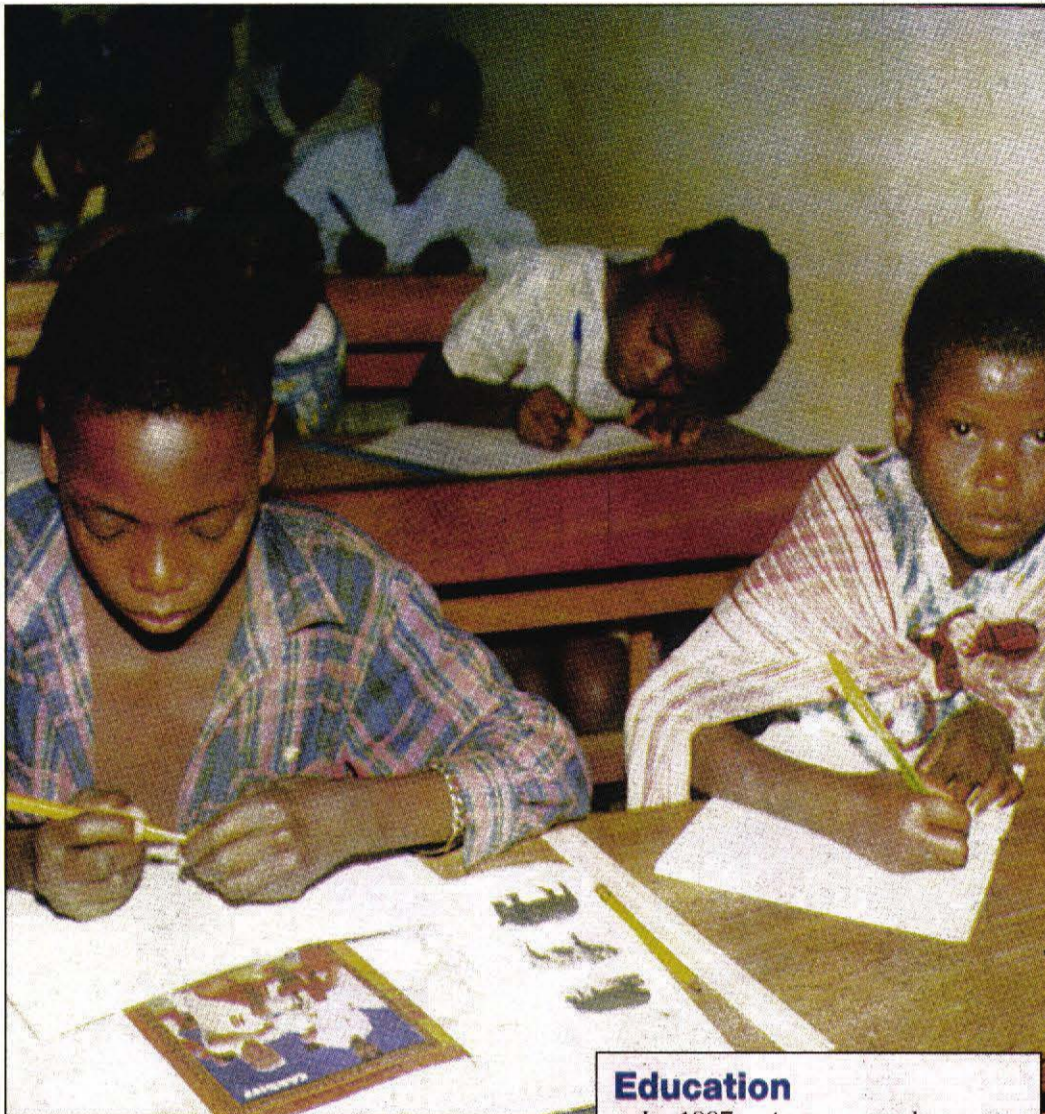
"While I do not support the girl alone leaving school due to pregnancy, asking a fourteen-year-old boy to drop out of school is not good either. At least if the boy continued with school, he would be in a better position to support his family in the future. When both leave school so early they start a life of poverty and misery for themselves and their children."

Evening classes in the rural areas are not possible because of distance and lack of electricity.

And pregnancy is not the only problem. Reports from the nearby health centre indicate a high number of both boys and girls seeking treatment for sexually transmitted diseases.

"These children must be educated about when to have sex, with whom, the consequences of both early and unprotected sex. The ministry of education must step up the campaign that will encourage boys and girls to remain in school. Families must be made aware of

if the back-to-school policy and should discuss cases of pregnancy with teachers when it happens.



*These fourteen-year-olds could easily become husband and wife if the girl became pregnant*

# Rosta's

Rosta Francisco Cumbane looks far much older than her 41 years. A widow, she takes care of her five children as well as her 18-year-old daughter's two-year old twins. Rosta's story is one of hopelessness, and her story portrays poverty and the struggle to stay alive against all odds.

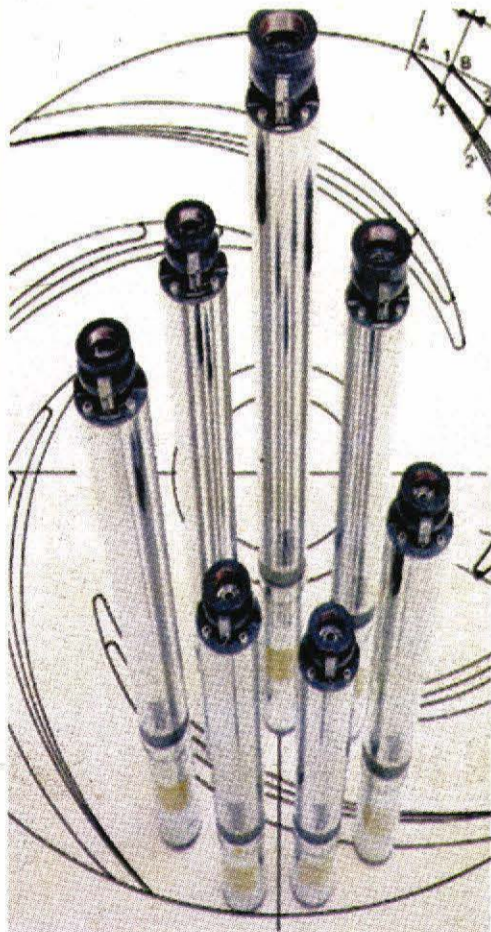
Rosta lives on a fairly big plot of land, on which she and her daughter attempt to grow maize, cassava, sweet potatoes, peanuts, beans and vegetables. She also has a few goats, some chicken and a pig. The farm has sparse unhealthy crops that will obviously not feed this family adequately. Good farming practice is not something Rosta has heard of, and she has no means to put these into practice anyway. The miserable crops growing on Rosta's shamba are mirrored by the obvious malnutrition all the children manifest - the soft sandy hair, protruding stomachs and flabby skins. Even though the twins are still breast feeding they are the worst of the lot. The family diet is cassava and maize and more cassava. There is no sign of beans, or any other source of protein.

Cash income is not part of Rosta's vocabulary. She grows food just for the family. If she sells anything at all it is her and her daughter's labour, to neighbours who then pay them in kind - salt, soap or paraffin, old clothes. She recalls only one season when the harvest was 'very good' and she made about 6.25 dollars from her farm produce!

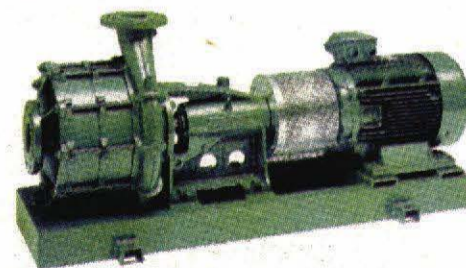
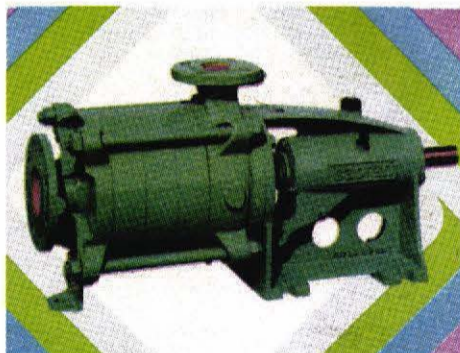
### Education

- In 1997 primary attendance was only 39.9 per cent.
- In technical and higher education attendance was only 0.3 and 0.2 for men and 0.1 and 0.1 for women respectively.
- Illiteracy rate: 60.5 per cent. Women's illiteracy rates are as high as 85.1 per cent in the rural areas.

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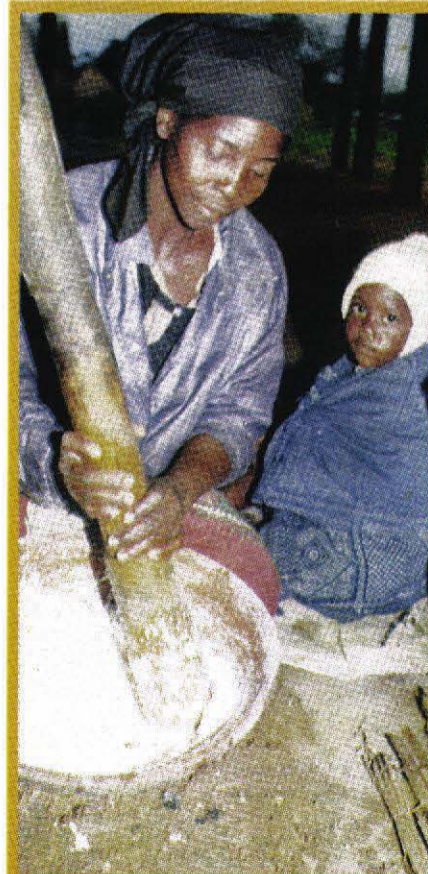
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## Mozambique's nutritional status

Malnutrition in Mozambique is alarming. For example in 1997, 52 per cent of children under five suffered chronic malnutrition. Nine per cent of hospital admissions of children under eight were due to kwashiorkor or marasmus. Fourteen per cent of children's deaths registered in hospitals were due to severe malnutrition and is the condition is third largest cause of death in children under five. The most vulnerable are children aged 4-12 months.



Malnutrition has led to high levels of goitre, anaemia, and Vitamin A deficiency. Goitre, which results from lack of iodine, can lead to mental congenital anomalies, depression etc.

In Mozambique the prevalence of goitre is very high. In the provinces of Niassa and Tete the prevalence is 50-90 per cent.

Anaemia is especially high in children and women of child bearing age. The main causes for this high anaemia are malaria, intestinal parasites and low intake of animal products rich in iron.

Statistics show that prevalence of anaemia is 85 per cent. Hospital admissions due to anaemia are 9 per cent with maternal mortality rate in hospitals due to anaemia standing at 4 per cent.

Cases of pellagra have been reported in emergency situations and amongst refugees or displaced people. Pellagra is a nicotinic acid deficiency disease characterised by cracking of skin and often ending in insanity. Nicotinic acid is a vitamin of the B complex found in milk, liver and yeast.

# daily struggle



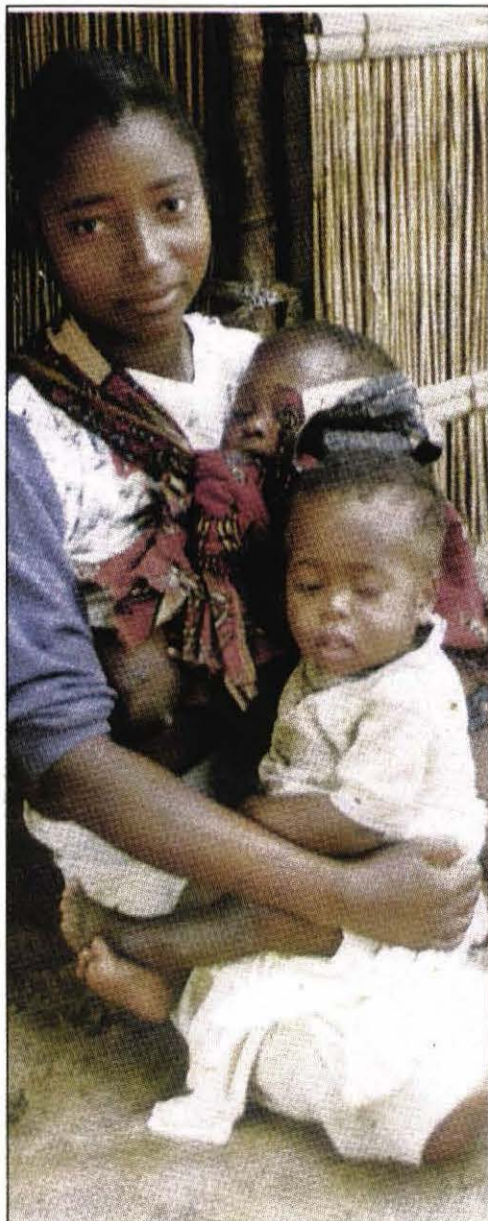
Rosta with one of her children and her daughter's twin

"I know I am poor, I live it and I feel it. There is nothing I can do about it, other than trying to at least feed myself and my children. Even my neighbours know I am poor, and to help us they invite my daughter and I to work for them in return for things we would require money to buy. I do not think of the future. I think of the immediate, now, which means what to eat. I would like a good life, but how? They say people can help each other by coming together, but among the poor here what support can we give each other beyond salt and paraffin? My daughter too has to devote her life to growing food for her children."

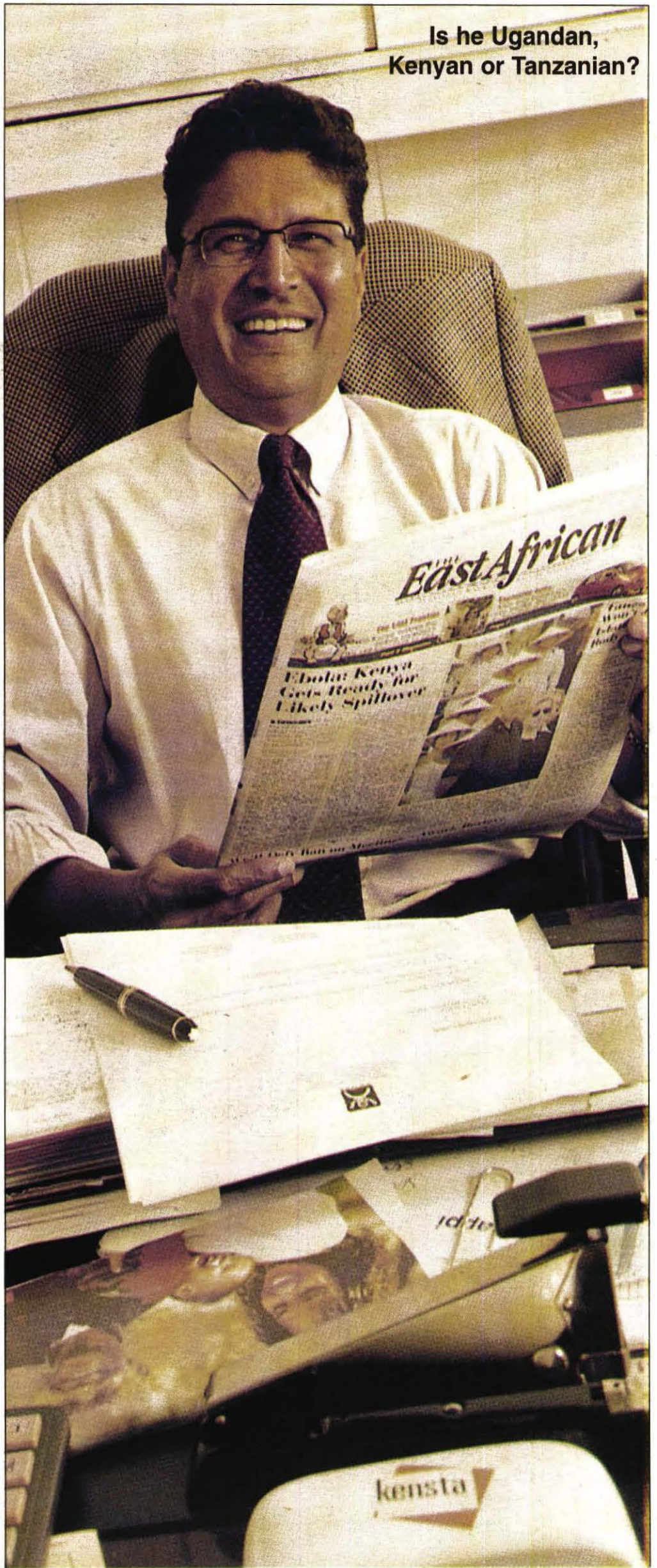
Daughter Emilia Antonia got pregnant at 16. The 17-year-old boy's family refused to meet with Rosta, and the community had to force a meeting. After the twins were born the boy's family reluctantly accepted responsibility and took Emilia and the children. But after five months Rosta realised her daughter was starving, and she brought her home.

Rosta has a son attending school in Nampula, some 500 kilometres in the north. He lives with relatives. Perhaps in this son there is a slim chance that Rosta's life might improve slightly. A very slim chance indeed, considering the already high unemployment levels among young people in Mozambique.

Rosta is a vivid personification of the 60 per cent of the Mozambicans who live below the poverty line.



Emilia with her twins



Is he Ugandan, Kenyan or Tanzanian?

Anoop Shah, Group Managing Director, The Kensta Group.

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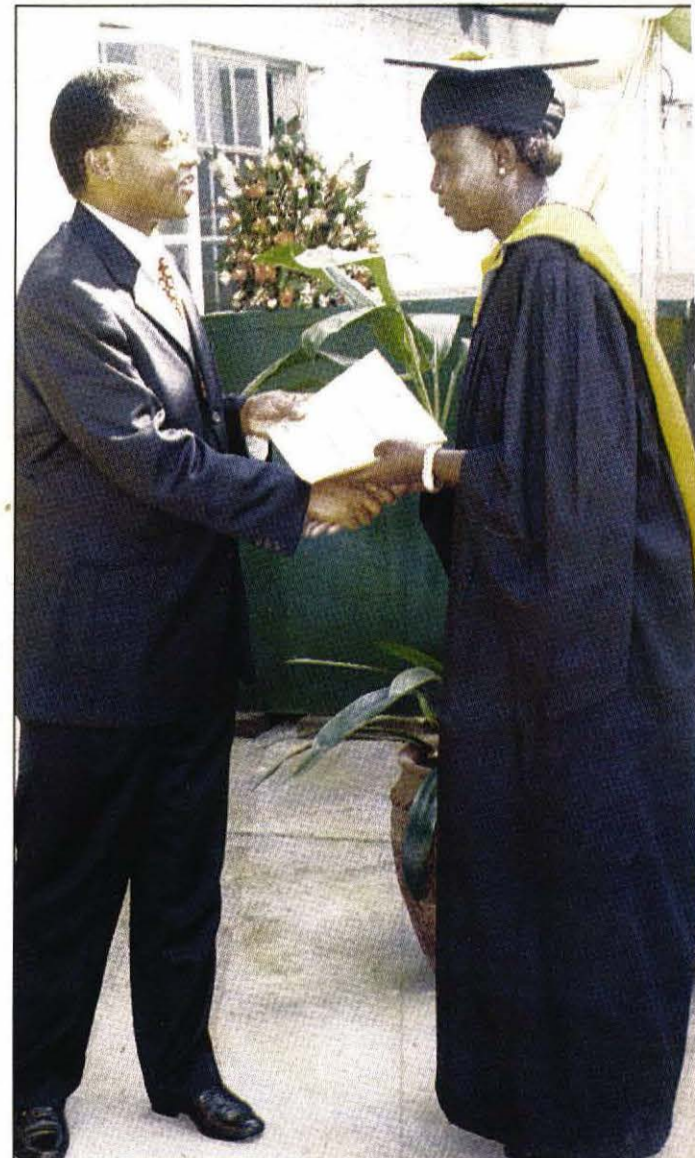


Young people from Thika recite a poem during the World AIDS Day in December. AMREF implements a community AIDS project in Thika.

# AMREF

## Pictorial

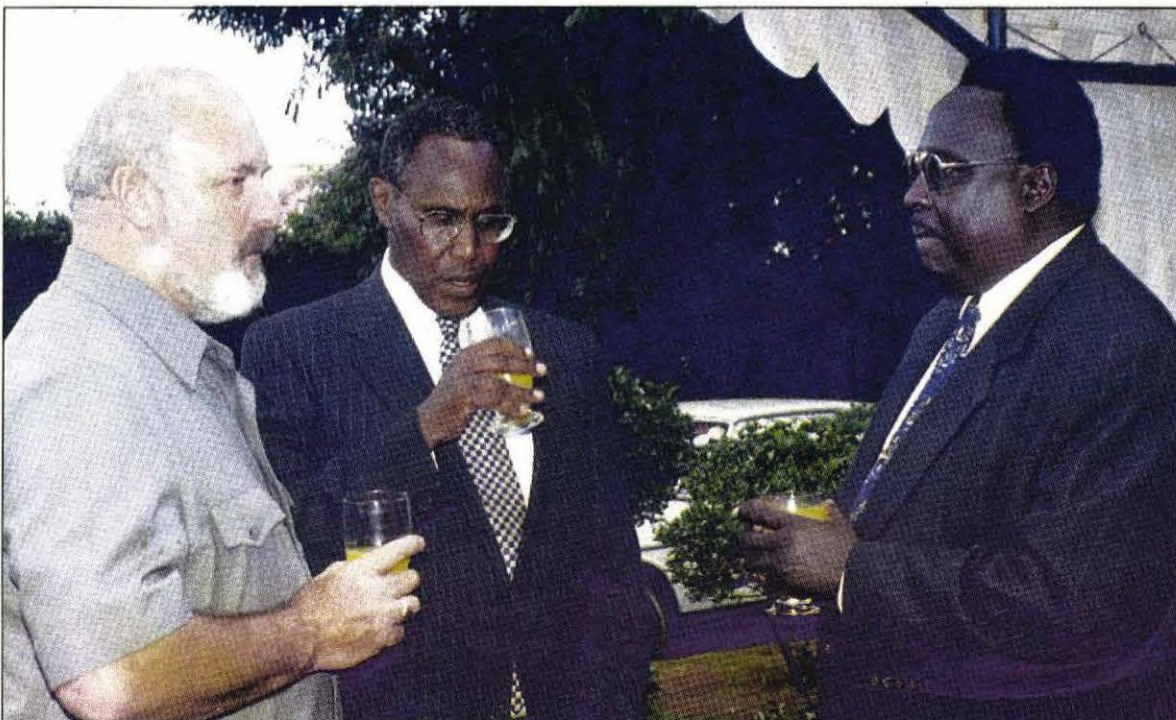
Kenya Country Office held a technical review meeting where project managers presented their work. A series of displays depicted specific activities of the different projects. In the picture, Mrs Margaret Mwiti of the Kaloleni project explains a point to Professor Julius Meme, the Director of Medical Services who was the guest of honour.



The Minister of Health Dr Amukowa Anangwe presents a certificate to Jennifer Onyango, a graduate of the Community Health Diploma course.



Dr Vinand Nantulya is presented with a gift by Nancy Ndungu and Eliab Some at a farewell party held in his honour. Dr Nantulya, who has been Director of Programming at Headquarters, has left AMREF for further studies at Harvard University



The AMREF Kenya Strategic Plan 2000 and Beyond was officially launched in December by Vice President George Saitoti, pictured with John Batten, AMREF Director General, and Dr Peter Eriki, WHO Resident Representative.

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The winner of the one million dollar Conrad N. Hilton Foundation Prize for year 2000 is Casa Alianza, the largest private agency in the Americas serving abandoned children and youth. The announcement was made at a prize giving ceremony held at the Noga Hilton Hotel in Geneva, Switzerland in October.

Among the invited guests at the ceremony were Dr John Batten and Dr Daraus Bukenya from AMREF, winner of the 1999 Hilton Prize. Others included Mr Steve Hilton, the President, Conrad N. Hilton Foundation, Her Majesty Queen Noor of Jordan and Mr Bruce Harris, the Executive Director, Casa Alianza.

Congratulating Casa Alianza, Dr John Batten of AMREF, reflected on the many benefits the prize has brought to his organisation.

"A series of international consultations on major health topics have been organized by AMREF involving its staff, key partners and donors from all over Africa to learn from each other and to identify new ways forward. The first of these series was on the impact of HIV/AIDS in Africa where a consultative meeting was held in August."

Dr Batten further said: "The availability of funds has also enabled AMREF to co-finance a number of specific initiatives with a focus on AIDS orphans, prostitutes in Uganda, marginalized communities suffering from severe drought in Kenya, groups of disadvantaged women in Tanzania and capacity building for the communities in South Africa."

# AMREF congratulates 2000 Hilton Award winner

"Beyond the specific impact of this award AMREF has become more financially secure and confident in pursuing its own strategic objectives," Dr Batten adds.

The Hilton award has seen AMREF develop its public relations skills and improve its internal and external communication capacity, while the AMREF public profile has been raised in many parts of the world. There are also signs of much greater interest and support from donors, Dr Batten says.

Welcoming guests, Mr Steven M. Hilton, President, Conrad N. Hilton Foundation said: "Casa Alianza shares my grandfather's and our Foundation's philosophy: that we must protect and give aid to children, as they are our investment in the future. Yet throughout the world, millions of children are living on their own, trying to survive in the slums and alleys of the world's streets."

"We are pleased to honour Casa Alianza for not only providing shelter, guidance and other basic needs to abandoned children but also for acting as an advocate in defending their human rights," Mr Hilton added.



Pictured at the ceremony in Geneva are from left, Daraus Bukenya, AMREF, Eric Hilton, a juror and Dyanne Hayes of the Hilton Foundation.

AMREF won the 1999 Conrad N. Hilton Foundation Prize for its humanitarian work in the promotion of the health of the communities in rural Africa.

The Conrad N. Hilton Humanitarian Prize is presented annually to a charitable, non-governmental organization that has

made extraordinary contributions toward alleviating human suffering.

Established in 1996, the one million dollar Prize is the world's largest humanitarian award. It honors the efforts of those who help others, often at great personal sacrifice for the benefit and progress of humanity.

## SOME AMREF PUBLICATIONS NOW AVAILABLE

These, and other AMREF publications, are available from the  
Book Distribution Unit, AMREF Kenya, Wilson Airport,  
Box 30125, Nairobi; Tel: (02) 501301, 500950;  
E-mail: amrefkco@africaonline.co.ke

### AMREF New Books

**Communicable Diseases, Third Edition:** Edited by E. Nordberg. *This revised edition combines all the essential information for diagnosing and managing individual patients. It is written for those working in community health centres. Price Ksh860/=*

**Community Health, Second Edition:** Edited by C.H. Wood, H. de Glanville and J.P. Vaughan. *The book is written for health workers. It contains information about community structures and the pattern of disease in Africa. Price Ksh700/=*

**Obstetric Emergencies, Second Edition:** edited by J. Everett, Revised by L. Wambua. *This booklet is intended for midwives, nurses and clinical officers. Price Ksh400/=*

**Community Health Workers Manuals, Second Edition:** edited by E. Wood. *This manual is for both trainers and health workers. Available in English and Arabic languages. Price Ksh 700/=*

### Forthcoming Books

**Surgery, second edition:** Edited by P. Bewes. *The book clearly shows what should and what should not be attempted in a health centre. Price Ksh650/=.*

**Epidemiology in Community Health, Second Edition:** edited by J. McCusker. *This book is a self-teaching manual recommended for trainees and workers in the field.*

### AMREF HLM Kit

AMREF is offering a set of 25 health learning material titles as an essential basic learning tool at a special reduced price of Ksh14,000. This cost excludes shipping and bank charges. The kit includes:

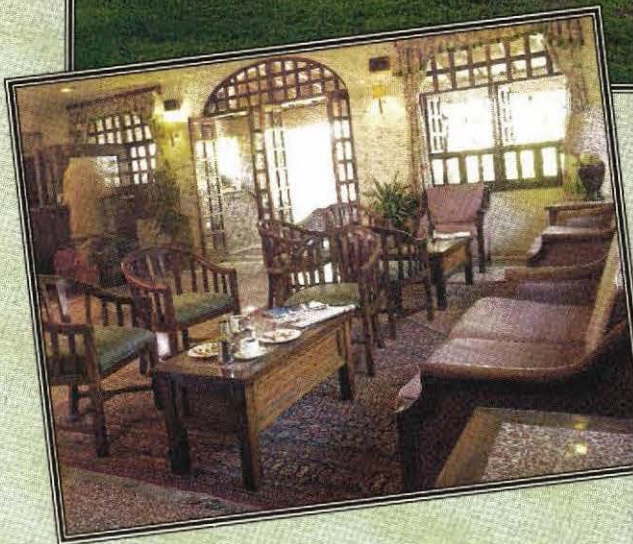
- Communicable Diseases, 3rd edition 1999
- Community Health Workers Manual, 2nd edition, 1998
- Child Health, 2nd edition, 1997
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- Community Nutrition for East Africa, 1994
- Practical Laboratory Manual for Health Centres in Eastern Africa 1994
- Guide for Training Teachers, 1993
- Health Education, 1993
- Helping Mothers to Breastfeed, 1992
- Obstetric Problems, 1991
- Medicine, Non-Communicable Disease, 1985
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- Management of Solid and Liquid Wastes, 1994
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- Caring for Mothers, 1994
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## STAYING IN NAIROBI?

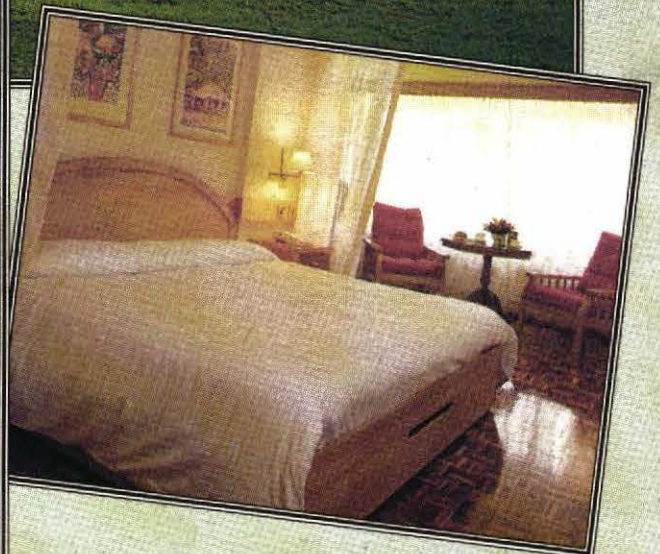
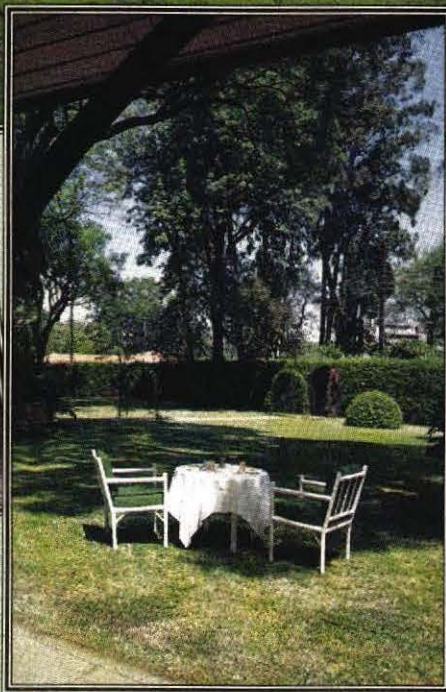
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