

AMREF registered as an NGO in Mozambique

By Isabel Mbugua

AMREF has been registered as an NGO in Mozambique, setting the ground for increased interventions and for more aggressive and focused local and international fundraising.

In line with this new impetus is the completion of a Five-Year Framework of Action (1999-2003), which is a major step towards developing a strategic plan. This framework defines the AMREF goal in Mozambique as "to strengthen the capacities of the Ministry of Health, Ministry of Local Government, NGOs, Community Based Organisations (CBOs) to be able to plan, implement, monitor and evaluate, effectively coordinate and support primary and community-based health care initiatives in

Mozambique". Strategies include capacity building, partnership and networking, modelling best practices, technical assistance and advocacy.

The health care needs in Mozambique are momentous: By 1990, over 1000 health units including 48 per cent of the primary health care network in rural areas had been destroyed or forced to close due to anti-government rebel activities. Health services cover less than 40 per cent of the population. The country's health statistics reflect a health care system that requires a major input of resources and manpower development: infant mortality is 134.4 per 1000 live births, a maternal mortality rate ranges from 692 in Maputo City to 1751 in Zambezia per 100,000 live births. HIV is estimated to be 10

per cent in adults. The main causes of death in children under five are malaria, malnutrition, anaemia and acute lower respiratory infections. In adults tuberculosis and malaria are the major causes of death.

According to Dr Pat Youri, the director in charge of Mozambique, AMREF will operate in the country on three levels — national, provincial and district.

"At the three levels AMREF will be a facilitator and advocate, rather than an implementer. At the national level we intend to provide assistance in health policy and continuing education. At the provincial level AMREF has already been designated to work in Inhambane province, a

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WHO/AMREF collaboration



Dr Desmond O'Byrne, WHO Head of Health Promotion and Health Education Unit, addressing a meeting in Nairobi. During a meeting at AMREF HQ between Dr O'Byrne and Dr David Nyamwaya, the AMREF Director for Education, Training and Extension, progress on the proposed WHO/AMREF collaborative centre for health promotion and education was discussed. They also touched on the Fourth International Conference on Health Promotion to be held in Mexico in June 2000. AMREF and WHO will co-host the meeting.

The church and adolescents

By Isabel Mbugua

The African Medical and Research Foundation (AMREF) and the Medical Assistant Programme (MAP) International, recently organised a three-day workshop in Mombasa, for Kenyan church leaders so that the churches can review their policies on AIDS and the youth. The workshop, whose theme was "The AIDS challenge is the church's challenge", was sponsored by United Nations Fund for Population Activities (UNFPA), and was intended to give the clergy an opportunity to critically review the government sessional paper, National Population Policy for Sustainable Development, in which adolescents are a priority group. The 1994 Cairo In-

ternational Conference on Population and Development recommended the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs.

Research conducted in Kenya among church youth and leaders reveals that sexual practices and perceptions are not compatible with church doctrines or AIDS prevention initiatives. In one study it was found that 49 per cent of church youth were sexually active, and 32 per cent of clergy were unfaithful to their spouses. Another 47 per cent stated that AIDS is rarely discussed in their churches.

Some churches have acknowledged their

responsibility and have developed programmes for sexual and reproductive health education for young people.

"There is a real need for bringing the church leadership together so that they can appraise the challenges of irresponsible sexual behaviour that leads to early, unwanted pregnancies, girls dropping out of school and sexually transmitted diseases, including HIV/AIDS. This is a fight that churches cannot undertake in isolation. They must form partnerships with others who are equally concerned," says Dr Lillian Wambua, coordinator of the AMREF regional adolescent health programme.

The workshop participants passed resolutions

that touched on church policy, education and training, advocacy and resource mobilisation. The church leaders recognised "our previous limited ability to address uncoordinated efforts to address the issues that challenge our youth and threaten the very existence of our communities. The main mode of HIV transmission is heterosexual. We realise that the prevalence of HIV has drastically increased in the last 10 years with the age group 15 to 24 years being the most affected, while the cost of management is far beyond the reach of the majority of our people. The church therefore recognises that value-based behaviour change is the key to abating the spread of HIV infection."

Child Survival in Tanzania

A new child survival and development project will be implemented in 20 villages in three wards of Temeke district, Dar es Salaam Region. The three-year project, with a 590,000 US dollar funding from the European Union, AMREF Austria and AMREF Netherlands, will apply the integrated management of childhood illness strategy (IMCI). This strategy has been introduced in Tanzania by the government with the support of WHO and UNICEF as an important step in reducing deaths and illness in children below five years that is often caused by malaria, pneumonia, diarrhoea, measles and malnutrition. In Tanzania, malaria, diarrhoea and pneumonia are still the main cause of illness and death in young children, accounting for over 50 per cent of childhood mortality. Measles is the number one killer among the vaccine-preventable diseases in children.

The IMCI strategy has three components: case management skills of health workers; improving the health delivery system and improving household, family and community practices towards child health promotive prevention and curative elements



AMREF

Editorial

Malaria must be controlled

In the last couple of weeks, the newspapers in Kenya have been full of reports on malaria deaths, especially in areas that are not traditional malaria zones. Hundreds have died, thousands others were hospitalised. The rainy months of May, June and July are known for increased mosquito breeding, and of course higher rates of malaria episodes. In most of Africa, malaria has continued to be a major killer. Children under five years and pregnant women are especially at risk. The malaria cycle seems fairly simple, and therefore easy to break: mosquito breeding leads to adult mosquitoes that bite human beings who then get the disease malaria. The logical and obvious thing to do is to prevent the breeding of mosquitoes, and to prevent mosquitoes from biting people. This has been the key thrust in malaria prevention messages for decades. They do not seem to have worked. Yet they remain the most logical ways of preventing malaria. The use of insecticide-treated nets (ITNs) was introduced several years ago, and studies have shown that this technology can reduce the illness and deaths caused by malaria. AMREF has been involved in some of the studies and experiments that have attempted to popularise these nets, as you will read in this issue. Currently the AMREF malaria unit is trying to make insecticide treated nets affordable and available to large numbers of employees in the malaria endemic zones - Coast, Western and Nyanza provinces. In Bungoma AMREF is coordinating another malaria project whose major activities is management of malaria at home and in health facilities. In Uganda we have been involved in similar work.

As the world re-focuses on malaria through the WHO-driven programme Roll Back Malaria, we at AMREF are proud of what we have attempted to do — getting communities, the private sector and the health workers to be actively involved in the prevention and control of this killer disease.

Partnerships for AMREF Germany

By Scott Kelleher

AMREF Germany is now supporting much of AMREF's programmes in East Africa through partnership agreements with other German non-governmental organisations and institutions.

Based upon formal three-year "contracts", these partnership agreements support a variety of projects and programmes, while giving these donors the security of working with a reliable and well-respected partner organisation that has the same development objectives.

The AMREF regional laboratory programme is supported by partnership funding from Stiftung

Barmherzigkeit and Gesundheitshilfe Dritte Welt, the German Pharma Health Fund.

Together, Brot fur die Welt, the Evangelischen Zentralstelle fur Entwicklungshilfe (EZE), Misereor and Stiftung Ubersee Hilfswerk, are all supporting specialist and surgical outreach programmes in Kenya and Tanzania.

The Touristik Union (TUI) in Hanover, is providing support for the north, north-western specialist outreach programme in Tanzania, while the reconstructive surgery work with leprosy sufferers is funded with

assistance from Deutschen Aussatigen Hilfswerk (DAHW).

The European Union is a major supporter. Through its agreements with AMREF Germany, EU supports printing and laboratory work in Dar-es-Salaam, mobile health clinics in Rombo, Tanzania, and hospitals and health posts at Luuq and Abduwak in Somalia.

Other AMREF Germany partners include Centrum fur Internationale Migration unde Entwicklung (CIM), Deutsche Stiftung Weltbevölkerung (DSW), Kindermissionswerk and Kindermothilfe (KNH).

International News

Taking the specialist outreach to Italy

By Scott Kelleher

AMREF Specialist Outreach surgeons, Dr John Wachira and Dr Marlene Long, recently visited Italy to speak at several prestigious universities and help promote the specialist and surgical outreach service.

Their trip was organised by AMREF Italy. Their stay in Italy was also intended to increase the organization's public profile, establish contacts with Italian institutions and raise funds. Dr Wachira and Dr Long were accompanied on their speaking engagements by AMREF Italy specialist outreach "goodwill ambassador", Kuki Gallman, the celebrated Kenyan-Italian author.

The three spent a hectic 10 days in Italy, speaking to professional audiences at Rome University, where special guests included WHO representatives and the Italian government's Director-General of the Directorate for Development Cooperation. They also spoke at the universities of Bologna and Milan.



Dr Long and Dr Wachira outside the Colosseum in Rome

Dr Long particularly enjoyed her visits to the University of Bologna, which she describes as the home of the father of reconstructive surgery, Professor Gaspare Tagliacozzi, who lectured there in the 16th Century. It is also the university at which two African medical students are studying under scholarships provided by AMREF Italy and the university.

Dr Long also gave a presentation at the University of Milan, where she was able to visit the

university hospital's burns unit and orthopaedic rehabilitation laboratory, receiving donations of equipment and offers from specialists wishing to work as volunteers with AMREF in East Africa.

Urologist Dr Wachira was a special guest of the University of Bologna's Department of Urology, where he was able to observe surgery, receive donations of medical equipment and discuss his work in Africa at great length with interested

Italian colleagues.

Their tour also included a media blitz of appearances on three national television and four radio programmes, as well as interviews with six Italian popular magazines.

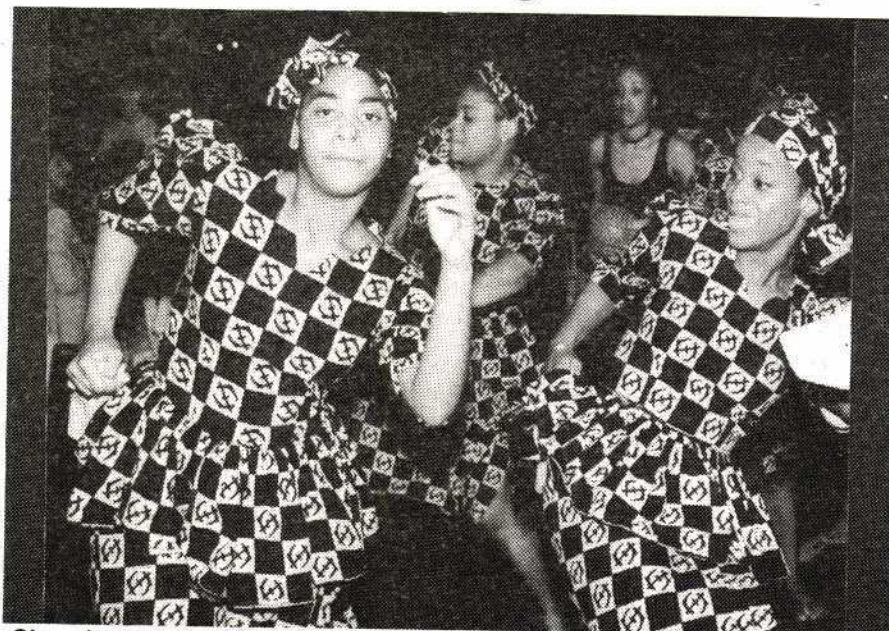
A final highlight of the trip for Dr Long and Dr Wachira, both Roman Catholics, was the opportunity to attend the Palm Sunday Mass, celebrated by the Pope at the Vatican, before their return to Kenya.

AMREF Italy Director, Tommy Simmons, said that the trip had been a successful one, despite the fact that it had occurred during the first week of the Kosovo crisis, where media attention was focussed.

"We have so far raised about US\$12,000 from about 200 new donors, and helped to strengthen the commitment of our existing donors," he said.

The burns and orthopaedic units at Milan University Hospital and the urological units in Bologna are all expected to provide long-term support for outreach activities in the form of materials and training."

AMREF Canada third gala



Ghanaian dancers entertaining guests during the gala

AMREF Canada is celebrating the unprecedented success of their third annual African Marketplace Gala on 27 May in Toronto.

Through the suppliers,

ticket buyers and over 100 volunteers, they raised over \$195,000 Cdn net—\$35,000 more than last year!

Over 550 guests enjoyed African cuisine prepared by ten different

caterers, swayed to West African drumming and dancing by local Ghanaian performers, bid on fantastic live and silent auction prizes and meandered in the colourful Marketplace Tent.

Project News

A South Africa Evaluation

By Isabel Mbugua

As part the on-going AMREF strategic planning exercise, AMREF South Africa undertook a comprehensive evaluation to review its scope, appropriateness, strengths, weaknesses and the sustainability of its strategy in South Africa, within an ever changing socio-economic environment. The evaluation also examined AMREF's capacity building strategy, assessed the perceptions of stake holders and staff on AMREF's future role in this country.

In-depth qualitative interviews were carried out with partners in the four main provinces in which AMREF has been working. Friends of AMREF and government personnel were also interviewed by the evaluator, Dr Irwin Friedman.

AMREF South Africa was established in 1995. It has since co-ordinated and been involved in many health and development activities in the country and has also expanded to serve Mozambique. The earliest contacts between



Participants at an AMREF workshop

AMREF and other groups in South Africa originated in the patriotic and liberation movement returnees who knew of the excellent work that AMREF was undertaking in various African countries.

AMREF South Africa's overall goal is to contribute to the improvement of health care for the underserved communities in the country through the provision of technical support to government, and other organizations. Unlike other AMREF country offices, the South African office is not directly involved in project

implementation but places more emphasis on capacity building, monitoring and technical support. Such support includes health resources development, health promotion activities backup and participatory research. Primary Health Care is maintained as a backdrop for all the activities.

The approach to achieving these goals has revolved around the principles of sharing experience rather than competing, building capacity rather than implementing, developing a few reference sites rather than diffusing energy over

many projects and using practical participatory self-discovery rather than theoretical didactic teaching. The success of this method has been demonstrated in that partners now not only do more, but are willing to share, involve communities, work across sectors and demonstrate relevant new knowledge, attitudes and skills. Field sites have been established in at least three provinces: Mpumalanga, North West Province and KwaZulu-Natal. There has been widespread collaboration with many NGOs and CBOs.

Partners interviewed relate the advantages of working with AMREF to its vast community-based health development experience elsewhere in Africa, the competence of its facilitators, the fact that it assisted in providing resources (fundraising for the work undertaken), the participatory approach and the approachable, pleasant manner of its staff.

Recommendations based on the findings of the evaluation suggest that greater focus around an axis of development from Gauteng through Mpumalanga to Mozambique would be

beneficial. It would also be useful to develop several integrated projects through sustained contact at sites that would become reference sites. There is a great need to market AMREF more effectively, and create a mechanism to develop perceptions of the organisation as an indigenous South African organisation with African linkages rather than vice versa. This would require innovative approaches to developing a new governance mechanism as well as building up more substantive partnerships with government and other NGOs.

Rockefeller funds health equity study

By Isabel Mbugua

The Rockefeller Foundation has funded a one-year study in Makueni district, eastern Kenya, whose purpose is to strengthen and support the implementation of decentralisation policy through a partnership approach. The 150,000 dollar study will demonstrate how a common and unifying strategy for health development can be used to build partnership in the context of health sector reforms.

According to the AMREF study co-ordinator, Dr Muthoni Kariuki, health sector reforms aim to improve

community accessibility to quality health services as well as to promote people's participation in health system governance.

"Equity in health care requires equity in the way health care resources are allocated, in the way health services are actually received and in the way health services are paid for."

The end-product of the study will be a report for discussion with the ministry of health and other stakeholders, and an intervention design of a model decentralised district that would enhance access and equity of health services.

Luwero and Nakasongola project evaluated

By Isabel Mbugua

The sexual and reproductive health project in Luwero and Nakasongola districts is an integrated project specifically addressing young people's sexual and reproductive health needs, including knowledge and services. This four-year project is funded by the Commission of European Union, DSW and AMREF Germany.

In April the project was evaluated by Dr Lillian Wambua, the AMREF regional adolescent health coordinator, and Dr Ulrich Laukamm-Josten, a public health consultant.

The adolescent project is a component of on-going health projects in Luwero and Nakasongola districts.



Beneficiaries of adolescent reproductive health with the evaluators

Others include child survival and maternal health, water and

sanitation and support and care to orphans. The primary beneficiaries are

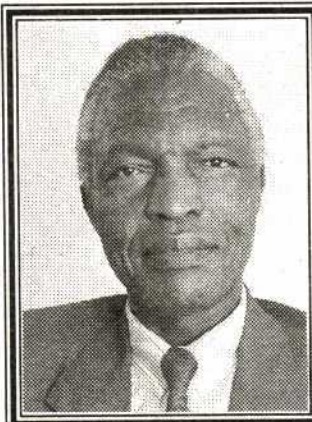
adolescents and secondary beneficiaries are their parents and teachers.

Early sexual debut, especially in girls, is clearly documented in the project sites. The population expressed mixed feelings of hopelessness or hope concerning the magnitude and the apparent relentless progression of the HIV epidemic.

The overall conclusion of the evaluators is that the "project is being implemented with greatly strained resources, but better and longer term benefits would be obtained if the initial ambitious plans were curtailed so that

activities are consolidated in the initial four sub-counties only. While touring the entire catchment area, one realises the great need and demand, but this although painful, will have to be restricted to meet the present funding level. In future, geographical coverage should be matched adequately with funding level. This was a good attempt to integrate youth sexual and reproductive health within other community based projects".

Meet AMREF new Board members



Mr Bethuel A Kiplagat, 62, Kenyan. Senior consultant on peace and foreign issues. Has wide experience in the NGO field as well as in diplomacy and development. Chairman of the current AMREF Board. Residence: Kenya.

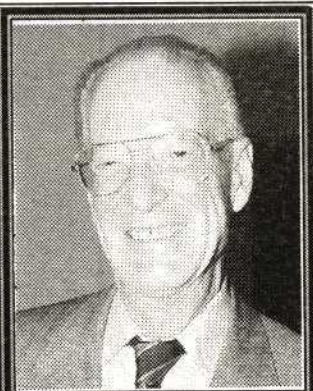
ISABELLA OCHOLA-WILSON, 49, Kenyan has a masters degree in business administration. Mrs Ochola-Wilson is currently deputy director of the Kenya Wildlife Services, responsible for managing the Tourism Department. Her key strengths are general management and business strategy development skills acquired during her seventeen years with Johnson & Johnson and three years with KWS. She has been a member of the AMREF Board of Directors and the Health Programme Committee. She also previously served as a member of the Executive Committee. Residence: Kenya.



Mr J. J. TUYT, Dutch, 69, has a masters degree in Dutch law. He is a retired senior executive with wide and varied international experience, mainly at board level. Main areas of specialisation include consumer goods, turnaround management, human resource management and organisational structures. Has been chairman and president of the Netherlands Philips Group of companies. Currently Mr Tuyt is chairman of AMREF Netherlands. Residence: Netherlands.



DR JOHN C NIXON, is a Canadian medical doctor with post-doctoral training in biochemistry (M.Sc. and PhD). He has been a member of the medical staff of the Ottawa General Hospital and the departments of Biochemistry and Pathology at Ottawa University. He has also been medical director of a large, international health and life sciences company based in Canada. He has served as a member and chairman of the Board of AMREF Canada for several years, as well as member of the AMREF Board of Directors, the Executive Committee and the Health Programme Committee.



DR EUNICE MURINGO KIEREINI, MBS, Nurse/mid-wife, Kenyan. Chairman of WHO Nursing/Midwifery Task Force (Africa Region), Family Health Foundation of Kenya, Flying Doctor's Society of Africa and Board member of Nairobi Hospital. As Chief Nursing Officer, Ministry of Health, she initiated the first Advanced Nursing Diploma Course in East and Southern Africa at the University of Nairobi; completely overhauled nursing education in Kenya, shifting emphasis from hospital orientation to the community. She was active in the formulation and adoption by Parliament of a new Nurses Act empowering Kenyan nurses to practice independently if necessary. Residence: Kenya.



DR FRED BINKA, MD, PhD, is a senior member of the new WHO malaria programme and out-going director of the Navrongo Health Research Station in northern Ghana. Dr Binka is a leading African epidemiologist who has carried out path breaking field experiments in vitamin A supplementation, use of insecticide-impregnated bednets for malaria control, and reproductive health/family planning in a severely disadvantaged population. He is one of Africa's best and brightest health scientists. Residence: Switzerland.



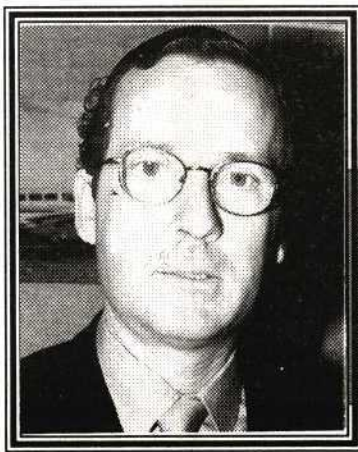
DR JESSICA SIMWOGERERE JITTA, MB ChB, Ugandan, 53. Physician and specialist in paediatrics and child health. Currently Director, Child Health and Development Centre, Makerere University. Previously involved in training of health workers in Uganda and Kenya. Over the last 20 years has been involved in the health of children and women at national and international level. Major achievements have been in the area of assessing health needs of children and women in Uganda, generating information for development and formulation of national policies, developing strategies for participatory research and planning with government ministries and districts and developing community-based interventions with active involvement of the communities. Residence: Uganda.



DR ADELINE KIMAMBO, Tanzanian medical officer and public health specialist. She has been working in different fields and in various capacities including as Director of Human Resource Development and Chief Medical Officer. She has as a very objective assessment of health projects. She served on the AMREF Board of Directors when she was the Chief Medical Officer, Ministry of Health, Tanzania. Residence: Tanzania.

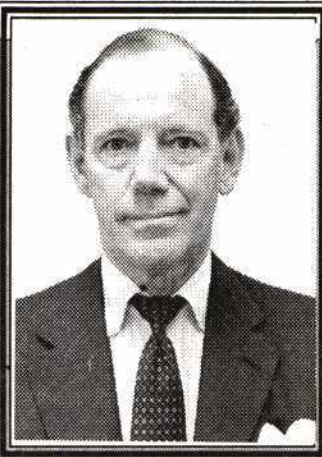


DR ULRICH LAUKAMM-JOSTEN, German, 49, is a consultant in public health, epidemiologist and specialist in infectious diseases, tropical medicine, reproductive health; research and health data management, district health systems and training. He has over 10 years practical experience in developing countries in project planning, formulation, implementation, management, monitoring and evaluation, including administration and financial management of projects; collaboration at international and national level with multilateral organisations, donors, governments, NGOs, scientific institutions, professional and community groups. Dr Laukamm also has experience in collection, analysis and presentation of data, implementation of record systems, including installation, maintenance of micro-computer hard and software. Dr Laukamm worked for five years as the AMREF Tanzania AIDS/HIV programme coordinator in Dar es Salaam. Residence: Germany.



DR ALFONSO VILLALONGA NAVARRO, Spanish, 42, is a plastic and reconstructive surgeon. He is a member of the Spanish Society of Plastic and Reconstructive Surgery and the American Society of Aesthetics Surgery. He is President, AMREF Spain. Residence: Spain.

MR FRANCIS HOWARD, British, 63, an accountant, spent much of his career engaged in the financial and general management aspects of large mining and industrial businesses, including 13 years in Africa. He became involved with AMREF UK in 1990, and served on the Board of Directors of AMREF ex officio as Chairman of AMREF UK from 1991 to early 1999. Mr Howard has long experience in financial, managerial and organisational matters, has direct experience in fund raising for AMREF from government, foundations, corporate and individual sources, and has been closely involved in evolving the organisation of AMREF today. Residence: UK.



MR ROBERT A. BIRD, 56, British, is an associate of the Chartered Institute of Bankers, and has spent almost forty years working in the banking and finance fields, throughout the world, with more than 20 years as chief executive of relatively large corporate bodies. His main contribution to the AMREF Board is in the areas of finance and management. During his ten year's residence in Kenya, he has had regular contact with the organisation and its staff and was a member of the Friends of AMREF for a number of years and, more recently, served on two AMREF committees. Residence: Kenya.

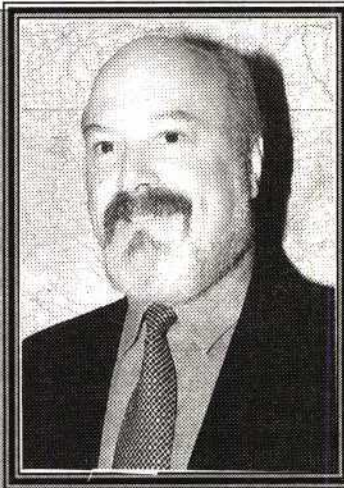


MR BO KARLSTROM, 65, is Swedish, and his professional background is in international economics and banking. Mr Karlstrom worked for eighteen years at the International Monetary Fund, Washington D.C., the last part of that period as head of the

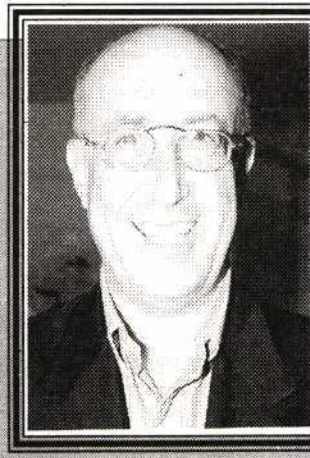


IMF's East African operations. In the mid eighties he was Chief Economist at Sida (the Swedish Development Agency). He has also worked as Senior Financial Advisor to Kenya's Minister of Finance (a World Bank consultancy), and more recently various other consultancies for the World Bank, Harvard Institute of International Development and the Swedish Ministry of Foreign Affairs. He has participated in AMREF work, national and internationally, over the past thirteen years. He has been deeply involved as a member of the Executive Committee. He negotiated an institutional support arrangement with Sida worth around 8 million US dollars over three years from 1998. Has published books and articles on foreign aid, economic development and financial markets in development countries. Residence: Sweden.

DR JOHN BATTEN, 51, was appointed Director General on 11 September 1998. John's academic background is in adolescent, childhood and adult education, psychology, supervision and administration. He earned an MA (1975) and a Ph.D. (1978) in the USA after which he joined IIRR in the Philippines, as the Chairman of Education and Culture programmes and, later, Director of International Training. In 1985, John came to Kenya as Deputy Director for Training with CARE International and joined ActionAid as Kenya Country Director in 1989. In 1995 John became CEO of ActionAid until he joined AMREF. John's areas of experience and competence include: strategic planning, organisational development, project development and fund raising. John was elected Vice-Chairman of the International Fund Raising Group (IFRG) in October 1998 and is a member of the Association of NGO Chief Executive Officers (ACENVO). He was a founder member of the NGO Council in Kenya and a member of the NGO Co-ordinating Board from 1993 to 1995.



MR BRUCE BODNER, a lawyer, American. He has served on the Board of Directors of AMREF USA for approximately eight years and as Chairman of AMREF USA from 1993 to 1998. In his capacity as Chairman of AMREF USA, he also served on the Board of Directors of AMREF and for the last three years has served on the Executive Committee. He practised law in New York City and was a partner with a large, multinational law firm. Since leaving the practice in 1980, he has acted as an investment banker and business advisor to a wide range of businesses. In addition he has produced three major motion pictures (two for Warner Brothers, and one for Universal Studios) as well as a television show for the Fox Corporation. For the past ten years, AMREF has been a major philanthropic commitment to him. Residence: USA.



ADANETCH KIANEMARIAM, 57, Ethiopian, has a public health background. Upon graduation with a diploma in nursing in 1961 and a certificate in nurse/midwifery in 1962 from the former Gonder Public Health College and Training Centre, she was selected to remain in the institution where she became an instructor. Until her retirement in July, 1994, she served her country at various capacities and learned a great deal from the opportunities and challenges coming with each position held during the 32 years of service. Residence: Ethiopia.



AMREF Board Members retire

By Scott Kelleher

As part of its restructuring process, AMREF has a new board of 16 members, who were introduced at the final meeting of the old board in Nairobi in May.

The AMREF board has been strengthened with the inclusion of a greater number of health professionals and Africa-based members. The newly-formed International AMREF Forum will provide the channel for communication on issues between the National Offices, other AMREF affiliates, the Board and Executive.

RIGHT: Leonore Semler, the Chairman of AMREF Germany, was one of seven retiring board members who were presented with certificates of appreciation for their many years of service by the Chairman, Bethuel Kiplagat.

Mrs Semler was thanked for her 30 years of service to AMREF.



New AMREF France office

Mme Zarina Tourraud is the new coordinator for AMREF France.

The new office address is: AMREF France, 11, rue Madame Sanzillon, Clichy 92110, Paris. The office fax and telephone number is (33) 01 40 87 13 87 and e-mail addresses are • **H Y P E R L I N K** "mailto:amref-france@hotmail.com" amref-france@hotmail.com and **H Y P E R L I N K** "mailto:zarina@club-internet.fr" tzarina@club-internet.fr

To Homa Bay with Tom Noel



Women are some of the main beneficiaries of improved water and sanitation

With Wangui, Joyce and Peter from UNGANA, and Patrick Mwaura driving, we arrived late in the evening to meet the Homa Bay Theatre Group and various other youth representatives, all of whom have been galvanised by Rose Agengo. They won first prize in the National Youth AIDS Theatre Competition (a superb trophy) and we were treated to a performance of "The Lecherous Fishmonger" - a side splitting comedy with a moral on infidelity and AIDS.

Drama and puppet shows are performed in market places, schools, and churches. Trained counsellors then talk to youth, men and women about the plays, after which condoms and information handouts are distributed.

In order to pay for their activities, these young people have begun to produce furniture, jewellery and household items from the water hyacinth which clogs Homa Bay. The leaves and roots are made into fertiliser, and the fibre from the stalks is wound into thin rope for making 'rattan'-type furniture.

The Ungana visitors were fascinated by all that had been achieved and it seems likely that there will be a lively exchange of

ideas and information between the two groups.

17.1.99

We assembled in the morning to watch the artisans at work, making latrine slabs and trapezoidal blocks, which are used in the latrine shaft to prevent collapse in soft soil. They have made over 3,000 slabs so far; 150 in 1998. It costs approximately 2,000 shillings to build a VIP, and the community has to put forward 30 per cent of the cost. Interestingly, some communities have started making their own slabs and selling some to neighbouring villages. A nice little earner!

From here we went straight to St Paul's Catholic Church, where we just managed to squeeze in. At the end of the musical two-hour service, the theatre group performed a play based on the story of Mordechai and the rescue of the Jews by his Queen, watched with wonder and laughter by some 200 children.

After church, Rose took us to Pundo Kalanya, a village I had visited last year. What a difference! With the shallow well now built, the villagers have become a model of community participation even, I would say, leadership. They now have

clean water for themselves and their animals. The women have a laundry slab and washroom next to the well. Hours have been saved in this way, so they fill in the time by growing vegetables in a nearby shamba, collectively and with the help of the local agricultural department. They have raised 3,000 Ksh in the last two months by selling these vegetables at the market. Nearby, the village youth group is also starting its own shamba, experimenting with different crops. A VIP latrine has been built and the villagers are making their own slabs now, some of which they sell locally to generate further income.

The Bamako Initiative and a malaria bed net programme are in full swing. A poultry house has been started, some 75 families having donated hens and money for the building. The agricultural department is loaning a Rhode Island Red to build up the stock. With the money raised from these activities, the community will build a pharmacy. Rose is clearly adored and revered by all ages. I was given a Luo name: Onyango Pundo (born in the morning in Pundo).

This is CBHC at its zenith, and the excitement and initiative of the whole community was infectious, with umpteen dances, songs, poems and

performances to entertain us all.

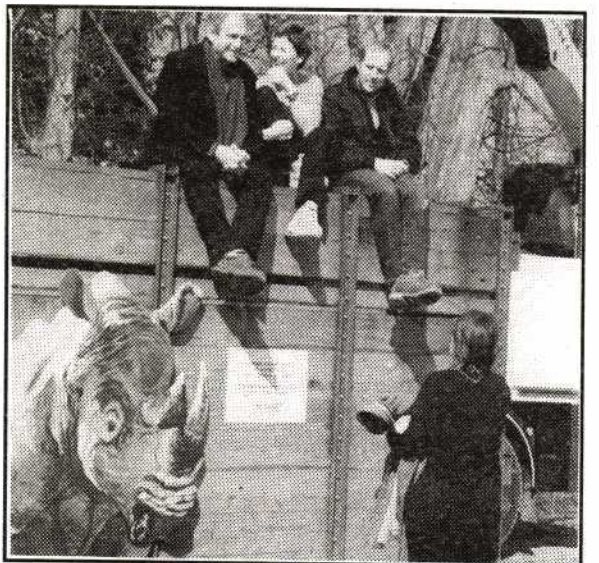
We then had a brief rest, joining the local fishermen on the pier that juts out into the bay. The Ungana girls were a complete hit, and managed to catch one fish about two inches long. After which, we had a meeting with the local youth groups who have been working with AMREF, watching more performances, listening to the AIDS songs of the Ochunge Boys Band (interesting; they have been developing music to reflect the moods of the lyrics: the passion of the quick fling followed by the tragedy of the illness and the isolation and family break up).

18.1.99 - Obwanda CBHC

Approximately a 90-minute drive from Homa Bay is this remote community over appalling roads. The reception, though, made up for it! AMREF is working with the Homa Bay government district hospital to set up a CBHC programme here. This is another energetic group. A community member has donated a large piece of land near the school for a community dispensary.

Water-borne diseases are a massive problem, so there are plans to dig water points (the communities are charged 350 Ksh per foot for digging done by AMREF artisans. The artisans take banana leaves down deep shafts to enable them to breathe - the leaves continue to produce oxygen for 20 to 30 minutes after being picked). The village health committee (six women, six men) has already started training with AMREF in mother and child health care, family planning, child health monitoring, Bamako Initiative and mosquito bednets. A temporary building now houses these activities (loaned by a community member), and the clinic has been named Thomas Noel!

Austria holds second family safari

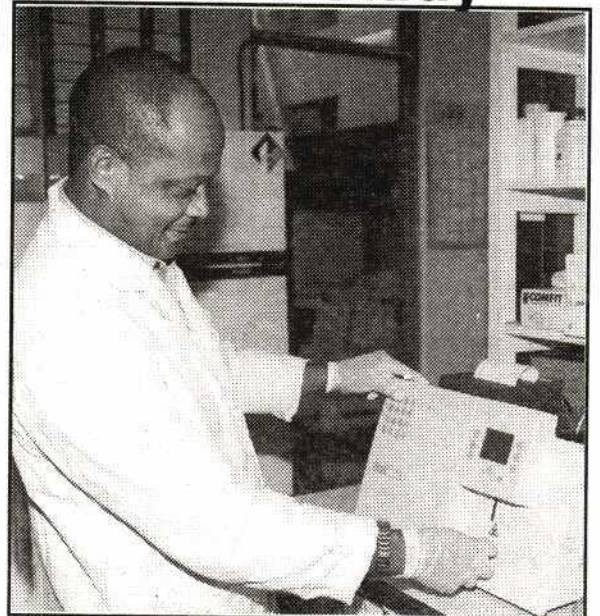


From Left: Fritz Egger, Sabine Pelzl and Harald Krassnitzer share a light moment with Austria office staff Christine

AMREF Austria organized a second family safari at Tiergarten Hellbrunn, Salzburg, where US\$10,000 was raised. The funds will be used towards the Temeke Child Survival project in Tanzania.

Special guests included famous Austrian actors Fritz Egger, Harald Krassnitzer, Sabine Petzl and Franz Buchrieser. The prizes included wooden animals and tombola flights to Kenya provided by Africa Safari Club and Austrian Airlines. The first second family safari was held in last December.

AMREF in diarrhoea study



Sadiki working in the laboratory

In collaboration with the Ministry of Health, the AMREF laboratory is carrying out a diarrhoea study at Mbagathi Hospital in Nairobi. The hospital serves people mostly from the city slums.

The study's main objective is to find out the common parasites and bacteria that cause diarrhoea in Kenya. Similar work is also being carried out in Machakos by staff of the Walter Reed

project, an American army research organization working at KEMRI which is funding the study. The findings from Mbagathi will be compared to those from the other site, and a final report presented to the Ministry of Health.

According to Sadiki Materu, an AMREF laboratory technologist, the data has yet to be analysed. However out of the bacteria components, bacillary dysentery seems to be the major problem.

Managing malaria in children

Of the 12 million deaths in children under five years that occur in developing countries, 70 per cent of the deaths are caused by respiratory infections, diarrhoea, malaria, measles or malnutrition, often in combination. Programs that focus on a specific cause such as diarrhoea or malnutrition can reduce these deaths, but often such programs do not identify and treat co-existing conditions that increase a sick child's risk of death.

To overcome this short coming, WHO and UNICEF developed a single set of guidelines for managing sick children presenting to a first-level out-patient health facility. The Integrated Management of Childhood Illness (IMCI) guidelines are appropriate for use by all health workers including doctors, clinical officers, nurses and other literate health workers who routinely treat sick children. Each sick child is evaluated for each of the five major causes of death regardless of what the mother tells the health worker.

In Bungoma better management of childhood illness was intended to focus especially on malaria and diarrhoea. Eight IMCI training sessions have been

organised for health centre and dispensary level staff, and at least each facility has two people trained. Clinical and nursing officers have been trained as IMCI trainers and supervisors.

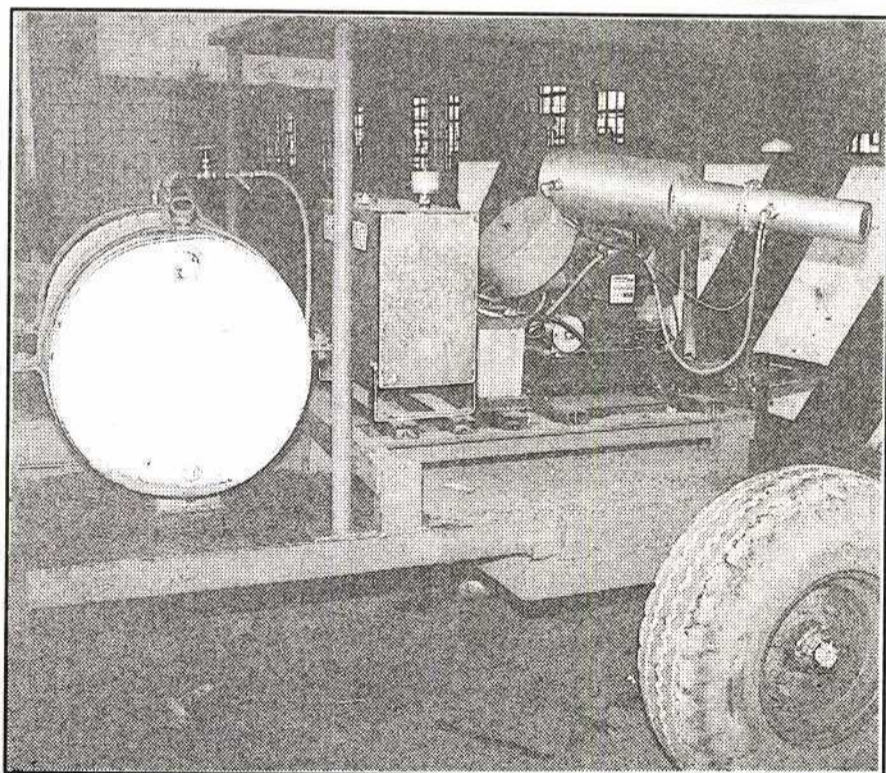
A 1997 evaluation showed that IMCI was either being partially practised or not at all. Some children were not getting the necessary management. To deal with this a quality assurance component has been introduced to improve IMCI in the district. Children do not get integrated management of illness because of a variety of problems at the health facility level. Health workers may report late, sometimes they do not work as a team, and they may be overworked and not adequately trained.

Quality assurance

The quality assurance intervention is intended to give health workers problem — solving techniques that will help them identify barriers to IMCI. The health workers of a given health centre or dispensary will first be introduced to the concept of IMCI. Then they will list all the possible problems the facility might be experiencing in using IMCI. The problems are

then prioritised, and each problem is tackled one by one. The team must, through discussions, understand each problem, identify its cause, and who among them is to work on solving it. For example who is directly involved when a sick child is brought to a health centre or dispensary up to the point of departure? Is the registration clerk at the desk? Is the service provider available? Is the pharmacy open? As they categorise the problems and solutions, the team members immediately implement the solutions, and monitor their performance. At Chwele Health Centre, for instance, the team realised that major problems were failure to understand IMCI, little team work, and poor time management. Following a seminar organised by the DHMT, the team resolved to report to work on time, work as a team, reallocate duties so that those trained in IMCI attended to the under fives. As a result, the number of children getting IMCI is increasing.

In some health centres, they have introduced on-the-job IMCI training. When majority of health workers in a dispensary or health centre have IMCI training, children are likely to get better management all the time.



A fog machine. A mixture of diesel and an insecticide are warmed to a given temperature in the drum, and then released as a fog which kills mosquitoes. Mounted on a tractor, the machine releases this fog in the SONY residential areas and the factory, a great relief to workers.

Malaria mapping in Uganda

In Uganda malaria contributes 25 per cent of hospital outpatient attendance, 20 per cent of hospital admissions and 14 per cent of inpatient deaths.

Malaria is generally endemic in all areas of Uganda, and according to the Health Management Information System reports for the period January/October 1997, malaria was responsible for the highest outpatient diagnoses.

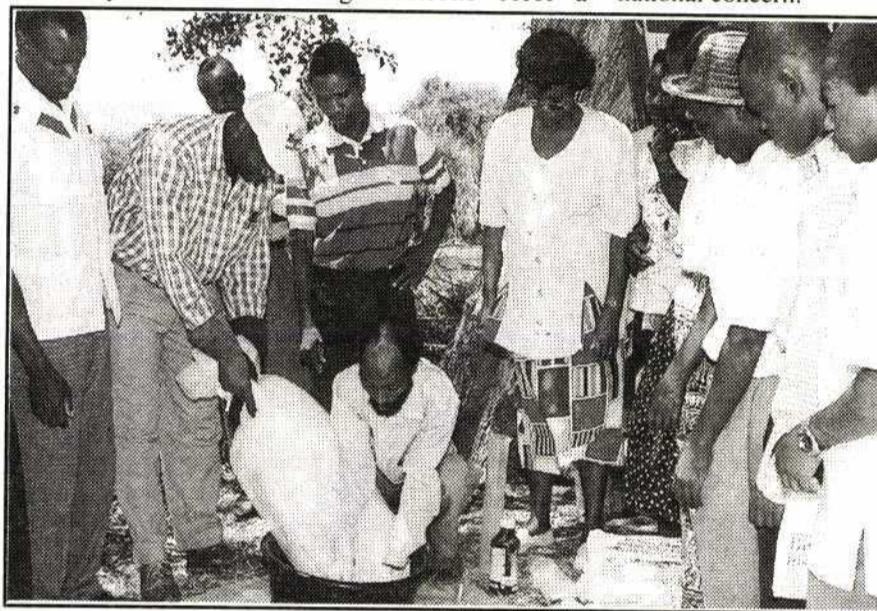
Due to the prevalence and severity of malaria, it has become a major focus for many health deve-

lopment organisations in Uganda. To understand who is working where and doing what, AMREF recently undertook a malaria mapping study for the Malaria Control Unit of the Ministry of Health, funded by WHO Uganda Field Office.

The study was intended to provide information on institutions and organisations currently working directly or indirectly in malaria control in Uganda, as a starting point for better communication and coordination of activities.

Most of the organisations offer a

variety of interventions, ranging from health education, sale of insecticide-treated materials, repellents and insecticides, environmental control, to distribution of anti-malaria drugs and related studies. Of the 94 organisations interviewed, 10 were identified as having well established activities and the technical capacity for malaria control. Those interviewed recommended that a participatory workshop be organised to map out the way forward in malaria control as a national concern.



Community members learn how to treat mosquito nets

Assessment of net availability in Uganda

Over the last decade, there has been renewed interest in one of the oldest technologies for mosquito control, the bed net. The effectiveness of the bed net was enhanced by dipping nets. Insecticide impregnated bed nets (IBNs) have been shown in The Gambia, Kenya and Ghana to be effective in lowering childhood morbidity from malaria and overall child mortality rates. It is increasingly clear that these nets are an effective tool against malaria. A major question, however, is whether IBNs are a feasible and sustainable intervention on a wide scale.

AMREF Uganda undertook a study, funded by PATH Canada, to gather information that policy makers and implementers could use to make decisions on malaria

control strategies, including the possible use of IBNs.

The study covered Kampala, Luwero, Soroti and Rukungiri. The study concluded that IBNs had a considerable potential as part of the malaria control strategy in Uganda. Key findings were:

- a high degree of awareness among heads of health institutions that IBNs are effective against malaria;
- reasonable availability of untreated bednets through the private sector, except in one study site where IBNs were promoted by an NGO;
- a good degree of interest on the part of consumers in having bednets, with the main advantage perceived to be fewer insect bites,

not malaria prevention;

- little knowledge of the use of insecticide on bednets except in areas where they have been promoted.

The study concluded that for IBNs to be successfully introduced in Uganda there would need to be large efforts to increase public awareness of the connection between mosquito bites and malaria and the potential role of insecticide treated nets. IBN cost-benefit issues would have to be emphasised. For example the fact that a single attack of severe malaria frequently costs as much as or more than an IBN might help overcome any financial obstacles. Policies concerning distribution systems, pricing, and taxation of inputs were identified as of prime importance.

PROFILES

A chat with Dr Javier Beut

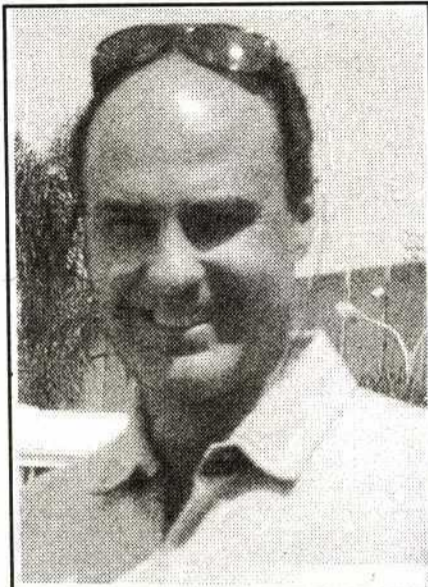
By Nancy Maksud

Africa is a unique continent to many people. The continent is perceived differently by different personalities. There are those who see Africa as a dark continent with endless problems, while others feel obliged to be participants in solving these problems. A few see Africa as a paradise, as a place to be during holidays, for relaxation and a different kind of entertainment.

Dr Francis Javier Beut, a 40-year-old single, Spanish plastic surgeon and founder of AMREF Spain, fell in love with Africa during his early years at a medical training college in Italy. "Doctors at this Italian hospital talked about a hospital in Africa in the middle of the savannah, and this amazed me. That's how I heard about Africa and after my course in 1990 I visited Kenya for the first time," Dr Beut says.

Born 40 years ago in Barcelona, Spain, Dr Beut speaks Italian, English and French. At age 19, he joined the University Central of Barcelona to study medicine. During the six years at the university, Dr Beut worked with a maxillo facial surgeon.

However, it is the Italian plastic and reconstructive surgery training with the famous Professor Morelli, one of the best



Dr Javier Beut

in micro and plastic surgery in Europe, that Dr Beut is proud of. It led him to Africa. "From 1995, I have spent a month between July and August during my supposed vacation at Wamba Hospital, in Samburu area of Kenya as a consultant surgeon. Wamba is the hospital referred to by the Italian doctors as "a health facility in the middle of savannah.

"During my visits to Kenya I got to know about AMREF's work. I became familiar with AMREF because Wamba Hospital was part of the AMREF radio network, and AMREF doctors were among the consultants.

"I think AMREF's development activities in partnership with the rural communities and other agencies is an excellent idea, but the fact that the Flying Doctors was created by plastic surgeons, and its base in Nairobi, attracted me the most," Dr Beut says.

Dr Beut saw potential in fundraising for AMREF in Spain. After consultation with the AMREF board of directors in 1996, he established AMREF Spain. The eleventh and youngest of the AMREF national offices, based in Europe and north America, national offices are responsible for raising funds for AMREF work in Africa.

AMREF Spain works in two locations. In Madrid, Spain's capital city, a team of staff has seen a number of projects supported through government and other donors. In Palma de Mallorca, an island in the Mediterranean, Dr Beut sensitizes supporters through organized lectures, social events, conferences as well as through videos and photographs.

Dr Beut's experiences in Africa have been documented in his book titled "Jambo Daktari". A fundraising tool, the book looks at the AMREF history through the eyes of Lady Wood, the wife of Sir Michael Wood, one of the AMREF founders, as well as the formation of AMREF Spain.

On his impressions with the health services in East Africa, Dr Beut says: "African people think as African people. We foreigners have to understand them and they have to understand us before we begin working together."

For example, looking at the set up of Wamba hospital, it seems unaffordable, expensive and crazy. But one must look at the castle inside and not outside. Its management and organization is important for the smooth functioning, cleanliness, a good working laboratory, medical drugs and other qualities it is known for.

"From what I have seen, for many projects, and it's not money they need, but organization. There are excellent doctors, nurses, laboratory technologists, whose output is half of their capacity; they need to be supported, remunerated well and encouraged."

"The original AMREF philosophy of taking medicine to the people must continue. This is what makes AMREF different from other agencies. Even if I try to be objective, taking into account my eight years experience in the region, I think AMREF services are vital. For example, the specialist outreach service that takes medical specialists to rural health facilities to perform surgery must continue because the need still persists."

For all those working to help solve problems in the rural communities, Dr Beut and others will be with them for a long time to come.

Agnes Musembi talks about the Disabled People's Organization

By Nancy Maksud

Poverty causes human suffering all over the world, but for people with disabilities, the suffering can be even more unbearable.

Agnes Musembi, a 39-year-old mother of four, born in Kibwezi, southeastern Kenya, is among the 50 million disabled people in Africa. At the age of six, a snake bite wound saw Mrs Musembi's right leg amputated from above the knee.

"I was a determined child, and the loss of my leg would not interfere with my plans. Using clutches to move around, I finished my secondary education in 1978," Mrs Musembi says.

She then joined the Kenya Posts and Telecommunication Corporation as a clerk. She acquired her first artificial leg. This was the beginning of good things for Mrs Musembi who was now able to move about. But this leg was cumbersome and heavy, limiting her movements. This forced her

to leave her clerical job.

"In 1993, I learned about the Kibwezi Disabled Peoples Organization (DPO). Established in 1990, the DPO begun with seven members only, after an AMREF survey, revealed that the disabled people of Kibwezi were disadvantaged and needed to come together to deal with their problems," explains Mrs Musembi.

The DPO's main objective was to come up with ways of identifying and helping the disabled people in Kibwezi to improve their lives.

Mr Nguli Mutisya, himself physically disabled and also in charge of the appliances workshop in the CBR AMREF project, invited Mrs Musembi for a meeting that led to her enrolment as a member after paying Kshs a 20 registration fee.

"In 1994 I was elected DPO chairperson. Through the DPO, I received a free better artificial leg and took part in a workshop that taught us how to fit artificial

legs. Life became much easier for me. I can now dig, carry my children and do other work without any problem," an appreciative Mrs Musembi says.

Under the leadership of Mrs Musembi, the DPO membership has grown from 40 in 1993 to 428 in 1998. The club creates awareness among people with disabilities in order to help them lead a better life. Through AMREF, the club started a loan scheme that enables members to receive loans to start projects.

Through this loan scheme Mrs Musembi has bought a water pump with which she grows vegetables as an income generation activity. For Jackson Katherya, a DPO member, the KShs 5000 loan has not only enabled him to revive his watch repair shop but as he says: "The scheme has built a sense of responsibility among the disabled people in the area."

According to Mr Katherya, some people thought the loans were handouts, but the members



Agnes prepares vegetables

now know they have to pay back the money. This has reduced dependency among people with disabilities. Some of the training opportunities offered to DPO members include carpentry, tailoring and making ornamental objects.

Among the challenges that face the club members is the high levels of illiteracy, which extends to their children. For the few who have completed primary education,

disability seems to interfere with admission to high schools and leads to many closed doors for employment.

DPO members began to create more awareness about their activities through the local administration - the sub-chiefs and chiefs. They visited homes where they knew disabled people lived and encouraged them to join the organization. The Kibwezi DPO is now

formally registered as a self-help group.

In Africa due to traditional and superstitious beliefs, families with disabled children did their best to hide them in order to avoid stigmatization. Today, however, the DPO has been able to change such attitudes and members of the community are now treating disabled people with respect.

In the past parents with disabled children were not willing to take them to school. While some still feel that educating such children is a waste of resources, Mrs Musembi says the organization has continued to fight against such thinking and now many parents with disabled children are beginning to send them to school.

For Mrs Musembi and her colleagues their future depends very much on their empowerment through organizations such as AMREF.

Diptsick malaria test kit



A nurse examines a baby at Mtwapa

One of the activities of the AMREF Laboratory Programme is to field test new diagnostic tests and kits. Inexpensive, quicker, simpler test kits, especially when they do not require specialised skills or even mains

power, can go a long way in improved health care service provision in rural Africa.

The AMREF Laboratory Programme has been involved in the testing of such kits and other tests for manufacturers, at the request of WHO. The latest request, from the Kenya National Laboratory Programme, was to test a portable dipstick malaria kit from Becton Dickinson.

Jane Carter and Orgenes Lema from AMREF spent a week at the Mtwapa dispensary testing this kit. Aply assisted by nurse Dorothy Mwandoe Mwadeghu, and with the support of staff from the Kilifi District hospital, the team intend to test roughly 1,000

patients, randomly selected. Mrs Mwadeghu has been trained to use the dipstick, and a support team of laboratory technologists take blood slides from each of the patients. The results from the dipstick and those from the blood slides will be compared at the end of the study.

The kit does not need any source of power and any dispensary level health worker can be trained over a few days to use it. The patients are all given a thorough examination to rule out other diseases such as ear infections or pneumonia which also cause high fever, especially in children. All patients are put on treatment and asked to come back on day four and day 14 or on any day in between should they feel

unwell.

"During this exercise we have realised that children with bad malaria probably do not always take the correct doses, as prescribed. Children who have malaria also lose their appetite, even for the sweet syrup that normally children have a taste for. Therefore they resist, and when mothers force medicine down their throats, they throw up. If the mother doesn't give a repeat dose after ten minutes, that child is not yet on treatment".

Hence the mothers were being given instructions on how to give malaria medicine to a very sick, unco-operative child by Mr Clement Shungu, the district paediatrics clinical officer.

Dr Spoerry's challenge

By Nicky Blundell Brown

Thanks to £1000 from Wolfson College, Oxford UK, and DM10,000 from AMREF Germany. AMREF was able to send a team of staff to assess the situation in Lamu where Dr Anne Spoerry provided services for years.

Anne's regular Mobile Clinics provided essential contact and care with the remotest Boni communities in the Dodori Reserve, neighbouring the Somali border. The assessment team (Dr Basil King and Nicky Blundell Brown), was able to deliver Unimix and milk powder to the Boni people. The main diet of these hunter gatherers is roots and maize, but bad weather and insecurity has reduced their already meagre supplies.

Basil King and Nicky, were greatly assisted in the whole exercise by World Wildlife Fund (WWF) and Kenya Wildlife Services, who provided the transport and armed rangers, as well as the Ministry of Health who provided four staff members to help us to provide the immunisation services and clinical care. The workshop organised by WWF for us to meet with representatives from

all the local communities gave us a useful insight into their problems.

The visit started in torrential rain, and after meeting the District Commissioner and hospital management team, we embarked on an exciting five-hour boat journey to Mkokoni where we all stayed at the WWF Education Centre, hosted by the project manager, Julie Church.

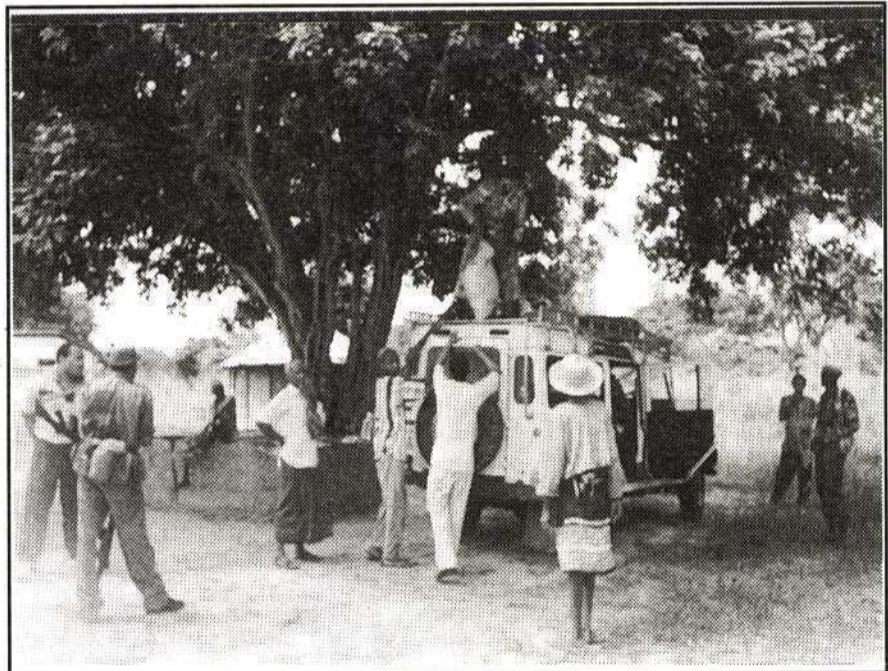
Disembarking at 10pm. into churning waves with all our medical supplies, suitcases in pitch darkness, was the beginning of an ever increasing admiration for what Mama Daktari had been doing on the Lamu Coast for the past 18 years. This admiration grew hourly as we visited the remote villages, often cut off for days. Frequently Anne had to walk nine or ten kilometres as the 4WD car was stuck, and she would have been bombarded by the squadrons of tsetsefly that attacked us in the car whenever we had to slow down because of difficult terrain. At times she must have been stranded as we were for three hours, due to poor communication, with one part of the team at one end of Kiwayu and

the rest of us at the other end of the island.

In every community we visited, we were greeted by expressions of sympathy for Anne and appreciation for what she had done for these families. There was also great concern for the future.

Approximately \$30,000 would enable the Ministry of Health staff to run regular monthly clinics. AMREF could provide specialist care such as ophthalmology, organize an annual community health worker training course for community members and sponsor the laboratory technician at Lamu Hospital to the AMREF refresher course. This will enable him to revive the existing three laboratories in the area. There are other initiatives which we are developing, and fortunately as this is a partnership scheme with the Ministry of Health, the Kenya Wildlife Service, and World Wildlife Fund, we are optimistic.

We had a good debriefing with the hospital staff, and the visit ended with a showing of the new French documentary 'Envoye



The assessment team distribute Unimix and milk to the Boni people

Speciale' featuring Anne's work in Lamu district and in Northern Kenya, to enthusiastic audiences in

the Lamu Fort and the Shella Primary School.

The community's response was evidence that

'Mama Daktari remains as much part of the Lamu community now as she did in her life..

Kisumu STD/AIDS project

AMREF has started a new STD/AIDS project in Kisumu. The two-year STD/AIDS project will focus on training doctors and nurses on syndromic management of sexually transmitted illness (STIs). The project will cover 12 districts and is funded by DFID through Futures International UK.

CORRECTION

In the last issue of AMREF News, in the Special Report which focused on our activities in Uganda, we reported maternal mortality as 506 per 1000. In fact it is 506 per 100,000. We apologise for this typographical error.

Flying Doctors Activities

FDS team airlift burnt school boys



Flying Doctors Emergency team carry one of the fire victims out of an AMREF plane

By Anastasia Mutisya

The Flying Doctors Services in May evacuated four boys from Nyeri High School in Central province of Kenya with critical burn wounds. The patients were evacuated by two AMREF planes after their condition deteriorated while admitted at the Consolata Mathari Mission Hospital in Nyeri.

The free evacuation was requested by the Office of the President in Kenya on humanitarian grounds. The boys were all admitted at the Kenyatta National Hospital Intensive Care Unit. The students, who

were prefects, were burnt, as they slept at night, when their cubicle was doused with petrol and set on fire by fellow students. Three of the boys suffered 90 per cent burns while the other suffered 60 per cent burns. They suffered face and air passage injuries.

"The AMREF team arrived in Nyeri in a record twenty minutes after they were alerted about the incident", stated the East African Standard Newspaper.

Unfortunately, all the four boys have since died.

Hundreds at "Mama Daktari" memorial

By Tom Noel

Hundreds of people attended Dr Anne Spoerry's memorial service at St. Mary's Church in London on 18 June.

Yves Spoerry, Anne's brother, and four AMREF staff addressed the crowd. A reception followed at the Frances Holland School where Anne had spent some time before going on to study medicine.

The service was attended by AMREF staff, friends and Anne's relatives. Anne will be remembered for her dedication to the people of Kenya for over 50 years.

Flowers for the service were donated by Michael Owens from Waridi Roses in Kenya.

AMREF and FDSA discuss collaboration

By Nancy Maksud

The need to be more creative when looking by both non-governmental organizations and the private sector is more obvious now than ever before. The competitive market no longer allows companies to operate in an individualistic manner. Collaboration, cooperation, mergers and skills strengthening are now common for survival.

AMREF is therefore reviewing its relationship with its donors, board, friends and collaborators.

One such review brought together a team of staff from AMREF and the Flying Doctors Society of Africa (FDSA) to look at ways of intensifying collaboration and cooperation between the Flying Doctors Service and the Society.

The Society, one of the fundraising arms of AMREF, was established in the early 1970s to support the Flying Doctor Service programmes including the emergency evacuations, radio communication network, specialist/surgical outreach services. The Society's annual grant to AMREF is Kshs 20 million.

In his opening remarks Dr John Batten, AMREF's Director General said: "The main objective of the meeting is to identify problems that affect the department's ability to attain its mission and at the same time plan a way forward."

Dr Batten told the meeting that AMREF had undertaken major changes in the membership and

structure of its board and was in the process of engaging new staff to enhance professionalism and expertise, making the Foundation more effective and accountable."

Among the newly established positions is the Manager for the Flying Doctors Service programmes and the Director of Resource Development, whose main role will be to develop a corporate marketing strategy, diversify the funding base by involving the general public as donors.

Mrs Eunice Kiereini, the FDSA Chairperson said: "Changes are inevitable. The Society is

also in the process of modifying its constitution, to change the method of election and tenure of office. There is need to inform the public about health care delivery service, as a means of soliciting funds from the public and the corporate sector.

The Society's Public Relations and Marketing Committee has prepared a marketing strategy plan.

Representatives of ALICO and Aon insurance companies made presentations on services they offer. An arrangement is in place where some of ALICO's clients are covered by the FDSA for air evacuations.

THE FLYING DOCTORS' SOCIETY

Membership Rates 1999

Members within a 500-km radius of Wilson Airport, Nairobi

Annual membership per person Ksh 1500
Annual membership Junior, under 18 years, per junior Ksh 1000
Tourist membership (for two months) US \$25
Corporate 'A' (companies) annual, Ksh 30,000 for up to 20 people, Ksh 500 for each additional person

Members outside a 500-km radius of Wilson Airport, Nairobi

Annual membership (Residents and Tourists) US \$50 per person
Annual membership Junior, under 18 years, US \$30 per person
Corporate 'B' (companies) annual, US\$1500 for up to 20 people, US\$10 for each additional person

No radius restrictions apply to the following

Life Membership US\$1000 per person
Overseas Annual Membership US \$50 per person

Residents of Kenya, Tanzania and Uganda may pay their subscriptions in their own currency at the rate in force at the time of payment.

In case of serious illness or injury, the Flying Doctors will, conditions permitting, provide its members with emergency treatment and air transport to a medical centre, if deemed necessary after direct consultation with an authorised person, namely a tour company representative, lodge or hotel manager, police or member of medical or nursing professions. Individual members are entitled to one free emergency evacuation flight in the period of their membership. Corporate members obtain 30% discount on all evacuation flights.

Membership is not transferable



Membership enrolment form

Cheques should be crossed and payable to The Flying Doctors' Society of Africa, and should be sent to the Society at P.O. Box 30125, Nairobi, Kenya or brought personally to the office at Wilson Airport.

Telephone numbers: Nairobi 501301, 502699
Telex: 23254 AMREF; Fax: (+ 254 2) 502699

Please enrol me as a member

Name (in capitals): Dr/Mr/Mrs/Miss/Ms*

Address:

I enclose my cheque/cash for

Date

Signature

Date of birth for junior member

*delete as necessary

Day Month Year

NB: Residents of Tanzania should apply to the Tanzanian Representative, Flying Doctors' Society of Africa, P.O. Box 34, Arusha; tel: Arusha 8144.

Statistics

1997

Kshs 60 million was raised by FDSA.
KShs 20 million was granted to AMREF for Clinical services.
KShs 35 million covered for emergency flight costs.
600 people were evacuated out of which 60 were humanitarian (free) evacuations while 230 were from the EA region.

1998

Kshs 59,692.627 was raised by FDSA.
Kshs 20 million was granted to AMREF for clinical services.
Kshs 37 million covered evacuation flight costs.

The fruits of partnership as seen in the Dagoretti project

By Nancy Maksud



From Left: John Ngethe, the new chairman of the Dagoretti village health committee, with the outgoing chairman, John Muchunu, and a committee member, Jane Kinuthia

Partnership can be defined in many ways. In the corporate sector the number of shares determine the level of partnership. For non-governmental organizations the concept is the same but the level of participation is the key determinant.

For AMREF, the Ministry of Health and the Dagoretti community, their partnership has enabled the three to run a successful joint community based health care services project backed up by a health centre.

The project integrates primary health care, community-based health care activities covering a population of over 72,082 in Waithaka, Mutuini and Ruthimitu locations, Dagoretti division, in the outskirts of Nairobi.

Nurses, laboratory technologists, clinical officers, a nursing officer and a public health technician are some of the 16 personnel attached to the project by the Ministry of Health. Among them is Peter Njenga, a public health technician who spearheads the HIV/AIDS/STI control as well as carrying out enviro-

mental health activities. "Dagoretti is a place of many activities, and sexually transmitted infections (STI) are common," Mr Njenga says.

"There are five slaughter houses with 600 employees and about 4000 hawkers and casual workers in the area. Our

activities include training of community based health workers, counseling and home-based care for AIDS patients, health education through folk media festivals for schools and other groups, outreach services and protection of water sources," Mr Njenga adds.

According to Anthony Mundoh, the AMREF project leader, in developing countries there is a rapid population growth in urban area caused by rural-urban immigration of young job seekers who settle in already congested slum areas placing serious constraints on the provision of social services, especially health care. Dagoretti therefore is not an exception.

A 1997 survey showed that in Dagoretti, out of 3425 adults tested for STIs, 524 were infected with various STD diseases, with 21 out of 86 testing positive for HIV/AIDS. "Sexually transmitted diseases became an important component of the project, targeting leaders, health workers, expectant mothers as well as high risk groups like bar maids, commercial sex workers, slaughter houses employees, *matatu* drivers, youth, street children, church goers, teachers and pupils," Mr Mundoh says.

Diminishing sanitary amenities and an insufficient water supply system has led to deterioration of people's

health. Less than 60 per cent of Dagoretti's population has proper refuse disposal systems. Proper latrine coverage is only at about 65 per cent, and only 30 per cent of the population has piped water, leaving 70 per cent to either buy water from vendors or use unprotected shallow wells," Mr Mundoh adds.

The five slaughter houses are an added burden to the community. They handle about 600 carcasses daily and wastes including blood, waste water, intestinal contents, skin, horns and bones is disposed off indiscriminately. With a poorly maintained open drain, waste water and blood find their way through Nairobi River tributaries to people, posing a great environmental and health hazard to the Dagoretti community.

The need for health education is therefore vital. Mr Nicholas Kiema, an AMREF Dagoretti health education officer says that since 1998 AMREF has trained 868 community volunteers including community health workers, traditional birth attendants, community based distributors, counsellors/home based care givers and peer educators.

Grace Wangui Hinga, a 42 year-old mother of four is a trained community health worker, a traditional birth attendant, and a community-based distributor of contraceptives, a counsellor and a home-based care trainer. Mrs Hinga is also the current vice-chairperson of the joint health committee.

Of all the training courses, the Traditional Birth Attendants (TBAs) course is what Mrs Hinga is most proud of. Although she trained as a TBA since 1995, she only became active recently. She has so far helped deliver 45 children. "Women come at night to call me, and I help them to deliver their

babies," says Mrs Hinga.

"We were trained as volunteers and used to get free delivery kits that included: gloves, razor blades, strings, cotton wool and soap, but nowadays we have to buy the kits ourselves," Mrs Hinga adds.

"I advise women to buy their own kits during check up visits, but the poor ones cannot afford. I also started charging a small fee of Ksh 200 to Ksh 300. TBA is a difficult job. Some women cannot afford even a minimal amount. When complications arise, it is my responsibility to transport mothers to the hospital."

It is Mrs Hinga's wish that all first time pregnant mothers and women who have had Caesarian section should be delivered by a doctor in a hospital.

Mrs Hinga recalls the two most exciting delivery experiences.

"I was called in the last minutes to deliver a woman whose water had already broken. I expected one child, but after it was born, the mother was still un-comfortable and in pain. After 10 minutes another child came out. I was so happy. The babies were very health and in good condition. I never thought I could deliver twins.

"In another experience the baby's legs came out first instead of the head. As I was telling the mother how we needed to go to a hospital quickly, suddenly the baby came out, very tired and she only cried after four minutes. The mother too was very tired too," Mrs Hinga says.

"Out of the 60 trained TBAs in Dagoretti only a few are active," says Mrs Hinga, whose wish is to one day run a maternity ward for TBAs. The TBA cum business woman, Mrs Hinga also owns a kiosk at the Dagoretti market.

For the many women living in the rural areas and peri-urban slums in Africa, their only hope of safe delivery depend on the likes of Mrs Hinga.



Mrs Grace Hinga, a traditional birth attendant at Dagoretti

WHO Support Laboratory Assessment Programme

By Scott Kelleher



Technologists at the AMREF laboratory

The AMREF laboratory services programme has been asked by the World Health Organization to extend its External Quality Assessment activities into a further two countries in the East African region.

With a small grant of US\$10,000 from WHO, AMREF will expand its current programme into Somalia and southern

Sudan.

During the recent Africa Regional WHO meeting on Laboratory Quality Assurance in Addis Ababa, several countries expressed interest in joining the AMREF programme. This support from WHO has led the regional authorities to recognise AMREF's position as the organisation most capable of

developing and implementing laboratory quality assessment in the region.

Following another recommendation from the WHO, AMREF's laboratory programme has also been invited by the government of Swaziland to perform an evaluation of the country's national laboratory services. AMREF has performed a similar exercise for the

Tanzanian government in the past.

The AMREF laboratory programme began in 1985 and has established itself as an important element in the foundation's clinical services programme, not only as a working laboratory and teaching centre, but as a referral and focal point for government, mission and NGO hospitals and health centres.

The AMREF's laboratory in the Kenya Country Office, at Wilson Airport is monitored and tested several times each year by reference laboratories in Europe, as part of a WHO-supported international scheme. This testing ensures that AMREF's own laboratory standards are kept to the international mark.

AMREF uses a similar system to monitor the standards of regional laboratories.

"We send out 'tests' to regional laboratories on a

regular basis, by post or courier or on AMREF outreach flights. We send them some test samples and a clinical history of the patient, along with an accompanying questionnaire, asking them to test the specimens, looking at both the clinical and public health relevance of the results, and then send them to us," Dr Jane Carter, head of the AMREF Laboratory Programme, explains.

"In this way, we can monitor laboratory's standards and help them to learn and improve. We sent out 41 tests in April and May this year and after we receive the tests we will give each laboratory their results and other feedback to help them improve their skills," she said.

The programme is designed to be supportive and educational rather than performing a policing or accreditation role. Dr Carter says that these regular challenges from

AMREF have clearly demonstrated improvements in the standards of quality by encouraging laboratories to improve their performance and identify problem areas.

Results from the laboratory external quality assessment programme are in turn passed on to WHO in Geneva to allow the organization to monitor laboratory testing standards in Africa.

Dr Carter says that the programme itself is still small, but that the importance of AMREF's regional role is now being clearly recognised by WHO and regional governments.

"With just over 40 laboratories now as part of the programme, we are just barely scratching the surface and the programme has the potential for expansion into thousands of laboratories in different countries throughout the region," she said.

AMREF support Nyumbani Children

By Nancy Maksud



Nyumbani children just before the flight

AMREF, Boskovic and the Aero Club of East Africa organized a 30-minute flight for 24 children from Nyumbani Hospice, a home for orphaned and HIV positive children. This was the first air ride for the children aged between five and eight years old.

The two Caravan planes from AMREF and Boskovic took off from Wilson Airport with the children and their

caretakers for the 30-minute ride. Nyumbani, the Children of God Relief Institute, currently supports 65 HIV-positive abandoned infants by providing nutritional, medical, psycho-social and spiritual care. The children who convert to a negative status are often adopted or transferred to appropriate settings, while for those who do not convert, Nyumbani becomes their permanent

home.

Michael Duckworth, Chairman of the Aero Club said: "It was a good gesture for AMREF, Boskovic and Aero Club to join forces to give Nyumbani children the air-ride."

"This will be a day the children will always remember," said Mr Ephraim Gathaiya, the General Manager of Nyumbani. The children were also hosted to lunch at the Aero Club.

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AMREF registered in Mozambique

five-hour drive from Maputo, and here we will be looking at malaria and AIDS, results of which will also have national level implications. AMREF will provide technical support to the provincial medical team, who are very enthusiastic towards the collaboration", says Dr Youri.

In Mozambique the government decides which donor supports what province, and which agency implements in what province. The major donors for Inhambane at the moment are UNICEF, Irish Aid, Swiss Development Cooperation and Norad. Donor funds are entrusted to the provincial administration who then allocate it to various

implementers.

At the district level AMREF has already been working in the vast rural Inharrime district where, with funding from AMREF Spain, community based primary health care interventions have been strengthened. The two-year 200,000 dollar project has been implemented in one of the most underserved areas, where there is no medical doctor and there are only a few middle level health workers.

In Maxixe City, AMREF has been dealing with a variety of health issues, but particularly adolescent reproductive health. The other activity that AMREF Spain has been funding building the

capacity of the 22-member Mozambican Council of Churches to improve primary health care service delivery. This has involved training of health personnel in management and other technical areas.

"Other than assisting the Mozambican government in improving the health of the people, AMREF is also looking forward to the challenges that working in that country will provide. For example working in Inharrime district where there is no medical doctor in the seven health centres and dispensaries and working in the Maxixe City, an urban district that has more resources will provide useful learning experiences," says Dr Youri.

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