NATRON HEALTHCARE PROJECT: SITE VISIT, APRIL, 2017

This site visit by Dr. Penny Aeberhard and Melanie Finn, from April 17- May 1, had several purposes:

1) Maintaining general management of the project with stakeholders
2) Providing feedback from PA’s visit in November, in particular her assessment of attitudes of Traditional Birth Attendants (TBA) and Government Midwives (GMW) and other healthcare workers toward each other
3) Implementing a Family Planning (FP)sensitization intervention for men in Wosiwosi and Magadini
4) Implementing a TBA training
5) Beginning conversations about “The Value of the Girl Child” to change attitudes to FGM and higher education for girls
6) Holding health education workshops in the communities
7) Connecting with other, similar NGOs to discuss possible synergies

Summary of our visit:

PA and MF met at the Flying Medical Service compound on April 17. We then travelled to Longido for three nights, for meetings with District officials and healthcare workers. We touched base with officials, informed them of our intentions and provided them with feedback from PA’s November visit. We also held two workshops at Longido District Hospital for hospital staff. PA then travelled to Ketumbeine, where she and our project manager, Rehema Simon, held a five-day workshop for 12 TBAs from Magadini and Wosiwosi. PA and RS worked on improving the skills of TBAs, not only in delivery but in “red-flagging” problem pregnancies for referral to primary care. This workshop also included a site visit by the TBAs to Longido Hospital and Tembo Lodge.

MF went on to Magadini to implement the FP initiative, hold several health education workshops for the students, provide the community with feedback from PA’s November visit, and meet with the School Lunch Committee. MF also conducted a survey on attitudes and use of the Flying Medical Service.

PA and MF then met up again in Wosiwosi. Here, we ensured the FMS radio was working properly and communications with FMS by phone could be made. After a teaching session, we donated a blood pressure cuff to the community (one was also sent on to Magadini). MF held an FP intervention with the men, and PA discussed contraceptive methods and “the value of the girl child” with a group of women. Both groups were given PA’s November feedback. MF also conducted the FMS survey.

On April 27, we returned to Longido for one night to touch base with the DAS and other key district healthcare workers; and then on to Arusha. In Arusha, we met with FMS staff and provided them with a verbal overview of the survey results as well as other comments and observations. We then met with Joanna Waddington of ACE, Africa, to discuss ways in which we might work together to replicate the work we’ve done in Magadini and Wosiwosi.

There are separate reports on the TBA and FP interventions.

Meetings with organisations and people at Longido.
The ethos of NHP, since its inception in 2008, is to work with and alongside existing Tanzanian authorities and groups, both government and NGOs, collaborating and supporting.
1. Longido District Administrative Secretary.

Dr Penny Aeberhard met in November 2016, the new DC, Mr Daniel Chongolo, who listened and questioned her with interest, about Natron Healthcare Project (NHP) and gave his approval, as did previous DCs.

In this visit, 2017, Melanie Finn found the DC was not present, but was received by his District Administrative Secretary Mr. Toba Nguvila with great courtesy. We appraised the DAS of our intended plans for the Family Planning intervention and TBA training. We also informed him about our project’s other efforts in health education and support.

We had discussions about the value of the newly introduced Community Health Fund cards to mitigate healthcare costs. As the Flying Medical Service and the Lutheran clinics – the two organisations serving Magadini and Wosowosi are not able to accept payment by this means, we agreed this should be further investigated.

At the end of the two-weeks intervention phase of teaching the Traditional Birth Attendants (TBAs), and Communities of Magadini (Makat) and Wosiwosi areas, MF and PA returned to his office to give feedback on 29.4.17. Together we had wide-ranging discussions about our predominantly educational interventions. In community meetings and with individual one-to-one questionnaires, MF had sought to understand Maasai traditional beliefs and then, using a number of techniques, the existing attitudes and knowledge of men re family planning and the role of women. NHP has, over a number of years, changed to see this as an essential element to promote improved maternal mortality (and of course better neonatal mortality). See other papers.

The DAS said he was interested to see our final reports and the subsequent follow-up/assessment phases.

2. Longido District Department of Health

Visits were made on 19, 20 and 29th April, to the council offices.

Department of Health.

Dr Munisi, DMO, met with PA on the preceding visit in November 2016 and was aware of our visit this time. He welcomed our visit, and kindly provided NHP with letters to ensure safe passage for our teams.

However he was called away, so that we were met by his deputy, Mr Victor Ndale, and a team of about five others, including the District Health Officer. Although his profession was dental, in the role we met him; he showed interest and gave us his time in a very hospitable manner. We presented to him the findings of the two survey questionnaires we had completed with communities and a sample of 12 Longido Government Midwives. He agreed with our findings that the maternal mortality was probably poorly documented and that it would be much higher than the statistics. He agreed that there was a serious problem of communication for patients with health professionals, when only 1/12 GMWs could speak Maa. He stressed there was an onus on the health staff to better communicate with this major part of the Longido (if 80% population are Maasai, in Longido, and half are women, then somewhere approaching 40% of population couldn’t speak Kiswahili). He heard us report that there was a problem for accompanying carers for
pregnant women and it was a barrier to more seeking hospital confinement, even if medically at risk.
He was especially interested that we should attempt the challenge to examine attitudes and beliefs of Maasai men to family planning and the role of women in general.

He received from PA two medical books and two teaching CD’s ref neonatal resuscitation as gifts for the hospital departments.

NHP thought that Longido could follow the example of an area in Kenya, where a successful introduction of a traditional “Maasai boma” of birthing huts in, or next to, the hospital delivery suite, for TBA’s to take their high risk women pre-delivery or in labour

PA and MF met District Public Health officer Mr Aludo Mwansinga (Jacob) and Mr Josiah Muruve, senior nurse, at the start of the programme. Mr Aludo was interested in the de-fluoridation programme that had been introduced at the Magadini school (rainwater catchment), and was surprised to hear that our water analysis by a reputable international expert had revealed levels x15 WHO standards in the Magadini area. Other methods were discussed, but the scale of the population and problem meant that these would be impractical.

Also discussed with the DHO were: household fires which could be more smoke free were also discussed; hygiene education for students; introduction of the CHF card to Magadini and Wosiwosi – do they know about this card?

Then at the end they met again to debrief, verbally, particularly about the Men’s FP initiative and the programme in the villages (see other papers). Discussions again were wide ranging, for instance about whether men had an idea how much it costs to raise a child, let alone send them to school. Which most stated as an aspiration for their children? MF also discussed how in this society, goats are equivalent to currency, and one could equate number of goats with costs of housekeeping/education etc.

Attempts were made to meet again with the DED, DEO (primary schools) but on this occasion the department heads were out of the office.

**Longido District Hospital.**

These visits were in part coordinated with the help of senior Nurse Mr Josiah Muruve, who has formalised the supplies and training for use of Copack tests for Hb, given from NHP, for the past 5 years. He also was helpful to liaise with the DMO.

In a previous role PA was employed in England to inspect hospital and primary care facilities. She also “inspected” similar hospitals in Nepal and India. She says “I wish to congratulate sincerely the standard of this hospital not to mention the evident changes over the past nine years, of ad hoc, unannounced visits, where when I made myself known was not just received with courtesy, and people were open to showing me their departments. All departments and female wards, including the delivery suites and operating theatre, were very clean indeed, including the patients toilet area. Staff were open, seemed to keep good notes and were immaculately turned out.”

The departments were open to a couple of teaching sessions with PA on April 18-20. One day’s potential teaching was lost due to the bereavement and funeral of a long-standing hospital staff.
Two teaching sessions were given for approximately 12 and 16 staff members. Feedback re the survey results were given to them. There were three areas of agreement: maternal mortality rates, communication problems and need for education for the communities. PA also introduced the painful criticism that the TBAs felt that they were often “sneered” at by government health workers, and those from Wosiwosi area felt they were treated better in Kenya. The training that followed focused on pre-conceptions of the health workers to ethnic groups (for example English, Maasai, Chagga, Hadza, Pare or Meru). This indeed exposed that some health workers thought that the Maasai are “dirty”, “harsh”, “fierce and aggressive”, and “dislike to disclose their issues”. But one said they can be true friends.

With the assistance of MF and our Project Manager, Rehema Simon, another teaching session followed where in small groups people tried to communicate with no language at all but where they had to focus on good, open and friendly non-verbal communication.

Attention of the staff was high, and feedback at the time, by this group of students was good.

PA has offered to extend training to “Teaching the teachers”, that was missed this time. Also NHP can recommend two UK midwives who have a contract with the Kenyan government, to extend training for GMWs, and expressed interest and a willingness to extend over the border to Longido.

On 24th April, PA with Rehema for this TBA project, had a further day visit accompanying twelve TBAs for the last day of our 5 day training programme. During this time we met with staff. Maasai-spoken nursing sister, Claudia, was a very great resource for the visit, demonstrating family planning methods, and discussing women’s roles. She congratulated the TBAs for their song demonstrating their new knowledge of the “scorpion” signs (red flag) of at-risk pregnancies. Nurses Olivia and Seraphina were commendable for their efforts to welcome and introduce to the TBA the potentially rather frightening new environment, both in the outpatients and on the ward.

During their visit to the lab, the TBAs saw the same Copack tests as they themselves could use (donated to the whole Longido district by NHP), they heard of the tests they could have done, and saw intravenous transfusion sets an even the blood bank.

As feedback here the TBAs introduced another verse to their Scorpion song, of how Longido was a wonderful hospital!

3. Meetings with staff of NGO: Tembo Lodge

Guest house manager, Ms Carolyne
Accountant Mr Marivey
Tembo director, Paulina
Mary Laizer outreach educationalist.

Mary, a Maasai herself, gave the TBAs on their visit 1.5 hrs an introduction, as a “sensitizer”, to FGM. Despite qualms that we were overreaching or remit and over loading the TBAs with information and topics, this proved a success as a couple particularly thanked PA after this session. We tried also to interest them in the idea that a cohort of volunteers could be formed who could act as interpreters for Maasai women, as patients in the obstetrics unit. And who could have a little more training with some technical maternity words. But they felt that the role of a volunteer was not so well established in Tanzania and there would be little, or no, financial rewards for such a role.
We also suggested that a local sewing group could take on production of sanitary (menstruation) pads for young girls. MF showed them a different design from those that they had seen from Canada. With panties (that are not well received by Maasai ladies) more of a waist band sling, and although they thought this was nice and very acceptable they did not think they had a unit that might make this a little business. They did refer us to Mennonite Charity of Christ in Arusha.

**Community meetings and work in Wosiwosi (PA)**

**Vit A and deworming tabs were confirmed as being given, in November.**

**Visits to “patients” in bomas**

1. The woman (Narmai) I had seen in Nov. thanked me as I had treated her (antibiotics and referred to Swai), Her Hb then was normal (12.0) : 7m antenatal bleeding: had gone into early labour and delivered a prem baby. Seeing again. Hb now 9 only: given iron, vits and calcium with VitD. Baby, F, bright, smiling, but small. She survived as they gave her cow’s milk with mother’s milk. Baby had had BCG. Advised to get on with other imms (they had thought to wait as she was too small) With husband present, discussed spacing for children. She now has four: spacing is 4,3,3,3. Husband not interested in further family planning. However, he seemed kind and attentive; he had given her 20 goats, so couldn’t understand why she was anaemic. (Of course, she sold the goats, and didn’t eat them!)

2. “Please to go and see child very ill in X boma.” The child was indeed very ill 5/12, one of twins, the other boy pretty healthy and suckling well. Grandma nursing this child. Sick vomiting, covered with flies, dehydrated, cough, rib recession and RR 60 =Pneumonia. Given paracetamol, agreed to tepid sponge to my surprise, ORS to be given all night, Amoxicillin (diluted from adult caps). RH and PA discussed if the mother, Nandotu, really wanted the child to be as always so small? (But grandmother did!). Next day, early visit: child alive, dressed, cooler, had sucked, and not vomited. Still v ill. They want to go to Swai and I was very pleased. They got an old Land Rover teamed up with some others. Told to keep feeding ORS etc. Letter to Swai. Next day saw again. Given (correctly, in my opinion) IM antibiotics. And somewhat better. Needs longer term treatment as a malnourished baby.

**Drought:** They are worried; their plan would be to go to Kenya, sell goats and cows there to buy food such as maize

**Kindergarten school.**

Teacher now is Nadamu (who we sponsored to have the three day residential course in Arusha the year before). She is unmarried with a child. She also helped me to do the mini clinic at ...boma in November. ally. Trying herself. Repetition of letter sounds. Blackboard so high the little ones could reach it when their turn. Play material urgently needed. When Mel and Bazili, went outside with the children, so I could discuss BP machines and how to use the two I had brought with me, they used some pencils we had brought and paper. The children had not ever (Mel thought) held a pencil

Nadamu was teaching 12x 4-6 year olds alphabet by rote. Abysmal standard of teaching, except once she got them to stand /sit and jump. Kids so keen and bright!
FMS Radio.
Does it work or not?
Not on the right wave length? Much trouble for Mel and team. Father Pat had to be contacted by phone! So: Why do they need a radio anyway if they have a mobile signal? We decided that it’s good to have both as some people do not have a mobile; also it is common for there to be no credit on phones. It was verified that there is radio signal. TBAs from Wosiwosi had told me during the Ketumbeine training that they didn’t know how to contact FMS. Decided to put a temporary notice in window of the office with details of contact number. We did not write the cost down (approx. 500,000/- for evacuation.)
PS: Upon return to Arusha we printed/laminated the numbers, and send via FMS to be given to TBAs on neck strings. We also sent a better notice for the office window.

Attempt to see if anyone could deal with a Sphygmomanometer (BP recording for eclampsia)
Teaching of about 12 people. Men, 8, and women 4.(Asked for 6). All v interested in circulation and flow of blood. Where are the pulses in the arm? What does the heart do etc. all tried a stethoscope to listen to heart! All amazed. Nadamu and Rachel got it! Especially Rtracheal. I took on 4-6 for more in-depth training for the reading of BP. Decided to just to Systolic reading and aim for under 140. (eg the danger zone for pregnant women)
Invited to pratice in the afternoon at camp. Ikayo came- he found reading numbers difficult, but could hear the pulses well, Nadamu again, (OK) parson Samuel and Peter -Both could not really, with this training time, and Likama who got it very fast and who could also detect diastolic.
Summary: it is possible! But I doubt if anyone would have the tenacity to practice more and to offer to the TBAs as a service except maybe Rachel, Nadamu and Likama.
As the Maternova ones are SO expensive, and we need to buy many, an alternative still needs to be found?

Meeting with about 20 Wosiwosi women.
Hot. Tree shade partial only. Naipandi boma. About 2 hours.
Range of ages.
All six TBAs who had attended workshop training came and sang their scorpion song. PA congratulated them. All also praised Longido hospital.

In six small groups of 3-4 women

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<th>how many children are desirable?</th>
<th>What is desirable spacing?</th>
<th>Best age for a girl to have first baby?</th>
<th>How many goats per year do you need per child?</th>
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* “best to get them married to espoused husband then them get pregnant by another man”
** 100 if you want them to go to secondary schooling.
Discussion points
Spacing and number of children:

- One coco said “these days there is not enough food and we need to space them”.
- One asked “why is it maize is now so expensive?”. 10Kg maize used to be 300 Kenyan shillings, now 1,200.
- PA answered: 1. there is more drought in world. 2. more storms to flood the crops when there is rain. 3. There are increasing numbers of people to want the food - the same amount of food.
- Chart was drawn of little people, multiplied each generation. They were silent, because they understood. (confirmed by RS)
- Role of the girl child. Cut outs as before with choice of dresses. No one chose a Maasai wife. They all wanted a teacher or doctor.
- Who would you NOT tell if you used family planning cut-outs and stones to place in a pile:
  - Old man: 12
  - Younger man: 4
  - Young woman
  - Old woman (coco) 4  (But PA drew forward the old woman who had said that there isn’t enough food now, and we need to space children; PA said, “I think you could tell this old woman”.
  - And she said so nicely that “Yes, they could come and tell her and she would keep their secret and help them”)

Family Planning Methods. And how to try to get them:

- Injections, Depo, plane
- Implants
- Lupu (coil)
- Condom mentioned in passing ref HIV
- Sterilisation If at risk of life for future pregnancy

nb. pill (o.c) and Beads were not mentioned through lack of time
Also side effects of irregular bleeding were mentioned.

Other: Noritet, a TBA thanked PA sincerely for the training they had had. The women also asked if PA could help them start a beading co-operative like the one they’d seen in Ketumbeine. I would think about it, but was doubtful if I could really do this.

Mel holds meeting with men about Family Planning
At the same time, Mel was meeting with about 50 men to assess their attitudes to and knowledge of family planning. (This was part and parcel of our family planning intervention, see more below under Surveys and also the intervention summary) They were initially reluctant, as they had gathered for a meeting to prepare for an important upcoming ceremony to which hundreds of people were expected. However, they agreed to give her their attention, and in the end were happy to give her more time than agreed. After giving them the feedback from Penny’s trip in November – emphasizing the real danger for pregnant women, Mel had the men break up into groups of 4-5. She handed out “props” such as small plastic sheep, goats and cows, as well as our laminated cut-outs; they could use these to answer the questions if they liked. But (as with Magadini) these served an even better purpose: to create a relaxed, almost playful atmosphere, rather than one that had felt resentful. Mel started the workshop by asking groups to complete Learning Scales which allowed participants to self-assess their attitudes to family planning. She
then asked the groups a series of questions:

**Surveys**

Over these few days, Mel had also been conducting two surveys: one, assessing male attitudes and knowledge of family planning and childhood and maternal health; the other on opinions and use of FMS and other area health services.

*Family Planning Survey:* This was given to nine men, approximately 20-55, from a variety of bomas and economic backgrounds. Key questions aimed to determine what method of family planning men were using, what they knew about childhood health, what they saw as the benefits to family planning, and what they saw as drawbacks to contraception, including knowledge, access and peer approval. Please see below for more.

*Health Services Survey:* Several key themes emerged from this survey of ten men and women:

FMS is viewed as reliable and regular service, preferred for and by women and children for maternal care, immunizations, etc. The reliability has allowed people to expect care, to become more pro-active in seeking care; and this is remarkable in a community (like Magadini) which suffered in isolation and ignorance until very recently. Dr. Swai is still deeply trusted as the destination for more serious health issues, or for ones arising between FMS visits. The community also utilises the clinic in Shompole, Kenya, and the hospital in Magadi, Kenya. The drawbacks of FMS were mostly noted as its expense and lack of transparency about costs – including charge for the government health card that clearly states “This is not for sale.” Not many knew how to contact FMS for an evacuation (we hope we solved this with the laminated cards noted above) and the cost was not sufficiently clear, either. Two men complained about lack of privacy in the banda, implying that they didn’t feel comfortable – perhaps because they had STDs. We heard this complaint from others, aside from the survey. It is true: the banda is not far enough away from where people wait, and anyone walking past can hear, and even see, what is going on. FMS staff also told us that they often line men up on one side of the plane and women on the other, and hand out medicines. There is absolutely no privacy in this! FMS told us people don’t seem to mind, but those who are modest or need privacy will self-select out of treatment. Certainly, if FMS is to become a reliable and trusted provider of contraception, then they must establish and enforce better privacy.

**Summary of the Family Planning Intervention (for both Wosiwosi and Magadini)**

Nearly all men stated they were practicing “natural” family planning through abstinence or counting days, recognizing that child-spacing of 2-4+ years was beneficial to both the mother and her newborn child. Men said that between 4-8 children was the ideal number, given the cost of raising a child. However, there was a wide array of opinion about that cost – from only 12 goats a year (approx. 500,000/-) to 800 goats (32,000,000/-), but with a median of about 40 goats (800,000/-). Many expressed concerns about contraception for their wives, including weight gain, bleeding, and reliability (65%). There were concerns, too, about disapproval of contraception by other men (75%). Lack of access (70%) and lack of knowledge (75%) prevented them from considering contraception as a family planning alternative.

Men in both communities are eager for reliable knowledge about contraception. They are aware of the impact of multiple, frequent pregnancies on the health of women, and that it is difficult to provide adequately for a large number of children. Family planning education for men must be delivered to both men and women in these communities. It should be embedded in a macro-socio-economic forum, so men and women can appreciate the forces directly and potentially impacting them; this knowledge will allow them to make informed decisions about family size.

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1 It was not always clear if this was the total preferred, or per wife, as certain men had more than one.
Community Meetings and work in Magadini (MF)

Merigoi Clinic
Stopping briefly here, I was able to meet Rahama and give her the feedback from Penny’s November trip. She is indeed very young, but she seemed (to me) more confident that Penny’s description, so we hope that she has settled in. She has gained a good reputation with people in Makat – as I would find out. She said many children were suffering from hunger due to the late rains. There is so much concern that these will fail altogether. She also complained that there are serious delays in her obtaining medicines from the district; though, she did say there were responsive when she needed an emergency vehicle. She uses the Copak, “It is very useful.”

School Lunch Programme
I delivered $600-worth of beans, lentils, oil, mangos and carrots. I also met with the school lunch committee to discuss the best way to move toward the regular, reliable provision of food for students. Inadequate funds and poor transport have been our main stumbling blocks. Teachers complain that students are so hungry they pass out; and the school’s exam results have plummeted to among the lowest in the District. Only one student matriculated to secondary school this year! So, I have committed myself afresh to getting this programme on track. We decided on a budget – about $2,000 a year; and that NHP would provide half of this, and the community the other half. We aim to deliver the food four times a year to coincide with the return to classes from holidays. NHP will buy high-value foods such as beans, lentil, fruit and veg; the community can supplement with more filling foods, such as maize. The village needs to work on transport – how to get the food? And also to take on an increased percentage (as we had always planned) of the burden. Next year, NHP will again provide 50%, and then 25% in 2019, and so by 2020 the village assumes the entire cost. While we recognise this will be a difficult goal in only three years, we all agreed we wanted to work towards it. We also agreed that the food is for students only; we cannot take on the cost of providing food for teachers. However, we offered to transport their food for free if it comes with the students’ food. I also pushed the committee to approach the District to find out what the DEO is supposed to provide, not only for students, but also for teachers. (The DEO seems to forget all about Magadini; Joshua, the head-teacher, asked me if I could give him the co-ordinates for the village because the District “wants to know where we are.”!!!) Finally, we agreed that Kilorit, the cook, should be given a regular salary. It appears he has not been paid in years.

Vitamin A and deworming confirmed to have been given, but will need new supplies this year.

FMS Banda
Hurrah! Raheli, Kisiaya and Kilorit have between them built an “examination couch” as requested by FMS two years ago.

Health Workshops
STD Awareness for Boys and for Girls – I held separate workshops for these two groups. I wanted to determine what they knew about STDs, and so asked them the following: 1) what is tisonono (STD)? 2) what are the symptoms of tisonono? 3) Can you tell if somone has tisonono? And 4) How do you get it? Participants wrote their answers on pieces of paper to ensure discretion. There were markedly different answers between boys and girls! Boys were well aware of what an STD is, how you get it, and the symptoms; girls much less so – though it’s possible they were also shy in
answering more frankly. Boys were all confident that you could easily tell when someone had an STD; the girls said, in full agreement, that you couldn’t. Based on these answers, I gave a short teaching session on the easy transmission of STDs, and anyone can have one; that it is particularly difficult for women to prevent, diagnose and treat an STD because of their sexual vulnerability. I made clear that the cost of repeated STD infections and lack of treatment for women was miscarriage and infertility.

Menstruation – Raheli and Keneto helped with this discussion, as we hope that either or both these leading women will become “school matrons.” In fact, Joshua, the head teacher, requested that they come back and teach this (and STDs) again twice a year. I handed out some counting beads, so the girls could understand their cycles, including their fertile days. They are very young (and thin) – I’m not sure any of them are menstruating yet; but I think it would be good to also teach them about contraception if we can get parental approval. I showed them a lovely set of cloths and pads with a waistband made in the US by Mooncatcher, a charity that has local American women sew “period kits” for girls such as these destined for secondary school.

Hygiene – This was for the whole school. I asked children to think about whether they had washed their hands after defecating that day, and then that they go next door, one by one. If they had, then they should put a pebbled in the cup with the bar of soap; if they hadn’t, they must put a pebbled in the empty cup. Off they went, and, it seems, answered with some truth as the empty cup held about a third of the pebbles. I thanked them for being so honest, and said that honesty is very important in matters of health or you can’t know what is really the problem. I gave each child a tiny dab of green sparkles, then asked them to wipe it off on their clothes. This they did, all confident that the sparkles were completely gone. But when we looked closer, we could see not only the residue on their hands and fingers, but how it was now on their clothes! I touched on the issue of worms as well as germ transmission. And pressed the teachers to enforce hand-washing; after all, they stand to benefit from clean hands all around!

Taking Rx properly. I feel this is one of my most important and effective modules. I ask children to draw the images on the pill packets as they see them, and then we discuss as a group what these images might be. There is general befuddlement. “An eye?” offers one. When we make clear what the images are intended to represent, I then talk about what the numbers underneath each symbol mean – and emphasize that their responsibility as literate members of the community is to help! We go over the three rules for taking medicines:
  1) Follow the instructions!
  2) Don’t share the medicines!
  3) Finish the medicines!

Family Planning Workshop for Men. There is a complete report on this, so I refer only to the summary in the Wosiwosi section above. And as with Wosiwosi, I gave them the feedback from Penny’s November trip, emphasizing the real dangers pregnant women face. I also explained what she was teaching the TBAs. The main difference in Makat workshop was that the men elected to attend; though from looking through the Learning Scale answers, attendance wasn’t simply tacit approval of contraception. At least a few men said they disagreed with contraception. Perhaps they had come to find out what I intended to teach their women? But I was very pleased that they came anyway as this is engagement. Outside, afterward, several of the men were chatting and asked me if I used contraception. I affirmed that I did, and said it meant Matt and I could have sex whenever we wanted without having to worry about pregnancy. Given that abstinence (including counting days) is the usual form of birth control, this reply was likely quite intriguing. Indeed, what does happen in relationships between men and women in a community such as this when sex and pregnancy become un-linked?
Surveys. As in Wosiwosi, we conducted the FMS and FP surveys.

Discussion with Women about Family Planning.
As an opening, I shared with them (as I had with the men) the findings from Penny’s November trip. I think they felt grateful to know their fears about maternity are not unfounded, and, in context, their situation is very dire. I also explained to them what the TBAs were learning in Ketumbeine, and they were very happy to hear this. Initially, I’d intended to do sensitization – what did women know about contraception, what did they think about it, etc. But after one talkative woman took up nearly 15 minutes of our time, the other women asked me to cut to the chase and simply tell them about the methods and their availability. I spoke, frankly and concisely, then, about the IUD, implant, injection, tubal ligation, and counting days. They eagerly accepted the counting beads, and it’d be interested to see if they make copies, as we discussed this. When the meeting broke up, Keneto and Raheli approached me with a young, though worn looking woman; she was desperate for contraception but her husband forbade her to get it. He beat her and took her money. So when she went to get her child immunized at FMS they refused her, and then she could not ask for the “shindano.” Raheli and Keneto asked me to help her. I passed on this message to FMS, and I did hear that she came to the plane and was given the shindano – and immunizations for her child, free of charge. It was good that Raheli and Keneto had taken the lead here, and to see women being protective of those who are so vulnerable. Another woman said she was taking her daughter to get an IUD or implant in Ketumbeine. The other informal discussion worth noting is when I told the women that some men thought it cost only 12 goats a year to raise a child; they scoffed at this! And we laughed when I said I had the same arguments with my husband, as neither did he understand the cost of food, shoes, clothes, school, etc. etc.

Changes.
This community continues to change in many ways, but I can only see the surface in my few days. Brigitta, the young wife of a teacher who is a trained pharmacist, still has her shop. She is a real asset to the community with her knowledge, interest, and happiness to be there. She told me mothers now regularly buy water and ORS from her as a treatment for diarrhoea in their children. (I wonder if this is the sad but crucial consequence of the death of Kisiaya’s child?). As if to confirm this major shift in treatment, Kadogo (an important village leader) came to the FP workshop with a bottle of ORS under his arm, preferring to treat his own bad stomach with this rather than bush medicine.

Kisiaya has said he will not stand again for Mwenye Kiti. He said the work is very hard, and he wants to focus on his passion, which is to be a teacher. I reiterated to him our commitment to pay for his tuition. He is so helpful, but I can see exhausted by the job.

The new roads. There is now an excellent muram road from Merigoi to Engaresero, and our trip took just under two hours. However, the government is intending to build – in fact, has started – a tarmac road from Ewaso to Mtu wa Mbu. My feeling is that the Magadini community is in no way prepared for the changes this road may bring – an influx of outsiders who may want to benefit from the resources the springs, in particular, provide. Tourism has fractured Engaresero, an community with long experience of it. Makat has put up a small shade boma above the main springs, and, I think, had a few tourists. But what if someone intends to build a lodge or camp? Now that TGT is no longer operating in the area, there is almost nothing to prevent poorly conceived projects.

Meetings with organizations in Arusha

1.Flying Medical Service
PA and MF met with FMS staff at the Arusha Airport, where they were repairing a plane. We highlighted feedback (which is in a separate report), including

- the need for greater privacy of patients, particularly if FMS intends to deliver contraception
- clarify the fees of the Child Health cards, for which FMS “charges” 2,000/- even though the card states, “Not for sale.” The 2000/- is not for the card; but rather for the service. However, people don’t understand this.
- be more pro-active in delivering contraception; FMS said they would offer the Depo shot to all women attending post-natal clinics
- clarify the costs of evacuation and other services; also, many people don’t understand that FMS will evacuate even if the patient and his/her family do not have the money
- ask for their help in tracking any uptick in interest/requests for contraception, as well as any evacuations, particularly of pregnant women?

2. Joanna Waddington, ACE Africa

PA and MF met with “Joe” to discuss ways we may work together to provide strong, culturally-relative, replicable public health education to Masai communities on northern Tanzania. In particular, we discussed the potential of bespoke films to provide key health messages, followed up with discussions and then with drama troupes.