



## Ananda Marga Universal Relief Team West Africa Newsletter – January 2012

### Burkina Faso, Cote d'Ivoire, Ghana Nigeria & Togo

Dear Friends,

Abakaliki, 30 December 2011

It's a good feeling to bring you the update of the AMURT projects in West Africa. I apologize for failing to send out a newsletter in the summer this year. This issue is bulky, still I hope that you will take time to skim through it. All of us in AMURT West Africa have a passion for what we do and value the opportunity to share with you our adventures and struggles, our disappointments and joys. There are many ways you can also be part of these projects.



The Bisséri Project in Burkina Faso has blossomed, quite literally, with growth in the agric activities and community extensions. The clinic is going steady. The TBAs in the desert villages continue to play an important role, as AMURT has taken new initiatives in water and agric. It's been nearly ten years since AMURT Cote d'Ivoire's excellent work during the Liberia refugee crisis. In 2011 AMURT Cote d'Ivoire has been revived and is getting ready to start projects. In Ghana, the Mafi-Zongo Water Project distribution network has finally been completed, all 61 km, seventeen years after work started. Community development work takes a lot of patience and perseverance! AMURT Nigeria is exploring new approaches to maternal health with some promising response. Drilling of boreholes accompanies by water and sanitation training has started. In Togo, the school project continues to expand and stabilize.

We are learning. We are slowly growing wiser and stronger. We are building our capacities and getting ready to reach more people in new project areas in 2012.

Our deep heartfelt thanks goes out to volunteers, donors and all of you who have given your love, encouragement and support in 2011.

Sincerely yours,

Dada Daneshananda, coordinator



## **A Christmas of Tears – Offia Oji Health Center, Nigeria**

### **24<sup>th</sup> Christmas Eve**

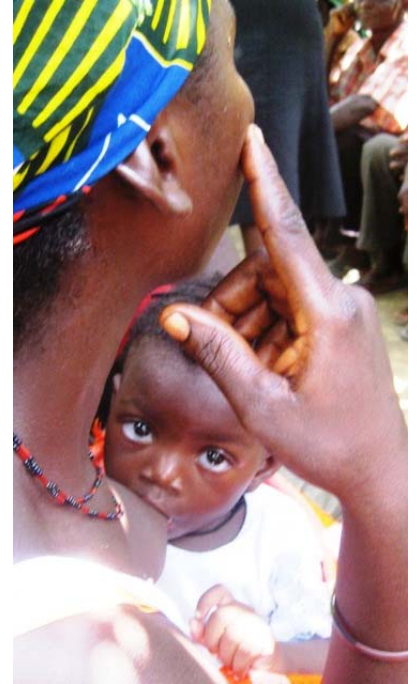
Offia Oji Health Center, Ebonyi State, Nigeria. The day started well with the sensitization meeting at Egu Ezi, the final village in AMURT's water and sanitation project for 2011. The WASHCOM was formed and dates for four days of training fixed. Returning to the health center we got word of an emergency at Onuenyim village. A woman had delivered alone, in a yam barn, and was bleeding heavily. Nancy takes the lead, as our vehicle rushed to the village 5 km away. But too late... the young woman is already dead. She has delivered premature twins, a boy and a girl. Our vehicle set out to bring the tiny twins to the Federal Medical Center in Abakaliki, 90 minutes drive. They were both alive upon reaching the health center. The husband, a student, arrives from town on motorcycle just as darkness fell. After 9 pm we receive word that that the boy has died. Blessing says that this will be a Christmas of tears.

Late night we are woken at the health center as another young woman, first pregnancy, arrives. Blessing and Paulinus, who has volunteered to forego Christmas with their families to be on duty at the health center, take care and the woman delivers a beautiful baby boy, just before midnight.

### **25<sup>th</sup> Christmas Day**

The husband buries his young wife at dawn before heading back to the hospital. He is not allowed to see his daughter who is in intensive care unit. He is too dusty they say. He returns in the afternoon with the body of his late son in a cardboard box. The doctors are cautiously hopeful for the girl to survive. ...the baby girl, named AMURT 1 by the hospital, dies on the 28th.

A woman from Mkpulachi visits the health center, and Blessing tells her of the video we have from the concluding celebrations of the village WASHCOM training. The woman laughs as she watches the video of the masquerade, the children dancing, and herself acting in a drama to illustrate lessons learnt from the training. She plays a young girl who wants to pursue her education. Her father says he has no money for her school fees. In desperation she looks for a young man to help her. He gives her money, but he also gets her pregnant. The story does not have a happy ending, but ends in misery, a melodrama in the best Nollywood tradition. The woman spots a little girl dancing on the video, and tells us that the mother died in childbirth this December, soon after the video was made.



### **26<sup>th</sup> Boxing Day**



Another young woman arrives with her mother at 3:30 am. The delivery is difficult, but Blessing does an episiotomy and the mother delivers her first baby a healthy baby girl at 9 am. The sound of a newborn crying... the sweetest sound to my ears. *Photo: The young mother with daughter and midwife Blessing on the 26<sup>th</sup>*

I spent six days at the clinic, sharing Christmas with the health workers, the patients and the villagers. An unforgettable Christmas. I would not have wanted to be anywhere else.

We have verified the details of 31 maternal deaths since 2009. Each story more heartbreaking than the last. In a population of about 5,000 women of child bearing age, this indicates a maternal mortality well above Nigeria's national rate which remains among the highest in the world. It was the high maternal mortality rate that brought us to Ebonyi State.

Working with maternal health brings us very close to the two most basic of human experiences, the joy of birth and the pain and helplessness of death. Earlier in the week another difficult labor at Gmelina health center ended well. Fetal distress was detected after a long and painful labor caused by oxy posterior positioning of the fetus. We made preparations should the baby need resuscitation. By His Grace things went well and the baby came out strong. The happiness and peace I felt entering the room after the delivery was palpable, filling the air, the mother resting serenely with a smile of pride and joy, and the relatives' beaming smiles in relief and gratitude to God and the efforts of the health workers.



*These experiences confirm to me that AMURT is in the right place, with the right focus. The rural African village is where we want to be. Struggling to prevent maternal and neo-natal deaths is what we want to do.*

Dada Daneshananda

## **NIGERIA**

### ***So that no mother is ignored, forgotten and neglected...*** **The evolution of AMURT's maternal health programs in West Africa & the search for the best strategy**

#### **Face to Face with maternal deaths**

Facing the first maternal deaths in the project area in area really shook me. Statistics are important, but having to face the tragedy, to be a participant in the heartbreaking events, really drove home the gravity of the responsibility we have taken on. The realization reminded me of when I first faced HIV/AIDS in Africa. What had been newspaper stories became real and I looked in AIDS in the eye, real people that I could touch and who needed me.

#### **Deciding how to work with maternal health in Nigeria**

Finding and deciding an effective strategy to address the maternal mortality rate has not been easy. We came to Nigeria after years of safe motherhood programs in Burkina Faso and Ghana where AMURT had focused on the training, equipping and supervising of Traditional Birth Attendants. It was only natural that we initially sought to carry our experience of working with TBAs to Nigeria.

We soon discovered that in Nigeria the official policy discouraged working with TBA's. Govt. and UNICEF had until recently worked along lines similar to AMURT's TBA training programs in Ghana and Burkina Faso. This strategy was scrapped when it became evident that these it did not reduce maternal mortality.

#### **Promoting natural childbirth and training TBAs in Ghana**

AMURT's TBA programs in Ghana and Burkina Faso still remain viable after six years. In Ghana we can still work with TBAs thanks to the low maternal mortality rate in our project area. Compare 1 death in 10 years in Ghana's Mafi-Seva project area, to 31 in three years in the Ekumenyi project area in Nigeria. An important component of the Ghana TBA program has been the introduction of natural childbirth practices in Mafi-Seva Community Clinic. The philosophy and practices of gentle birthing resonate so well with the TBAs. The tradition they belong to continue to carry the purity and wisdom of countless generations of midwives. This wisdom is often forgotten in modern medical facilities. [Photo: Dr. Jennifer Sparks from Boston during training for the TBA's at Mafi Seva in December](#)



#### **Extending maternal health services to the remote villages in Burkina Faso**

In Burkina Faso our TBA program remains relevant ten years after we started in February 2002. The Burkina Faso govt. has since also adopted the policy that all deliveries should be in health facilities and officially discourage the TBAs. Still, as the govt. has been unable to provide new health infrastructure in Deou department, the TBAs continue to play a role, particularly in the most remote villages, some as far as 40 km from the nearest health facility. The local health department recognizes the fact and wants AMURT to continue the safe motherhood project. Adding to the hospital built by AMURT in 1986, the govt. now runs two more health centers in Boulekessi and Gandafabou. An important contribution of our safe motherhood program in Burkina Faso has been the good coverage of mothers receiving ante-natal care. Neither the Fulani (Peuhl) nor the Bella tribes had any tradition of assisted delivery or midwives or birth attendants. When we started in 2002, a Bella woman at the health center was a very rare sight. AMURT safe motherhood program changed this through training Fulani and Bella woman as TBAs, who in return educated and mobilized the women in their villages to start attending the health centers. AMURT's sponsorship of monthly mobile ante-natal clinics in the villages most distant from the health centers continue to make a big difference.

### **Why are TBA programs not effective in Nigeria?**

I first reacted to the government's attitude to the TBAs. I felt that they deserved more respect for their service to the communities. After visiting many TBAs and seeing firsthand how they rely on magic and mystical secret practices, I understood that they would be difficult to train. As the news of maternal deaths in the villages started to come in, I understood the rationale behind the govt. policy and AMURT needed to find a different approach. The reason is simple: it is very difficult to properly train TBAs, most of whom are illiterate and elderly, to handle obstetric emergencies.

### **Why do 90 % of women still deliver at home?**

The key question was: how can we bring the women in to deliver at the health facility? The rounds I made visiting rural health facilities found many with zero or very few deliveries. Why, in an area with so many maternal and newborn deaths, do women still hesitate to go to the health facility for safe delivery? Here are some reasons:

- Poverty: The health facilities charge cash. The TBAs accept yam or fowls.
- Accessibility: The distance to the nearest health centers has been too far. Transport difficult, unavailable or too expensive.
- Habit: They know the village TBA. They trust her and are used to her. "Everybody else deliver with TBA, so I will also deliver with TBA."
- Ignorance: The women are not aware of danger signs and risks in pregnancy and delivery. They believe only God gives children and surrender to the cruel hand of destiny.
- Pride: At times the women who go to health centers are seen as weak. The women like to deliver at home to prove to their husbands, family and friends that they are strong.
- Distrust: The women fear that when they go to the health center it will be closed, or that there will be no nurse, midwife or doctor to assist them.

The location of our new health centers has addressed the difficulties of access. Our model of community owned and community managed health centers empowered the people to set fair and affordable fees themselves. The dilemma of free maternal health services vs. the need to ensure sustainability of the community owned facilities remains an issue under constant re-evaluation.



To create awareness and change attitudes take time. The only way is through outreach. We organized health education meetings in all the villages. We approached every pregnant woman we saw, on market days, on the road, or just passing by the health center. The mothers, rather than feeling hassled, appreciated the personal attention and gradually started coming for ante-natal check-up and delivery. [Photo: ante-natal day at Offia Oji health center](#)

To earn the trust of the community is essential for any work. With a negative history and distrust towards public institutions, building trust will take time. We needed to find enough committed staff. We can't do maternal health programs without staff on duty 24/7. We needed to build a team feeling among the staff, and motivate them to give their best. The health workers needed to be recognized for their sacrifice and services they provide.

### **The HOME BASED CARE FOR MOTHERS and NEWBORNS Program**

For AMURT Nigeria's maternal health project we have adopted a program originally designed by UNICEF and promoted by Nigeria's National Primary Health Care Development Agency. It is called Home Based Care for Mothers and Newborns. It's a wonderful program, but unfortunately, like so many other govt. health initiatives, it largely remains merely a good idea on paper, with very few examples of actual implementation. At the heart of the program are health workers making home visits to pregnant women and newborns. The health workers are trained to educate the mothers about risks during pregnancy and to teach her the danger signs to watch out for. The mothers are encouraged to come to the health centers for ante-natal check-ups. Finally the health workers assist the women and their families to make a birth plan, and advice them to deliver at the health center.

AMURT sponsored two training sessions in the month of May. The first three day session was for Family Planning Counseling. The three health centers and three additional health posts could for the first time offer an inventory of contraceptive products and counseling to the population. Until recently, there has been very little awareness, acceptance and access to family planning in the rural communities. Development has brought more exposure and the attitudes are beginning to change. The tradition here is to have many children. Many also reject family planning as they believe it to be



against church dictates. Making contraceptives available also plays an important role in the empowerment of women and also has a direct impact on maternal health.



The training on The Home Based Care for Mothers and Newborns lasted eight days. Thirteen health workers participated. We invited staff from the Ebonyi State Ministry of Health Reproductive Health Office to conduct the training. After the completion of the training, the health workers were assigned 1, 2 or 3 villages each, and they set out to visit every home in 34 villages. Their task was to introduce themselves and the program, and to register the details of every woman of child bearing age (aged betw.15 and 49), and to take note of all the pregnant and nursing mothers. In total we registered 4,788 women of child bearing age.

The heart of the program is to give individual attention and care to each and every mother and their newborn babies. This is a huge task and difficult to implement perfectly. Our aim is to ensure that no mother is ignored, forgotten or neglected. That each mother gets the opportunity to receive the care that she needs, and which is her right.

To enable us to monitor the effectiveness of the program we needed a baseline. The preparations for the survey took time, but by September we were finally able to carry out the survey. We received invaluable guidance from Hanna Ashar, the monitoring and evaluation consultant with AMURT Global Office in Washington DC.

The survey used random samples from among the registered women of child bearing age in 34 villages. Only women who had delivered within the last three years were included. We conducted a two day training session for the 15 surveyors. The survey questionnaire covered demographic information, background characteristics, maternal and child mortality, access to ante-natal, delivery and post natal care, child health services and family planning. [Photo Blessing conducting interview for the baseline survey at Okwerike village](#)



The survey yielded alarming figures on maternal and child mortality. Paulinus Nwangwu, the AMURT Safe Motherhood coordinator, took on the unenviable task of verifying the maternal deaths. He collected names, dates and details of 29 maternal deaths since 2009, all brought to our attention by the women interviewed in the survey.

The most common cause of maternal deaths is post-partum hemorrhage, followed by obstructed delivery. The most vulnerable group is women in their first delivery and women above 35 years of age.

Only 1 out of 579 interviewed had any education above secondary school. Only 4 % had attended secondary school. The women interviewed had lost a total of 369 children between them, giving a child mortality rate of 15.6 %. Many of the women had only had 1 or 2 births. This indicates that the actual child mortality will be much higher.

While 67 % of the women reported that they attended ante-natal care, only 13 % deliver in the health center. Less than half of the women said they planned on having their next baby in the health center, so we have a lot of work ahead of us.



Paulinus making home visits in Onuenyim village.



Steven registering women of child bearing age in yam barn at Efugbu

If you are interested in the full report of AMURT's Maternal Health Baseline Survey, you can contact [nigera@amurt.net](mailto:nigera@amurt.net).

### Step by step: the gradual growth of AMURT's three new health centers in 2011

After opening the doors in late 2010 we soon found that each of the new health centers had its own dynamics and were each affected by its own unique set of factors. Offia Oji health center took the early lead with more patients and deliveries. The health center's location, near a major market place, appears to have been significant. In planning further health centers we will favor locations close to market places. From the start Offia Oji had dedicated staff willing to come to work and do night shifts. This gave Offia Oji a flying start. Only after improvement in staff attendance did Ephuenyim health center start to catch up, and towards the end of year, particularly in outpatient attendance, they had drawn level with Offia Oji. Gmelina, in spite of having the biggest and best facility has had fewer patients and deliveries. We believe that the relative proximity to the city is a factor, as the people find it easy to access the hospitals in Abakaliki. After securing additional staff in October, there has been a marked improvement, proving once again that the human factor, health workers at work, is most important. A large number of staff is needed to ensure a round the clock care. Each of the health centers now has eleven staff each. Half of them are local community volunteers and apprentices.



Dr. Fatoba and the Offia Oji staff after training a training session. L to R Chinyere, Chinyere, Hanna, Dr. Fatoba, Blessing and one more Chinyere!



Volunteer health workers have been invaluable to ensure round the clock service at the health centers. Here we meet the dedicated volunteers at Ephuenyim health center L to R Blessing, Lucy, Louisa and Gloria

The three health centers together have reached 205 deliveries at the end of 2011, Offia Oji leading the way with 117. None of the women who have come to deliver at the health centers have died, and that's a great record. We have had about seven emergency referrals to the hospital in Abakaliki that saved the lives of the mothers, but some of the babies could not be saved. Using rural birth rate figures from the Nigeria National Demographic Health Survey, we find that in the Offia Oji area close to one out of four deliveries take place at the health center. While in the Gmelina area, the figure is closer to one out of eleven. In 2012 as we will aim at doubling the number of deliveries.

We had two maternal deaths at Ephuenyim Health Center. In both cases, the women delivered with TBA, but when post-partum hemorrhage set in after delivery, the TBA was unable to control the bleeding. The women were eventually carried to the health center by motorcycle, but arrived too late



to be saved. These tragic events clearly confirm that our strategy to motivate the women to deliver at the health center will save lives.



This baby boy's mother died from cancer a few weeks after giving birth. Her condition was so serious that the baby's birth was an amazing miracle. And his name is Miracle.



This young woman from Obegu Omega delivered at Gmelina clinic. .



In the clinics have had many children with pneumonia during the last months. Without the clinic, many of these children would not have survived.

### Cervical Cancer and HIV screening

AMURT was able to bring other services to the health centers. Our partner NIWA organized cervical cancer screening in all three health centers as well as HIV/AIDS testing. The cervical cancer rate in Nigeria is very high. The raising of awareness about sexual health and personal hygiene play an important role in reducing the spread of this disease. We have had several cases of HIV/AIDS at the clinics, and the HIV/AIDS awareness campaign is integrated into the water and sanitation training that has so far reached 15 villages. Photo: Nancy from NIWA teaches about personal hygiene and sexual health during cervical cancer screening at Ephuenyim health center



### Minor surgery

Nearly the whole population in Ekumenyi are farmers. Yam and rice are the main crops. There are no tractors. In the area the farmers make heaps to plant yam and other crops. It is all done by hoe. As a result, among older men in particular, hernias are common place. The health centers have made hernia operation and other minor surgeries available and affordable.

Photo – left: Yams of every shape and size at the Offia Oji market.

Photo – right: Hernia surgery at Gmelina health center.

Photo below: Maryjoy calling pregnant women to come to the clinic.





## The fight against female genital mutilation



One morning, as we arrived in Onuenyim village to work on the borehole, we met three young girls, aged around 12-13, that were painted in bright yellow and red. Upon inquiry we found that they had just completed a ceremony to initiate them into womanhood. Part of the ceremony was the circumcision. It was very heart wrenching to see how the girls had difficulties walking due to the pain. When we asked them if they knew the reason for the cutting, they said they

didn't. When we asked if they liked it, they said answered yes. They saw it as a step forward. We held meetings with the village leaders to discuss the practice of FGM. We are trying not to impose, but to give them information about the harmful effects of female circumcision to enable them decide to put an end to the practice themselves. We later had a meeting with a group of eight TBAs from the area and discussed about FGM. Being mostly elderly ladies, some of them expressed surprise. They said that they had never heard that the female circumcision could be harmful and that it should be stopped. Some of them said they had never delivered a woman who had not been circumcised. Our raising the issue gave them a new perspective. The practice of female circumcision is outlawed in Ebonyi State, but information does not reach the remote villages where centuries old traditions continue to harmfully affect the lives of girls and women in the rural villages. According to the 2008 Nigeria National Demographic Health Survey, 82.6 % of women in Ebonyi are circumcised. .



### Improving the clinic facilities

AMURT's daily role has been to supervise the clinics and manage the Home Based Care for Mothers and Newborns. We have worked closely with a Youth Service Doctor, Dr. Miyawa Fatoba, who has done an excellent job with the clinics, seeing patients, and giving additional training to the staff. He is now set to become AMURT's medical director in Nigeria for 2012. The outreach programs and home visits have been made possible by motorcycles donated by AMURT to each of the health centers.



Photo – left: the water tower and tank for the electric borehole in front of the four new rooms built for the Offia Oji health center.  
Photo – right: some of the staff in front of the new staff quarters at Offia Oji.

The Offia Oji health center was the first of the three to get its own staff quarters. Made possible by a private donation from Switzerland, the new building contains six rooms, including kitchen, quarters for female staff, male staff and doctor. We also added four additional rooms to clinic building, a new delivery room, post-delivery ward, operating theatre, and counseling room. With the help of AMURT Italy the Offia Oji clinic now has an electric borehole and overhead tank that supplies running water to kitchen, bathroom, delivery room, operating theatre, and two outdoor taps.

### A new project area. A new challenge – Okpuitumo, Ikwo Local Government Area.

The experience from Ekumenyi, though full of challenges, have given enough encouraging results for us to open up a second project area. The community is called Okpuitumo and we are preparing to work with three rural health centers, in Odeligbo, Ettam and Elugu Ettam. On 2<sup>nd</sup> November we signed an M.O.U. (Memorandum of Understanding) with the Ikwo local government for the program.

We were introduced to the project area by our partners in NIWA who knows the communities through work with water, sanitation and anti-child-trafficking. NIWA is assisting with the community mobilizing.



Odeligbo community has made an old town hall available for the new health center, and AMURT has taken on the task of the renovation together with the community who provide communal labor. We have replaced the pillars, put new roof and ceiling and built three new rooms to serve as wards. The latrine is under construction. Due to a series of delays and difficulties we missed our December deadline. We are now shooting for a January opening date.

Ettam clinic has recently been renovated at govt. expense. AMURT has provided drugs and additional equipments. This clinic is quite unique as it is one of the very few selected to be part of the govt's Midwifery Service Scheme (MSS) to reduce maternal mortality. The area will provide a special test for our strategy; the four midwives have been at work since June without having a single delivery. We have news of recent maternal deaths in the villages. We hope to turn things around by introducing the Home Based Care for Mothers and Newborns program, and more close supervision and support. On 9 December, AMURT brought Dr. Jennifer and Dr. Fatoba to Ettam for a full day clinic. 120 patients were seen. It was the first time Ettam had been visited by a doctor.



The final proposed clinic is in Elugu Ettam. The community has built a structure up to lental level that needs to be completed. They have also purchased a lot of the furniture and equipment needed for the clinic, but all is lying idle. Such community initiative deserves encouragement. We have started negotiations with the communities and hope to reach an agreement and be ready to open by spring.

The three clinics will cover the Okpuitumo community. The area is smaller than Ekumenyi, but just as remote, isolated and neglected. Indications are that maternal mortality rate is high. We will do a survey early on to get the baseline.

The success of the second project area will depend on many factors, primarily on finding dedicated staff for the clinics and the extent to which we will be able to implement the Home Based Care for Mothers and Newborns.

As the work progresses, we are getting noticed in Ebonyi state. We intend to present our model for endorsement by the state authorities. This will facilitate the implementation in our project areas, help to define and ease AMURT's working relationship with government and communities. If possible, we hope to expand and reach other remote areas over the coming years.

## **WATER, RIGHTS and COMMUNITY MANAGEMENT**

### **AMURT assists 25 villages with new boreholes and rehabilitation.**



villagers to trek long distances for water. In March this year, women from our project area villages were beaten by Cross River people who didn't like sharing their water. Some were taken to the Offia Oji Health Center with injuries. [Photo – above : Chukwu from NIWA works on the rehab at Odeligbo.](#) [Photo – right. The community help to move the drilling rig into position at Uwalakande.](#)

Access to safe drinking water is a human right. Making the rounds for outreach and health education, access to safe water was the most frequently expressed concern. The people find means of collecting water during the rainy season they rely on rivers and ponds. During the dry season the quality deteriorate fast and by the end of the year most sources have dried up, compelling the



In NIWA (Neighborhood Initiative for Women's Advancement), AMURT found an experienced partner to start water and sanitation work. We signed an agreement with the Abakaliki Local Government Area. The L.G.A. chairman provided matching funds for five village boreholes matching AMURT funds and enabling us to serve a total of ten villages. As part of the same phase we also rehabilitated



broken boreholes in four villages. Often the govt. agencies drill boreholes without involving the communities and without providing any training. It is common to see boreholes in disrepair. Photo – left The women of Ndiokenyi helps to install the head assembly of their new borehole.

As a part of the water and sanitation program, with assistance from our partners NIWA facilitated the formation of WASHCOMS (Water Sanitation & Hygiene Committees) in each of the villages. The WASHCOMs are composed of twelve men and women selected by the villagers and their training runs four full days. In addition to water management, borehole maintenance and repair, the training introduces human rights, leadership, conflict resolution, and the rights of women. The fight against Female Genital Mutilation and HIV/AIDS awareness is mainstreamed into the trainings. Finally the trainees also learn livelihood skills like soap and pomade production and bead making. They are encouraged to develop an enterprise for the WASHCOM to benefit the community.



The second phase of the water project brought boreholes and WASHCOM training to six more villages and five more rehabs, making a total of nine 25 villages benefitting from either new borehole or rehabilitation of broken boreholes. Photo – left First day of the new borehole at Onuenyim Photo – below – lifting the pipes to asses broken borehole at Azuoto



### Tippy Tap

Tippy Tap is an innovative and inexpensive way to promote hand washing. Studies indicate that half the deaths from dysentery and diarrhea in developing countries could have been prevented through good hand washing habits. We were introduced to this by Sowmya from India who has volunteered at our projects in Ghana and Burkina Faso. For more information check out [www.tippytap.org](http://www.tippytap.org)



Testing the Tippy Tap for easy hand washing at Nkaleke



Ejike and Michael loading pipes for the boreholes from the AMURT office



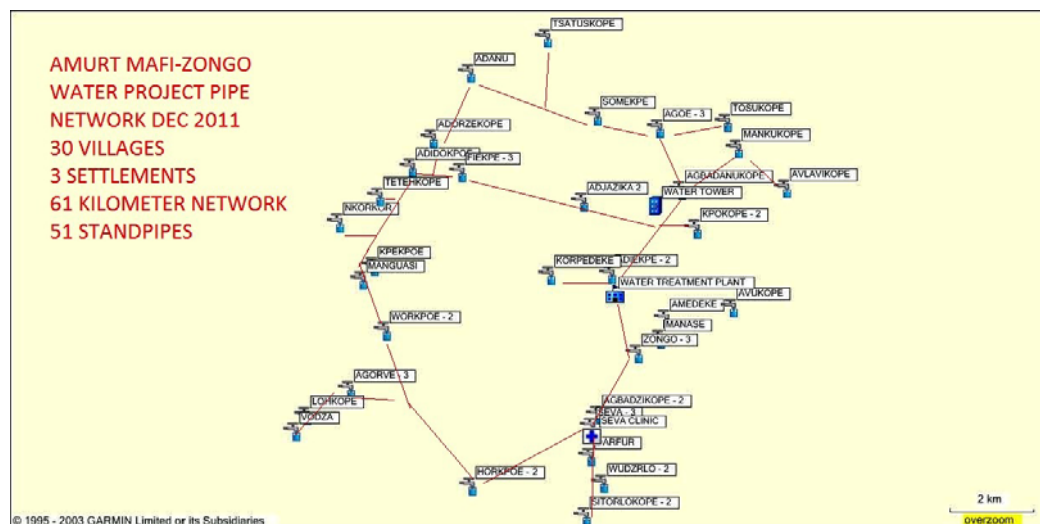
The men of Ndiokenyi proudly display the products they made after the WASHCOM training: soap, pomade and bead jewelry.



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## Ghana

The original design for Mafi-Zongo Water Project distribution network was finally completed in December 2011 with the help of AMURT Italy and a donation from Peter Dodge, AMURT US board member. In February Korpedeke was connected and in December Manguasi, Kpekpoe, Nkorkor and Tetehekope got pipe borne water. We were also able to close the northern loop of the distribution pipe network. The closing of the loop will help to balance the pressure at the standpipes throughout the thirty villages. The length of the pipe network is now 61 kilometers long, with a total of 51 standpipes in 30 villages and 3 settlements. Early in the year we purchased two new pumps for the water project, one a bigger more powerful pump selected to work economize operations. The local management committee has been struggling heroically to keep the water flowing and maintaining the project. The project is very big and complex, but they are doing well with a big project. With our water treatment plant and reservoir it will not be advisable to expand to further villages. AMURT will still look for sources and opportunities to improve the filtration system and further secure the dike of the dam.



Dona and Giovanni from AMURT Italy with Shriidhar and Agryabuddhi from AMURT Ghana at Kpekpoe village during the ceremony to connect four more villages to the Mafi-Zongo Water Project



In September The Mafi-Seva Community Clinic hosted a 10 day international seminar organized by Linda and Angie from the UK based Ghana Homeopathy Project with participants from the U.K. and Ghana. Trainers Dr. Kalyan and Kalishankar Bhattacharya from India returned to Ghana after two years to conduct the classes. The program was very successful and in the course of the training period more than 400 people received homeopathy treatment in many villages in the Volta Region. The participants enjoyed comfortable accommodation in the new volunteer quarters completed in January. AMURT and Mafi-Seva Community

Clinic are happy to continue working with the Ghana Homeopathy Project to popularize homeopathy in Ghana.

### **KEKELI PROGRAM: Health Education and support and training for TBAs**



From the base at Mafi-Seva Community Clinic, with the help of volunteers aided by clinic staff and the network of Kekeli women and TBAs, health education programs reached more than twenty villages. Topics covered in 2011 included nutrition, reproductive health and hygiene and sanitation. Volunteers Stephanie from Canada, Mimi from Germany and Peter from Australia played important roles. On Sundays the usual health talks in churches continued. In December, Dr. Jennifer from the U.S. did a full day seminar for the TBA's. On the 28<sup>th</sup> a busload of Kekeli women and TBAs went for an excursion on the coast, visiting a

historical slave fort, playing on the beach and enjoying a nice picnic. A well deserved reward for the service they these great women provide to their communities.

### **HEARING AIDS**

Dona and Giovanni from the Amplifon Company had lead the efforts of AMURT Italy to raise funds for the fourth phase of the water project. As they arrived for the inauguration of the four last villages, they brought a donation of twenty hearing aids. Dona and Giovanni brought the equipment to test the hearing and after the screening they selected the lucky recipients of the twenty new high quality hearing aids. Finally they brought full football suits including boots for two teams of boys from 10 to 13 years old. It was the first time ever that the boys wore football boots and their joy was great!



## **Volunteer stories: Mafi-Seva, Ghana and Nigeria**

### **Ghana:**

*The Mafia-Seva clinic and the local community has grown so much in the last four years! It brings me such excitement to see how well the community members are cared for by Emperor, Bernice, Jeanet, Holali, and Watson. These patients are receiving top notch care and are benefiting from the project there.*

*To see the Kekeli women again was absolutely amazing. Their hard work and dedication to their communities is inspiring. I know that they are providing the best quality care possible to the women in the remote parts of the Volta region. I am proud to have worked with and have learned form them.*



## **Nigeria:**

*In a country where there are many limitations, there are plenty of countrymen who are willing to help out. This I learned through Maryjoy and Nancy, two women who are dedicated to improving the lives of women and children in partnership with AMURTEL. Warm and welcoming, I was struck by their passion to improve the lives of villagers.*

*Gmelina clinic is a nice sized clinic which is appropriately stocked with medication and Immunizations for many illnesses. There are comfortable quarters for patients who need to be observed overnight and for laboring women. The staff are pleasant and eager to learn how to better care for their patient population.*

*Offia Oji clinic and maternity ward is an expansive clinic staffed with many persons who are excited to learn how to better care for patients as well as laboring women. During my time there we were able to see patients and teach on the fly to the health workers. Some time was spent reviewing neonatal resuscitation and how to use a pediatric ambu bag. The group here is so helpful and centered on teamness that I can really see this clinic taking off well with appropriate continuing education.*

*Photo – above: Jennifer teaching how to use ambu bag to staff at Offia Oji health center*



*Ettam clinic is the most up and coming of the clinics as it has recently been introduced to the community. With midwives and a large laboring area, as well as delivery room, this may be the location in which village women can come and deliver safely in. By day and night, though with continued education, the midwives can learn to care for more common day complaints of the community. I imagine that once in full service, this clinic will serve the needs of the community well.*

*Dr. Jennifer Sparks – Boston, MA, U.S.A.*

## **Burkina Faso**

The work is going very well with our 33 Traditional Birth Attendant (TBAs) in the Deou Department of the Sahel area. They have now proven their independence in doing the great service of guiding the women towards a better management of their pregnancy, delivery and infant care. Our current focus is on parallel programs such as organizing Antenatal Controls (AC), and conducting educational programs and medical camps in the remotest areas.

Our water supply related activities, started in cooperation with Water Management Group NGO also continues.

### **Deou: Ante-natal care - a very good record**



AMURT received the warm congratulations of the local health officials for an exceptional record of 100% of pregnant women following Antenatal Controls in our area of work (33 villages with a population close to 30 000 inhabitants). Through the coordinated efforts of the health department and AMURT donkey cart ambulances have been provided, trained TBA are stationed; and special Antenatal Control (AC) programs are conducted in the 6 main villages of the area - we finally reached our goal. We aim to extend these AC programs to more villages.



## Medical camps in the desert villages

We were fortunate to have the visit of 3 nurses, 2 from Canada and one from Ghana. We held 4 medical camps in N'dyawé, Gountawala, Ferrio and Deou. It was very intense and very appreciated, a huge number of patients came to benefit from free medical care. All worked very hard, approximately 200 people received free treatment. The condition of some of the patients were very severe, anemia, infections, dysentery, fever. Seeing the dire need 2 of the nurses will return in November this year for a longer program in the area.



## Water related initiatives and activities

This program that was initiated one year and an half ago. Its aim is to find ways to collect surface water (rain water) and to retain it from running away too fast without penetrating the soil (during rain falls). Water retention can be done through various kinds of small check dams, bouli (artificial pond), open wells, etc.

### The open wells:

We added a few cement rings to revitalize an old well in Ayagorou, the farmers will use it for vegetable cultivation after the rainy season.



A permanent well was established in Lila in the area where people formerly would dig every year some dangerous traditional wells (without any rigid structure) in the sands of a seasonal river bed (picture above, far right).

### Check dams:

Because of sand accumulation and consequent change of landscape the seasonal rivers tend to deviate from their usual position and change their path destroying old cultivable lands. We tried to reinforce the edges of such "moving rivers" with gabion (mesh wire in cage shape filled with stone and sand bags) in order to avoid another cultivable land to disappear. But... it is some time in vain, as the water flows with such a great force (photo above). We are now studying other affordable ways to cope with that recurring situation. We plan to hire a bulldozer for a week in early 2012.





## **Our community center in Bissiri (Master Unit)**

### **The clinic**

Our clinic in Bissiri is growing, we hired a second nurse and have nearly completed a new room for the increasing number of patients during the rainy season (which is the big malaria season too). We are also building a simple toilet and bathroom facility. One of the nurses is now living in the MU itself. This allows the patients to get care during the night.

We have been able to dig a bore hole. The regular supply of drinkable water in quantity is a very great improvement. We now study way to get funds in order to build a maternity ward, the next logical step after the clinic in an area where population of more than 5,000 inhabitants.



### **The bakery**

We now are making our own bread, thank to a very simple traditional mud brick oven. The bread is nice and our trainer, a French baker and friend, had the community taste its very first bits of pizza! Now the bread is made every day, small bread that the community can afford. There was no local bread available until now and everyone rejoices it. A brother found some earning in the meantime..



### **The start of our moringa project**

Moringa is a wonderful tree. The dried powdered leaves are a great food supplement - its nutritional value is comparable to the algae spirulina, but it is much easier to produce. Here these trees grow wild and people are used to consume the leaves. Nowadays NGOs and governments are studying the great potential of Moringa in countries where malnutrition is still prevalent. We want to find simple ways to produce big quantities of these leaves involving the community in their cultivation and processing. This October is the first harvest in our experimental field in our MU. We see great promise in this project!





## A LAST WORD...



Thanks to all who contributed in implementing those programs. This work could not have happen without your generosity. The betterment in people's life is a unique reward which I am fortunate to witness day after day.

*Dada Padmeshananda*

## Volunteer stories: Déou and Bissiri, Burkina Faso

After several months of preparation it was such a treat to finally land in Ouagadougou to work again with such capable, caring persons as Dada Padmesh'ananda, the AMURT in charge in Burkina Faso, Numéro Un, Déou' coordinator and Rasmané, Bissiri' coordinator. These amazing and dear friends I heavily rely upon to ensure my 6 week stay will indeed reach many villagers of the areas of Déou and Bissiri to enhance health and quality of life. I had with me \$7000.00 worth of medications, a variety of antibiotics, bronchodilators / inhalers, analgesics, vitamins, etc. The large bag of tricks I had (my suitcase) also contained dressing supplies and other nursing tools useful to attend to as many ailments as our patients may present. Christopher Honya, an English speaking, experienced health worker of the Seva clinic in Ghana joined us in Ouagadougou to be part of the team, I had worked with Christopher in earlier years of volunteering my nursing skills at Seva.



We worked in two different areas, Deou in Sahel (Northern Burkina) and Bissiri (a village 40 Kms south Ouagadougou, Burkina capital).



We travelled to Bissiri on 3 occasions to support the nurses working at the clinic and to do health promotion in the nearby community.

In Deou area the most frequent ailments treated were respiratory infections, asthma, epigastric pains, joint pains, fevers, wounds and malaria.

This time we assessed and treated a total over 700 people and visited 8 villages namely N'dyawé, Bangelday, Ferrerio, Gorolbay, Gountawala, Bangel, Tountré poly and Dibissi. We also did health promotion, educating villagers about basic principles of hygiene, wound care, care of infants, children and adults suffering of diarrhoea and/or fevers and when to consult at the nearest health centre.

After my arrival we left first for Bissiri.

So many changes could be seen as we drove in, and all done within a year of my previous stay: the front of the houses blooming with red, pink and white bougainvillea, a water pump filling the water cans as needed, the fields filled with ripening eggplants, papayas, cucumbers, corns, all so colorful and soon to be used for a fresh and delicious dinner meal. The clinic now managed by nurse Serge had expanded with a room for dressing wounds and two more beds added to accommodate 4 overnight-stay patients when needed. A medication room was soon added to divide examination /





assessments of patients from treatments and filling of prescriptions. The clinic not being so busy at this time of the year, allowed me to become familiar with the people, living life as a Burkinabé farmer, cooking meals Bissiri style in support of Rasmané' family who sadly, recently lost a wife and a mom.

With nurse Serge health promotion sessions were held in near-by villages and in a church on topics of hygiene and primary care of fevers in babies and children. The sessions were lively with questions and discussions and much appreciated by all, attendees and speakers.

November 17<sup>th</sup>, with much excitement our team left for a 2 week stay in Déou. It wasn't long after settling in that our neighbors, near and far, came around to reacquaint with the team and ask for health consultations. Their open arms, such an honor to be warmly welcomed by such brave and tenacious people living in such unforgiving land and climate, I love this area and the people.



From November 19<sup>th</sup> we started going to remote villages (distant from 15 up to 50 km from Déou) by truck or moto, on sandy, rocky, and bumpy roads sometimes getting stuck in the sand. We travelled to far away nomad villages, working in one or two villages a day; when returning before dark we would attend to our Déou neighbors' health. Some of the furthest villages we reached were located by the Mali border. The people of the villages had been informed ahead of time of our coming and of the services we could provide by Numero Un, our local AMURT coordinator, interpreter and planner extraordinaire. Often, we attended to our patients / villagers from the home of the village's traditional birth attendant, or a classroom, or a yard and hopefully protected from wind and sun. Our patients would be patiently awaiting our arrival and services with more people arriving through the day. When settled in someone's home the setting was very dark and I needed my head-light to be able to see.



Many patients told us how they appreciated our services last year and were happy to see us back and that they looked forward to our return again next year.

All these villagers, their way of life are so close to my heart, I learned so much from them, their patience, tolerance, endurance and courage will sustain me until I return next year with more health supplies, health promotion sessions and ready to learn and be embraced

by their kindness.

Thank you so very much to Dada Padmesh'ananda for his hospitality and sweetness, to Numero 1 for his vision of Déou in near future, to Rasmané for his courage and to Christopher for his assistance and humor. Ce n'est qu'un aurevoir mes frères.

Andree Bamfort, Vancouver B.C., Canada

## Togo

### **School Project**

Our Neohumanist School in Lomé, Togo, is growing. The new school manager, brother Arun'a has taken charge this year and created a wonderful atmosphere for over 315 children to progress in all spheres of life.



This coming school year we are planning to integrate the first secondary 2 classes in order to welcome those who finished the primary term. The new office and library building is almost over and the garden is abundant with vegetables.

The main aim now is to build new classrooms for the secondary school and provide the children with top quality education based on the principles of Neohumanism.



## **Cote d'Ivoire**

### **AMURT Cote d'Ivoire to start healthcare and agric programs in new project area.**

We welcome the news that AMURT Cote d'Ivoire has been revived. The chapter did excellent work during the Liberia Refugee Crisis some years back, and is now ready to start community development work. The project areas selected are Yakasse-me, Region d'Agneby, S/P d'Agou, 45 km the north of Abidjan and another village near Buake in the north. A plot of land has been donated to the organization for a community agric project and the local community has made a suitable building available to open a health centre. AMURT Cote d'Ivoire seeks partners to develop this promising new project. All interested see contact information below. We are looking forward to good news from the new AMURT Cote d'Ivoire in 2012.

## **Donations are welcome**

Credit card donations can be made through PAYPAL at [www.amurt.net/africa](http://www.amurt.net/africa)

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