Healing & Development

Yearbook of the Medical Missionaries of Mary

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Medical Missionaries of Mary:

Founded in Nigeria in 1937 by Dublin-born Mother Mary Martin. To-day MMMs number 435 Sisters, who come from 18 different countries. The three words in the Congregation's title carry the inspiration that gives us energy to become engaged in healing some of the world's pain.

Medical: "Be with those who suffer, the oppressed, and those on the margin of life. Heal the sick, excluding no one... Let your particular concern be the care of mother and child..." *MMM Constitutions*

Missionaries: "You are missionaries... work with all people of good will. Join resources with them especially in the field of health, so as to bring about a world of justice and peace, where true human development is fostered, and human dignity and rights are respected." *MMM Constitutions*

Mary: "Ponder in your hearts the mystery of the Visitation. Be inspired by Mary's selfless love, her simplicity and faith, as she goes in haste to answer a human need, bringing with her the light that is life." *MMM Constitutions*

Our Motto: Rooted and Founded in Love

(Eph.3,17)

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Mercedes Lorena Lara, agricultural advisor, and Sister Rita Higgins, trekking to a workshop at Mogola village, in the highlands of Honduras. They pause at a Waterfall the local people call El Chifledor – The Whistler!

Challenges and Creative Solutions

Dear Readers,

I am writing from the United States this year. I have come here to be with our Sisters and our faithful supporters, as they celebrate the 50th Anniversary of the founding of MMM in this country. What a difference they have made to the unfolding story of our Congregation!

Before arriving here, I visited our community in Honduras. The Sisters went there just two years ago, after hurricane Mitch had devastated towns and cities, brought bridges crashing down, and destroyed most of the agricultural land. The cover story of our Yearbook conveys something of the work the Sisters have been doing alongside the people of Marcala and the surrounding area. We have much to learn from the hope these resilient people radiate, despite the terrible disaster they have suffered.

As you will see, the pages that follow are often tinged with poverty and pain. But you will be touched, too, by the amazing dedication and many creative solutions to the challenges that confront the countries of the Southern hemisphere. We do none of this alone. We are happy to lend our skills and our support to local efforts to overcome so many problems.

This year we said our last goodbye to nine MMMs, each of whom has given us a unique example of living our motto – rooted and founded in love – with great zeal. It is lonely to see our loved ones go. As we pray for them, we remember those you have lost too.

Mixed with the sorrow of parting, there has also been the joy of new beginnings. News from the foundation made at Zaffe in the Republic of Benin on January 8 tells us that there has been great progress in the last few months. Zaffe was the first mission to be pioneered by an all African community of MMMs. On April 7, our new mission in Abuja, Nigeria began. On June 1, we opened a new house in Butare, Rwanda – our second house in that country where the people are still recovering from the horrific events of 1994. Another step for us this year is the involvement of two Sisters in the new Catholic hospital at Wolisso in Ethiopia. That got under way in September. And the latest word is that our newest mission is ready to open at Huambo in Angola – a town that has known terrible devastation due to the long-running war in that country.

An encouraging number of young women – mostly in Africa and Latin America – continue to join MMM. We are happy, too, that in several countries the MMM Associate Movement is taking root. For all of this we thank God.

We give thanks too for our long-term faithful donors, and our many new benefactors. Without your interest and help we could never undertake the number of projects in which we are involved in so many countries. We are also deeply grateful for the interest and continued support of donor agencies who have recognised the needs and have been behind us in endeavours where substantial funding is required.

We embark upon a new year with confidence, leaning on your support as we have always done, and asking God's help to enable us to continue to play our part in the healing of our wounded world.

Sister Phil Sheenan MMM

Congregational Leader

COVER STORY

Sister Rita Higgins writes from

Honduras

Plants that Cure

THE POT sits on an open fire in a smokey kitchen. It is a small room full of the sound of chopping, cutting and peeling. The scent of fresh pine resin, lemon, camomile, ginger and eucalyptus wafts about us.

Today we are making our own cough syrup. There is excitement in the air. Old and young, men and women and children are involved in the activity.

For the twentieth time the chickens are chased out, dogs are staring longingly through the doorway. Someone checks the recipe again and we sit and wait for the mixture to cook.

There is an animated discussion about what tea to drink when a child has asthma. Take 5 mint leaves, 5 eucalyptus leaves, 3 leaves of oregano, add boiling water and wait 5 mins.

Dona Carmen is painstakingly writing down the recipe. Dona Maria is illiterate so her grand-daughter Angelina writes it for her. It is a very reassuring atmosphere.

There is great peace amidst the activities. One of the elderly men is speaking about the recipes his father used. Don Angel commands attention when he speaks. He has a natural authority and a strong sonorous voice. He is saying 'although we are poor people we have great riches. Our plants, the soil, our families'. There is much quiet nodding in agreement.

Finally, the mixture on the fire is ready. Several people taste it with approval. Someone says it should be poured into the bottles in silence out of respect for the healing quality of the mixture. We look in awe at what has been produced and pray that whoever uses the syrup may find comfort and be restored to health.

As we come towards the end of the workshop, coffee is prepared. This is the staple drink, home grown and roasted. After mother's milk, coffee becomes everyone's drink, we savour its hot black sweet flavour. The chickens dash in once more and we are all too absorbed to chase them out again.

The radio plays in the background. It is almost time for the adult education programme. Two questions: When is Maria coming to visit us? (referring to Mary Egan, MMM Associate who is involved in the literacy programme.) 'She will come soon. How is your reading this week?

A final prayer is said. 'Goodbye, go well, and *que le vaya bien*! See you next month at the workshop.

The NUTRITION HOUSE

With the high degree of illiteracy we need teaching models that people can see, touch, understand and remember – something that is taken from their own lives. So we decided to make a demonstration house to launch discussion around this topic.

The house illustrates the four pillars of nutrition. The foundations of the house are the basic foods, the walls are the proteins, the roof that protects are the vitamins – it provides shelter for the the people and the animals. The fire, or hearth of the house, represents the foods that give energy.

You can't live in a house that has only a foundation, can't live in pillars and walls, can't live with a roof only! What is missing

if there are no people, no animals? This teaching tool was tremendously successful, when taken around to workshops held in ordinary homes, with up to 30 people, men women and children present.

Sister Renee Duignan (left) made the house from a cardboard box, using a knife to cut out the windows and doors. She made another piece for the roof, using crayons to colour it, then fitted it out with a miniature oven and tiny earthen pots and pans and other utensils all made from local clay. As there is always a roosting hen in the homes, it seemed appropriate to put a live orphan chick into the demonstration house too. The little *pollito* lapped up attention from all the children!

Central America has great richness in herbs and medicinal plants and Honduras has a wide variety of both. In the highlands of north-west Honduras live the Lenca indigenous people. They are mostly *campesinos* or subsistence farmers. Only vestiges of their ancient culture remain and of their language mere fragments. Centuries of governmental neglect have contributed to the decline of their culture and its values.

The legacy of the ancient culture is very rich in the whole area of healing plants. However, commercialisation and chemical medicines have contributed to a loss of confidence concerning the use of traditional herbal recipies. There is a desire among villagers to preserve the well-tried ancient recipies and to improve and develop them to hand on to a new generation.

This fact we heard repeated over and over as we visited the villages. Powerlessness and low self esteem are two huge difficulties for many people, further compounded by high rates of illiteracy.

An important thrust in our work here in Marcala is in reviving the tradition of herbal medicine and developing it alongside other aspects of health care. During the next three years we aim to cover a wide variety of themes at local level in health committees and in every zone of the parish. Each local committee has its communal herbal-vegetable garden.

One of the last remaining Lenca words is *alahu*. Its precise meaning is unclear, yet most agree that it is a word used for prayer, a prayer of praise or thanks. One such prayer is used before picking, using or cutting plants to make medicines. It involves asking permission to use the life of the plants for healing.

All aspects of health care are covered including when to use chemical medicines and what dangers to avoid. The approach is holistic, including complementary therapies such as reflexology, massage, and acupressure. Where domestic violence has been experienced, women can be afraid of the healing power of touch – Sister Mary McKearney runs a Workshop demonstrating the skills of massage.

HONDURAS:

PARISH DEVELOPMENT PROJECT

The parish of Marcala where MMMs work lies in the north-western highlands of Honduras. The parish is divided into four sectors. Each sector has a salaried Health Promoter who, together with the MMMs, make up the parish Health Team. The parish stretches over a radius of about 50km, but the mountainous terrain makes it difficult to access many of the communities. The population of Marcala itself is 14,000.

The Health Team has now established thirty-six health committees, covering Marcala and the mountainous rural area. Each committee has a voluntary Health Promoter who is liaison person between the health committee and health team.

Improving health education and health care is an important aspect of an integrated Development Project which has been running now for about eight years. This plan places great stress on agricultural development, with agricultural advisors helping people to make the most of their knowledge, and running a credit union scheme.

In surveying the attitudes of the population around agriculture the great desire to have a better working knowledge of the traditional ways of healing emerged. The people wanted workshops – not just for selected individuals but training in which the whole community could participate.

In the last week of every month, all the people involved in the different components of the parish development project come in from their field work to Marcala. The four Health Promoters representing the four sectors of the parish, have their monthly meeting with the MMMs. They look back on the work done, plan the coming month, rehearse the next workshop, try to solve problems, plan their visits to the village communities and decide the content of their hour-long weekly radio broadcast.

The Radio Station is the life-line of the parish. This is a crucial service in an area where people have no telephones, no regular means of transport.

There is a great dearth of people who can read and write, so the programme, *Maestro en Casa* run by MMM Associate, Mary Egan, is a key factor.

Every group in the parish has its own programme, women's groups, cursillo, youth, agriculture, health – the list is endless. The radio provides entertainment, traditional and modern music, greetings, story telling, recording and transmitting Mass, celebrating big occasions, and there are prayers at the start and end of each day – you could say it is "parish by radio".

Being Catholic is not measured by church attendance, but every village has its tiny Hermitage and there are prayers there on Sunday, with a *delegado* – a Delegate of the Word, who has some very basic training in Scripture. For the rest of its input, the Christian community relies on the radio, and the activities that bond them together in their struggle to overcome centuries of colonisation, poverty, and the terrible legacy of hurricane Mitch that struck Central America three years ago.

Green Fingers in São Paulo!

Sister Sheila Lenehan was born with green fingers. But when she set out for São Paulo to pioneer MMMs work in Brazil more than thirty years ago, she hardly dreamt how useful this talent would be in her work of healing!

"Plants are the natural birthright of people", she says. "So, in our health education and health care, we place emphasis on helping the people to reconnect with the home-based remedies that have been around for generations.

"But making up these remedies is labour intensive and time-consuming. So we got a room beneath the church where a group of three women can make the remedies, and they are sold in our "Home Cures" shop for very little. We have 30-35 different kinds of remedies.

"We don't have to buy ingredients apart from cloves and cinnemon, because the plants are growing all around us, in the people's own yard, on waste ground, in the hedgerows. Eucalyptus trees abound.

"Another therapy that is low cost and very effective is a method of removing ear wax that can seriously impair hearing as people get older.

"We cut strips of cloth – cotton or linen for preference, about half an inch wide and about 12 inches long. We melt wax in a pan and soak the cloth in it. While it is still hot, we wind it around a piece of wood (part of a brush handle is ideal), to make a hollow tube with a fine point on it. This fits into the ear.

"When the end is lit, the tube allows the smoke from the top to flow into the ear and melt the wax, which deposits itself on the inner walls of the tube.

"People here just love doing it and are amazed at the amount of wax it produces and at the great feeling afterwards of being able to hear easily!"

No problem for Pharmacist

Sister Brigid McDonagh, together with Sister Sheila Lenehan, founded the work of MMM in Brazil in 1969. Most of her work since then has involved training health workers, women's development groups and bible study groups. "As a pharmacist", she says, "I've never had any problem with people using natural remedies. Pharmaceutical drugs came from the earth in the first place. The older women here seem to know by tradition what to pluck from the garden when somebody has a minor illness. I tend to run for a book to look up the dosage, but at times I have learnt a lot from them. Problems like diabetes, menopausal problems, and control of blood pressure can be alleviated in this way, as well, of course, as plants that are useful for making expectorants, energy-giving products and vitamin drinks."

Herbal Register since 2,500 BC!

Sister Jean Clare Eason writes from north-east Brazil

Since the beginning of time human beings have depended on nature in order to survive and have used plants as medicines to cure diseases. 2500 years before the birth of Christ, China had a register of herbal medicines. Today with the increased interest in ecology and the realization that the human being is only one interdependent part of the eco-system, there is a return to natural and holistic therapeutic options. Once again people are looking to plants to prevent and to cure disease.

In Capim Grosso, a group of twelve women at the Community Center for Intregal Health work together with the MMMs to grow plants and make medicines which they sell at affordable prices to the people who live in the town and surrounding villages.

The process from start to finish is a long one. Healthy plants must be cultivated and as leaves are needed they are picked and washed and dried. There is a book of tried and tested recipes developed by interested doctors and pharmacists who work in a Health Project for the Benedictine Monastery in the city of Salvador. This is used by these women to fabricate the various medicines. Most recipies require the leaves of a few different plants and often the inner bark of various trees. It is important only to remove the amount of bark needed and then to leave the tree a 3-month period in which to renew its energies before going back for a second donation. The bark is washed, the outer portion is scraped away and the inner portion is cut into small pieces and dried. When all the ingredients are ready, the amounts indicated by the recipe are measured out and usually mixed together and processed.

The processing may require boiling in water, titrating with alcohol, mixing with other ingredients to get these herbs into a usable form (for example pills, or creams or pleasant tasting syrups), or leaving them in the dark for a period of time and allowing nature to do its work.

When the processing is completed the medicine is put into sterilized bottles, securely capped. A label giving its name, ingredients, its uses and dosage, its date of fabrication and validity is attached. When customers come to buy the medicines, they are instructed in its use by these women. This has now become an income generating project for the women involved and each month the profit from the sale of medicines is divided among them. This is a real help to struggling families.

At present the Integral Health Center makes a variety of syrups, tinctures, creams and pills, to treat colds, sore throats, anaemia, malnutrition, diabetes, high blood pressure, high cholestrol, gynecological problems, nerves, rhematism, arthritis, wounds, snake bites and worms. Every month this list expands as people come to the Center with a new need and the recipe books suggests a method to help.

Above: Sueli and Dina roll pills with the two MMMs. Right: Sister Siobhán Corkery and Jean Clare Eason drying medicinal plants. Above right: Sueli collects bark.

The Moringa Tree

Sister Maura O'Donohue is an MMM doctor currently working with CAFOD – the Catholic Fund for Overseas Development, based in London. Her job involves a fair amount of travel. The Editor caught up with her at London's Victoria Station before she boarded a train for Gatwick airport and a night flight to Kenya. We took our supper in haste in a café at Victoria. Then, as we said goodbye, Sister Maura dipped into her hand luggage, took out some notes she had printed for her Workshops in Kenya and said: take this and read it and make sure everyone knows about . . .

Gram for gram, Moringa leaves contain:

- 3 times the iron in spinach
- 4 times the vitamin A of carrots
- 7 times the vitamin C of oranges
- 3 times the potassium of bananas
- 4 times the calcium and twice the protein of milk.

The Moringa tree has its origin on the lower slopes of the Himalayas, but can be found today in most tropical countries. Colonial settlers in India called it the *Horseradish* tree because its roots resemble the horseradish. Others call it the *Drumstick* tree, for that is what its pods are like. In Australia, it is known as the *Kelor* tree. In Swahili speaking regions of East Africa it is called *Mzunze* or *Mlonge*. In the Philippines they call it the Malunggay, in Haiti the Benzolive. In West Africa it is called Nebeday, which is thought to mean "Never Die" because the tree is extraordinarily healthy. In the Nile Valley it is called *Shagara al Rauwaq*, which means "tree for purifying".

Several scientists, like Dr. Rob Fletcher of the School of Land and Food at the University of Queensland, Australia, have studied the nutritional value of the Moringa tree – to everyone's benefit.

Michael D. Benge, agroforestry officer with the US *Agency for International Development* in Washington DC, reported in 1987 that a cupful of Moringa leaves provides more than the recommended daily requirement for vitamins A and C and that the tree is rich in calcium and iron and a very good source of phosphorus.

In late 1992, Noel Vietmeyer of the US *National Academy of Sciences* said:

"Moringa could soon become one of the world's most valuable plants, at least in humanitarian terms...it has more than a dozen important uses, yielding, among other things, several types of food as well as oil, wood, paper, shade, beautification and liquid fuel."

In the Philippines, the Moringa Tree was chemically analyzed at the Food and Nutrition Research Center of the *National Science Development Board* in Manila. Recipes were tested there and advice given about how much Moringa you should eat.

Today, healthcare specialists working in the southern hemisphere are busily raising awareness about the benefits of this indigenous resource to communities where it has been neglected or undervalued up to now.

Inter Care, a charity that helps indigenous orders of African Sisters who work in rural areas, started a Moringa project in Uganda in 1996. Moringa Trees had been in wide use by the Asian community, but when they were expelled from Uganda by Idi Amin, the trees were left uncultivated and their uses were unknown to the African people. Dr. John Parker, a volunteer with Inter Care, changed all that. Earlier this year, he reported in the Mill Hill magazine *Mission Today* that the enthusiasm and interest in the tree and its products grew so much that they decided to organise a workshop to introduce it to a wider audience.

A paste made from ground Moringa seed will clear the dirtiest of river water in an hour!

In December 1983, *New Scientist* magazine reported that the seeds of this tree found in Sudan and Peru were being used to purify muddy river water. Village women collecting water from the River Nile would place powdered seeds in a small cloth bag to which a thread is attached. This would then be swirled around in the turbid water. Water soluble proteins released from the powdered seeds, attach themselves to, and bind between the suspended particles forming larger, agglomerated solids. These flocculated solids would then be allowed to settle prior to boiling and subsequent consumption of the water. Boiling is still essential!

The report also mentioned trials by pharmacologists at Gadja Mada University in Indonesia which "showed that one crushed seed can clear 90% of the total coliform bacteria in a litre of river water within 20 minutes."

Several Universities around the world began to look more closely at this tree, which has been known to the peoples of the East since ancient times. Since the early 1970s, a number of studies have been carried out to determine the effectiveness of the seeds for the treatment of surface water at individual household level, and later on continuous flow systems. Results demonstrated considerable success. The potential toxicity of the seeds has been considered in two major studies. The conclusions of both were that the doses typically used for water treatment posed no serious threat to human health. The University of Edinburgh, the University of Karlsruhe in Germany and the Polytechnic of Malawi are continuing studies in this connection.

Question: What is high in protein, calcium and vitamins;
grows easily in tropical climates;
is drought-resistant; tastes good;
and has been overlooked
by just about everyone?

Answer: The Moringa Tree

Monday Developments, Nov 22 1999

This took place at the Mill Hill facilities in Jinja, co-tutored by Dr. Parker and Reya Al-Kahali from Leicester University in the UK – a faculty that has undertaken major studies in this field. Arising from this, a seedbank and information centre was set up.

On the second day of the workshop, the main meal was produced from a Moringa menu. Dr. Parker says: "The list of dishes it can produce is amazing. Salad using fresh Moringa leaves (they look and taste like water cress). Leaves fried with tomatoes or simply boiled result just like spinach. Dried and ground Moringa leaf powder in a groundnut sauce is delicious with chicken. The pods make a curry and the accompanying chapattis may be made with Moringa seed flour cooked in Moringa oil garnished with dried ground Moringa leaves."

Even the flowers of the Moringa are edible, but they must be cooked. They are said to be simply delicious when done in batter. No wonder Fr. Denis Hartnett, a Mill Hill missionary working in the arid Karamoja region of northern Uganda, decided to establish a Moringa nursery!

Lowell Fuglie heads the West Africa regional office for Church World Service – the relief agency of the US National Council of Churches. Based in Dakar, Senegal, he read about the Moringa tree in the newsletter of ECHO (Educational Consensus for Hunger Organizations) two years ago. Since then he has dedicated himself to exploring the tree's possibilities and its implications for African countries. Partnering with Senegalese health clinics and *Alternative Action for African Development*, he helped lead a Church World Service project in southwestern Senegal that studied the nutritional value of the Moringa tree and its use as a weapon against malnutrition.

He found that parents of malnourished infants in Senegal reported watching their children gain pound after pound once Moringa was added to their diets.

"When you look at malnutrition in West Africa, you're looking at a lack of iron, a lack of protein, a lack of vitamin A – in effect you're looking at malnutrition caused by a lack of the very things Moringa contains", he said. "Here's an indigenous nutritional supplement that people can grow in their own back yards".

He presented a workshop about the Moringa tree during the HIV/AIDS & Malaria International Conference in Atlanta in April 2000. He told his audience Moringa is "an all-natural source of nutrition that could help people with HIV and AIDS live longer and healthier lives".

However, he admitted in a post-conference interview reported in the *Amarillo Globe News*: "We do have the Western academic skepticism to overcome. We found this true in Senegal too. The doctors and nurses and medical professionals we presented it to all knew about the tree, they had eaten it many times, but they've gone through Western training and been taught to rely on imported drugs made in the West. So they see this local plant as herbal medicine and as inferior to modern Western medicine."

Like Dr. Maura O'Donohue, Lowell Fuglie feels an international conference on this is long overdue. He says: "Every part of the tree had medicinal applications that deserve to be studied. We haven't begun to scratch the surface of what Moringa is capable of doing".

CULTIVATION

An immense amount of botanical literature has been produced about *Moringa Olifera* – the most widely utilised of the fourteen known species of the *Moringaceae* family. It likes sunshine and can withstand drought conditions, or even light frost! It grows quickly from seed or cuttings. It may be sown directly or in seed beds with transplanting after 2/3 months. *M. Olifera* can grow in a variety of soil conditions. Although preferring well-drained sandy or loamy soils, heavier clay soils will be tolerated, although water logging should be avoided. The tree can be established in slightly alkaline soils up to pH9.

From both seeds and cuttings the tree grows at a remarkable rate. Its first fruits may be expected within 6-12 months of planting out. It can reach a height of 12 feet within the first year, and regenerates itself even after the most severe pruning. Two harvests of seed pods can be produced in one year. A mature tree can produce 1,000 pods annually. Moringa leaves tend to appear toward the end of the dry season when few other sources of green leafy vegetables are available.

The best time of year for sowing is the beginning of the wet season. If planted out during the dry season, half-shade should be provided and watering should be carried out regularly until the tree is established. Watering every other day has been reported to increase the drought tolerance of the tree. Manuring prior to the rainy season is said to increase yields three-fold. However, the use of fertiliser and regular irrigation is not essential and is seldom practised outside of India. Pollarding or pruning following harvesting is recommended to promote branching, increase pod production and facilitate harvesting. Moringa is relatively short-lived, reaching only 20 years on average, but easy to replace with young trees.

Warning about Roots

The literature warns of essential preparation before eating Moringa roots. Dr. Julia Morton writes in *Economic Botany*: "The root bark must be completely removed since it contains two alkaloids allied to ephedrine - benzylamine (moringine), which is not physiologically active, and the toxic moringinine which acts on the sympathetic nerve endings as well as on the cardiac and smooth muscles all over the body. Also present is the potent antibiotic and fungicide, pterygospermin. The alkaloid, spirachin (a nerve-paralyzine agent) has been found in the roots. Even when free of bark, the condiment, in excess, may be harmful."

Experts warn us that there is no single solution to world hunger which is a complex problem. The Moringa tree is only one important player among several remedies needed to solve the problem. Debt relief is another.

The Internet is awash with information on the Moringa tree. You'll find links to several interesting sites, including sources for seeds at **www.medical-missionaries.com** Those who cannot access the Internet can write to us at the address on page two for a print-out of useful pages.

ANGOLA:
Prevention is Better than Cure

Sister Zita Iwuoha, a Nigerian MMM, writes about a successful Mosquito Net Project in Southern Angola.

Figures from international health agencies show that more than 400 million people suffer from malaria related illness every year. At least one million die annually from the disease. Most of those who die are African children.

Prevention, they say, is better than cure. But this is hard to achieve in our world, where so many are marginalized and disadvantaged and have not the necessary means to protect themselves from disease. Primary Health Care is the way we get to the 'grass roots' population with solutions.

Cunene Province where we work is the least developed part of Angola. Health care, like every other sector, has suffered and is still suffering on account of the continued war.

In 1998, when I was studying at the Liverpool School of Tropical Medicine, I learned a lot about malaria and its prevention. It sounded like an old story. I heard that the World Health Organization and UNICEF were encouraging health workers to promote the use of treated mosquito nets. But I never dreamed that, before long, I would become so involved in such a project.

Around the same time that I was in Liverpool, Sister Cecily Bourdillon, was asked by an old school friend, Joan O'Flynn, who is now living in Canada, what she could do to help our work in Angola.

'The big killer is malaria', Sister Cecily told her friend. 'If we could only do something about that, we could see change.'

Joan O'Flynn did not waste any time. Together with a small group of friends in Vancouver, she founded the "Chiulo Southern Angola Children's Death Prevention from Malaria Society". She wrote to newspapers, contacted radio stations. She even brought the problem to the attention of Julie Andrews, who has been involved in many projects to alleviate suffering. By June 2000, they had collected 25,000 Canadian dollars to get the mosquito net project off the ground.

Heading for Huambo

It is hardly the time, you might say, to be heading for Huambo. After all, the roads are not safe. It is hard to get a reservation to travel by air – and very expensive. Besides, the city has been badly hit by the war. Many organizations that were based there have moved elsewhere. Those who stayed have had to evacuate at times, returning when they felt it was safe. Huambo is far from the southern area, where MMMs have had a long tradition in Angola. There are many reasons not to go.

But – on the other hand – MMMs are no strangers to war. Mother Mary Martin built our Motherhouse in 1940, when World War II was really bad. We've been through civil war in Nigeria, the Idi Amin years in Uganda, the ups and downs endured in Ethiopia. And, we've been with the people of Angola through the recent troubled twenty-five years that have rarely known peace.

So, when our latest house was establised in Huambo at the end of October this year, the pioneering MMMs – Sister Opportuna who is a native of Tanzania, and Sister Laurinda, an Angolan MMM – felt they were part of a long tradition of hoping against hope that the future would be better than the past.

"We have been waiting to go to Huambo for years. Now the war has quietened down a bit. We hope and pray we will be able to stay there. We have been asked to take over a clinic in the parish run by the Redemptorists."

Already, ten young women from that part of Angola are interested in joining MMM. It seems to be the place where God wants us to be!

Meanwhile, back in Chiulo, we were donated some sewing machines and with the help of two dedicated seamstresses we got started. We had to buy the netting and insecticide in Namibia, transport it back to Angola, and find somewhere to set up a temporary workshop until we could build a more permanent place for this project.

Progress seemed slow, and I was frightened by the number of children being admitted to the paediatric ward with malaria and anaemia. The death rate was too high. This gave us more determination to get ahead with the mosquito net project.

When we had some nets ready, we took them to the ten areas where we do vaccinations, ante-natal care and health education. The number of people working on the project was gradually increased from three to eight as the demand was so high. Visits were made to other areas to look for people with the skills it takes. We bought bicycles to have the nets distributed to outlying villages so as to keep the costs as low as possible.

The next challenge was to get a proper workshop for this project. Despite all the difficulties, we found a builder willing to undertake this, and the new building will be ready soon.

Joan O'Flynn
Vancouver

Types of net and prices are explained

Urban health-care round

Sister Vera Fitzgerald

Sister Vera Fitzgerald spent twenty years at Chiulo Hospital. When she found an Angolan doctor to replace her there, she moved to the city of Lubango, 270 km to the north of Chiulo and commenced working with the Ministry of Health in community medicine. This includes five clinics.

Mitcha, just 4 km from the MMM house, has a population of 9,321. Nambambe, 16 km away, has 28,504 people. Around Huila, 20 km away, there are 115,754 people in the area. Bula Matady, 5 km away has a population of 9,644. Rio Caitão 8 km away has 21,500.

Despite her busy round, Sister Vera took time to write to us. "Many patients coming to these Clinics have been displaced by war. Some come from refugee settlements. Others find relatives.

"The Clinics are staffed by Health Promoters who have a very basic nursing qualification. Problem patients, medical, ante-natal, gynaecological, paediatric, are referred to me for diagnosis and treatment. Some require minor surgery.

"Many of the marasmic/kwashiorkor children have associated diseases such as scabies, acute respiratory illness, TB, skin diseases, diarrhoea, worm infestation or eye infections.

"Another part of my work involves the Provincial AIDS Education Program. Two nurses accompany me daily and give AIDS education to the waiting patients and their companions. We have also managed sessions on AIDS education at most big institutes including the Electricity Supply Board, the Post Office, factories, garages, police stations and church groups."

Creating Covenants: Healing Health Care in the New Millennium

Dr. Glenna Crooks' new book traces the 5,000-year-old path leading to the problems with health-care in the Western world and applies lessons from the past to the dilemmas of health care today. The book has been critically acclaimed by reviewers in the US as "a break-through in conventional thinking"; "a new paradigm for creating the future" and as having "the potential to transform the chaos of our current health delivery system into a caring and compassionate system of healing".

A well-known health strategist, Dr. Crooks points out that the healing relationships established millennia ago between patients and their healers were covenants, not contracts... communities were also engaged to support health and healing. It illustrates the web of relationships between the community, the healer and patient.

Dr. Crooks has generously offered to donate the proceeds from this book to support the ongoing work of MMM. For this we are most grateful.

Creating Covenants: Healing Health Care in the New Millennium, Medical Vision Press, ISBN 0-9679666-0-4

Like many other MMMs, our communities in Minna State, Nigeria are deeply involved in UNICEF's Extended Programme of Immunization

Sister Joan Melinn

From our Health Centre in Fuka, we visit fifteen villages once a month as part of UNICEF's Extended Programme of Immunization (EPI). The usual vaccine routine covers the six major diseases – TB, whooping cough, tetanus, diphtheria, measles and polio.

Only three people can go in the cabin of our vehicle. The furthest village is about an hour and a half away. There could be small rivers to cross in the rainy season. But that's not a big problem here. Most of the time it is hot and dry. When we get there, the clinic is held under the trees if it is too hot to be indoors. The people produce tables, benches, water, maybe some soap – but we carry our own just in case.

We already have trained health workers living in some of the villages. We invite them to come in to the Health Centre in Fuka for a month's course, during which they cover all the basics – prevention of things like malaria or tetanus, treatment of problems like diarrhoea and vomiting, in fact anything that happens in the village on which they can have some influence. That would include ensuring a clean water supply, not growing things too near the houses, because water sits in leaves and mosquitoes breed in the stagnant water.

Domestic and farm accidents are another area we cover in the basic course. It is common enough to find injuries because a hoe came down on a toe or lower leg, or a hatchet used to cut wood went through the person's hand. Ideally, we would like to think the people have been educated to take steps to prevent this type of accident. But, just in case, the health workers get training in how to stop the bleeding and clean the wound, to keep the person alive and to get any emergency transported in to us. That could mean strapping a patient onto the back of a push bike, or a motor bike, occcasionally a car might be available.

Sometimes we are called out to a village. If you go, you'll find the problem is everybody's concern. It is not just curiosity, there is also an interest in the person who has the problem and they want to find out what we are doing. There would be a natural suspicion about bringing strangers in, so they want to be sure they see what we are doing.

Children have no inhibition at all. We teach a lot by letting children be there and watch what we are doing to a little sister or brother, telling them what they can do themselves. Children learn very easily that way.

Before we went to Fuka we had to do a survey of the area. 2 years before that they had 32 births and 34 deaths over a 2-year period because of measles. They couldn't tell you how many had died but said 'our children are disappearing'. Well, we've just finished a survey of the same area now, and found there has not been one death in the past two years and every single child has been covered by the Extended Programme of Immunization.

Sister Christine Gill sets out for EPI visits.

When Sister Felicitas goes to Gussoro village to check on a newborn infant, she is asked to look at a couple of sick children.

Sister Grace Ahanonu

"We had six huge cooking pots but no small one, and three muzzles for dogs but no dog!" Unpacking for the new MMM house in Abuja that opened on April 7 this year, was like a 'lucky dip'. Boxes of stuff had been donated from here, there and everywhere.

"Accommodation is very hard to find in Abuja, so there were visitors from the very beginning. Now with the International Airport open, we expect the numbers will increase.

"There is a borehole in the estate where we live, but we have to buy the water and carry it in jerry cans or in buckets from the pipe.

"Our Primary Health Care programme is getting off the ground slowly. Sister Grace goes out with her team five days a week. Their target area consists of the twenty villages in the five parishes allotted to them. She has just one health worker.

Settling in to the suburbs of Abuja, Nigeria's New Capital City

Sister Joan Cosgrove

Sister Joan Cosgrove

Seventeen Voluntary Health Workers completed the course she ran, and are already working in their villages, having successfully passed their examinations."

An armed robbery on December 2 was a scary setback. The raiders broke down the door, took all the money the Sisters had, and left, shooting their way around the estate. When they were finished they returned to the Sisters' house to take the car – saying they would leave it someplace where it could be collected. Five days later they got it back.

When things quietened down, neighbours called in to see if the Sisters were alright. The whole estate was shocked, and very upset when they discovered their security guard had been shot dead.

Sister Joan Cosgrove is a pharmacist, and works with the Health Co-ordinator of the Abuja Archdiocese. Sister Joan keeps a supply of good quality essential drugs from the WHO basic list. These are for use in the health posts which they are setting up to serve the growing suburban population. Archdiocesan funds pay for the first supply, and after that each community is expected to pay for replacements, charging a standard basic fee to patients.

Nurses are like 'Gold dust' in Malawi

The people of Chipini deserve better, but the truth is that the odds are weighed against them. The 20 km. road out to the tarmacadam is in a dreadful condition. Last March, the ambulance from the Health Centre sank in the mud, with water reaching waist-deep into the cabin. The condition of the road also leaves Chipini isolated. Visitors are reluctant to make their way in from the main road, in case they might not manage to get out again if there was a spontaneous flood.

Sister Christine Lawler is the only resident trained nurse available, hardly finding time for a day off. There are two nurses who alternate night duty. Sister Christine likes Chipini, but is counting the days until Sister Theresa Agbam arrives. Sister Theresa is a young Nigerian MMM, nurse and midwife. She is currently doing an orientation programme at St. John's Hospital in the city of Mzuzu, but should join the Chipini community very soon. Nurses are like 'gold dust'. Nothing would attract them to Chipini when there are easier conditions in the urban centres.

Sisters Christine and Theresa.
Above: Sister Constantia Faul is Administrator at Chipini.

Sister Mary MacNamara is the Area Leader for MMM in Malawi. She worked in Chipini for five years, from 1992 when MMM was first invited there in response to a terrible drought. They used to see hundreds of mothers and infants at the clinics in those early days. Sister Mary takes heart from the success of that programme. She says:

"It seems pretty bad at the moment, with a lot of very bad malaria, chest infections, and of course AIDS topping the list. You could feel things are out of control. But when I realise that we got over the crisis of 1992, it gives me hope that somehow we will be able to help the people to recover from these bad times too. We are anxious to expand the EPI programme, as soon as Sister Theresa comes. It takes a lot of motivation, and when people are isolated from the outside world it is hard to give them a vision that things could be better. Poverty of mind is worse by far than material poverty, and isolation from other communities can bring about a poverty of mind."

This year we celebrate **Fifty Years** of MMM in the USA!

At 11.30 a.m. on Wednesday, July 5th 1950, the Tender left the quayside at Cobh bringing passengers and a few chosen well-wishers to the *Mauritania* anchored out in the bay. Mother Mary Martin and Sister Stella Phelan were on board. It was another major step in the establishment of MMM – the realisation of Mother Mary's dream to make her young Congregation known in America.

That dream had begun to take shape a year earlier, when Richard J. Cushing, Archbishop of Boston (later Cardinal), was in Drogheda visiting the parish priest, Monsignor Austin Quinn. Mother Mary was invited to meet him. She was deeply touched by the visitor's great interest in her work.

In January 1950, Mother Mary was surprised and delighted to receive a letter from Archbishop Cushing, inviting her to make a foundation in Boston and offering her a house and whatever moral support he could command on her behalf.

The diary of the journey, kept by Sister Stella Phelan, relates that the final days of preparation had been gruelling. Mother Mary's schedule of meetings, visits, interviews, letters, telegrams, would surely have exhausted the most robust person.

Yet, during the five-day voyage to New York, Mother Mary rested little. It is evident from these precious diary entries that her entire focus was on her mission:

– the Congregation she had founded thirteen years earlier had a role to play in bringing healthcare and healing to people who were in dire need;

– this could be greatly helped if young American women were attracted to join MMM, and if the people of America were attracted to support the endeavour.

The documentary film *Visitation*, which Mother Mary had made about the work of MMM in Africa was among her cabin luggage. By coincidence, Mass on July 6 was celebrated in the ship's Cinema. Mother Mary lost no time in making her way to the Purser's Office to ask if her film could be shown to the passengers.

The diary for Friday, July 7th, recounts how Mother Mary succeeded in arranging a showing of the film for Monday. That afternoon she "spoke to a group of Boston ladies who are anxious to help. Spent some time with them and gave them literature."

On Saturday, July 8th she "saw Operator about showing of film and printed invitations to Captain Thompson and Officers; Sisters Burgess and Knowles, Nurses; Mr. Thom, Chief Steward and Staff; Mr. Macgovern, Chief Engineer and Staff, Dr. Winer, Ship's Doctor; Mr. Thomas, Purser and Staff.

Sister Stella Phelan – author of precious diaries that chronicled the first visit of our Foundress to the United States.

She sent autographed *Visitation* book to Captain Thompson."

When Monday came, they packed their luggage for Customs. After lunch, they got ready for the film show at 2.30 p.m. The diary continues:

"Distributed literature to the people as they went in. Full house with only standing room. People seemed very interested and many suggested that we should have a collection."

And so began the story of MMM in the United States of America. Down the years that followed, a wonderful cohort of friends and missionary partners took up the cause. That same zeal to promote and support the work of MMM to bring healthcare to the people in greatest need is still strong today.

From the beginning, MMM won loyal and loving supporters in the Boston area. Bazaars held each winter in the Hancock building became legendary. The people who helped us back in the early days will never be forgotten. Neither will those who came later and remained with us through the decades. The energetic Committees in Chicago that support MMM had their 31st Annual Dinner Dance this year, realizing $61,000 for our mission in Honduras. Their 27th annual Fashion Show provided a further $15,000 for our new venture in Mexico.

Through the Office of the Propagation of the Faith, people all over the United States have been most generous in supporting MMM. And we have been blessed with many American Sisters who brought new energies, great talent and dedication. They opened up the Congregation to a vision of cultural diversity that has enriched MMM in bountiful and lasting ways.

Sister Stella recalls the hospitality she and Mother Mary received all along their route. They spoke about MMM crossing twelve States as far west as Minnesota where they visited the Mayo Clinic. On Saturday, October 28 1950, the diary noted that the luggage was once again stowed in the hold of the *Mauretania*. The first community of MMMs had been installed at 36 Commonwealth Avenue in Boston. The US première of Visitation had been arranged for New York. Now, more than one voyage was about to begin!

A REUNION OF DEEP EMOTION…

When it was first suggested that all the American-born MMMs might come together for a Jubilee event together with those currently missioned in the USA, it seemed like an impossible dream. Sister Carol Breslin, a native of Kingston, New York, was in Addis Ababa when her invitation arrived. "It took a great act of courage to believe it would come to pass", she wrote. "But it took a similar act of faith for the first group of MMMs to start a new foundation in America in 1950."

They came from Ethiopia, Uganda, Tanzania, Nigeria, Mexico and Brazil. Yes, they all made it to Tiverton, Rhode Island, for the appointed date, June 26 and spent a week together in a perfect setting by the Sakonnet River.

Sister Joanne Bierl, who coordinates the work of MMM in the Americas, wrote:

"…stories were shared, memories relived and tears – both of laughter and sadness – were shed. Some sisters were meeting up after a separation of thirty years, and trying to draw together the threads of their lives as they ministered in different parts of the world. Many of our former MMMs joined us for one day, and this too evoked deep emotions."

Sister Julie Urban (left), a native of Medford, MA, and Sister Madeleine Le Blanc from Irasburg, VT were the first professed American MMMs.

In 1958, Sister Mary Katherine Donato from Coatsville, PA, became the first American MMM to go to Africa.

Chicago-born Sister Catherine Anne Dougherty was the first American MMM to give her life in Africa. On her first missionary assignment in Minna, Nigeria, she became acutely ill and died on May 26 1970, aged 30 years.

In Chicago, **Sister Andree Brow** works at a Center for low incomes families which runs programs for the diversity of nationalities residing in the neighborhood. The population includes people from Africa, the Caribbean, Belize, Hispanic countries, Asia and Eastern Europe. Sister Andree has a cheery welcome for all who enter the doors of the Center, and when parents bring their little ones to the *Rain Forest Playroom* for childcare, she has a chance to listen to their stories and catch up on what is happening in their lives.

Sister Joanne Bierl (left) from Buffalo, NY, and **Sister Kay Lawlor** from Beverly, MA, are currently on the MMM Central Team. Sister Joanne provides leadership for MMM in the Americas – USA, Mexico, Honduras and Brazil. Sister Kay has a very wide brief, leading MMMs in Ethiopia, Kenya, Uganda, Rwanda, Tanzania, Malawi, and Angola! The entire Central Leadership Team meets once a year to review progress and formulate policy.

Sister Bernadette Kenny is on mission within the United States – among Appalachian communities in the State of Virginia. This year she and her co-workers organized the largest Health Fair ever held in rural America. More than 300 volunteer specialists flew in from many places to join the event. The people of Appalachia have suffered greatly from the exploitation of their land by strip mining, and deforestation. Sister Bernadette has been working in Appalachia since 1980.

Sister M. Andrew Philips *(right)* has been tireless in her efforts to promote the work of MMM in America. Together with **Sister Bernadette Gilsenan** *(below)*, she is engaged in our Mission Education Programs, including visits to parishes asigned to MMM by the Office of the Propagation of the Faith as part of the Missionary Cooperation Plan.

Every year, a number of MMMs on leave from overseas missions go to the US to help in this work.

For Sisters M. Andrew and Bernadette, this takes a lot of preparation. "Some of them are in the USA for the first time and they have to adjust to our Highways and learn map reading and the many other things that go with this job. But the people love to hear the stories of the Sisters from their personal experiences, and the response is always very generous."

Visits to parises are often followed up with visits to the schools, when young people can be educated about the wider mission of the church and encouraged to show concern for children in other parts of the world who may be less fortunate than they are.

Saint Thérèse and the Doodlebug

Sister Barbara Faulkner

When Sister Barbara Faulkner was eighteen years old, she became a Catholic. To mark this step, a friend gave her a statue of Saint Thérèse, and from then on Sister Barbara began to develop a great devotion to her.

Every time I moved house I took the statue of Saint Thérèse along with me. I was a pupil midwife during the war – those were the days of the blackout in London. While a colleague and I were working to get our district cases, we were supposed to sleep in an air-raid shelter. It was a surface one. It was used for children during the day and was a bit smelly. So we asked if we could sleep upstairs. This was agreed, provided we promised to go to the shelter if we heard an air raid warning.

My colleague of those student days, Elizabeth, was a Jewish girl, but she had faith in the silent prayer I would offer for protection as I shook Holy Water around the room before going to bed. Every night she would ask me 'Barbara, have you shaken the Holy Water?'

The Doodlebugs began to target London towards the end of the war. You could watch them as they flew very low. You'd listen to the engine. You knew that once the engine cut off it would start to dive.

You'd get off your bike and curl up like a little ball till it crashed. It was very frightening. But you always felt it will hit the other person, never you.

We used to cycle in for our lectures, and on one occasion I remember we had to jump off our bikes and roll up in a ball nine times along the way.

I woke up very early one day in that summer of 1944. It was a beautiful morning. I could hear the 'duv-duv-duv' of the Doodlebug on its way. I could tell it was quite close to us. I jumped out of bed – mine was the back bedroom. I curled up into a ball as we had been trained to do, and waited for it to strike.

It crashed onto the opposite side of the building, knocking down the front portion. When I uncurled and lifted my head I could see the whole window frame had been blown into my room and was

Replica of the V-1 on display at the Watten hardened V-weapons bunker in Calais, France. Photo by kind permission of Tracy Dungan of Midwest City, Oklahoma.

standing intact at the side of my bed. Not a bit of glass had been broken. I hadn't as much as a scratch.

I looked over at the dressing table where the statue of the Little Flower was standing. I felt sure she had protected me. All the rubble from the wall had fallen around her feet and had gone under my bed. I stepped through the rubble and lifted the statue in my arms. There was a tiny chip on her nose, another on her little finger, and a small mark on her veil just over her forehead.

When I joined MMM in 1948, that statue came too. I brought her to Nigeria and later to Waterford, and now here we are, once again, back in London. I know Saint Thérèse is protecting me to this day.

The V-1, known to Londoners as the "Doodlebug" or "Buzz Bomb", was a tiny, unmanned aircraft of simple construction but high performance, with a wingspan of 17.5 feet, and 25.5 feet in length. It carried a 2,000 lb. warhead.

Shortly before dawn on the 13th of June 1944, the first of the V-1s blasted off from its camoflagued launching ramp and noisily rattled northward, crossing twenty miles of French territory before heading across the English Channel towards London. A week earlier, June 6th, marked the massive Allied invasion of Normandy. Now, after two years in preparation, Hitler would wait no longer for the perfection of this weapon, and ordered his campaign of retaliation to be launched.

Powered by a relatively simple pulse jet engine which gave it a very distinctive sound, somewhat like a motorcycle without its silencer, the V-1 had a cruising speed of 340 to 400 mph, and its cruising altitude could be as low as 2000 to 3000 feet. This made it difficult to intercept by Allied fighter aircraft.

In daylight the little robot aircraft could be seen skimming along on a steady bearing and height, whilst at night the flame issuing from the exhaust could be seen from a considerable distance. A fair proportion of the V-1s were launched during the hours of darkness.

On June 16th 1944, 240 V-1s were launched from the French ramps and by June 18th, 500 had been launched – one of those destroyed the Chapel at Wellington Barracks, killing 121 people and injuring 68 others. Later, when Allied forces had destroyed the launching sites, these missiles and the V-2s that succeeded them were launched from aircraft.

Every day in the first week of July, an average of 120 of these flying bombs was launched. After the first two weeks of bombing, 1,769 people had been killed. In London's Strand, the Air Ministry itself was hit and 198 people were killed. On July 1, a flying bomb crashed in Chelsea, killing 124 people; four days later the total death toll had risen to 2,500.

In all, some 9,000 Doodlebugs were launched against Britain. Despite vigorous and successful defense strategies, some 2,000 of these weapons fell on the Greater London area. The last of these flying bombs was launched on March 29, 1945.

The final death toll was close to 9,000, with probably twice that number injured. The destruction of housing was enormous; bombs coming down in densely populated areas frequently causing damage to upwards of 1,000 houses each.

cf. www.nzfpm.co.nz/theatres/tow_tied.htm

They thought her real name was 'Champion'

Sister Elaine Campbell died at Drogheda on July 17, 2000. She is remembered very fondly by her family in England with whom she always spent her home leave. She is also remembered dearly by the MMMs, the missionary priests and the people who shared her life as a nurse and midwife in Nigeria and Kenya.

Sister Elaine was 'something of a character', had a great sense of humour, was ever ready for fun and socializing. She played 'canasta' to win, lived her life wholeheartedly and gave herself unstintingly to whatever task was at hand.

A native of Ipswich, England, Sister Elaine walked through life with a lightfooted gait – something that betrayed the sorrow and loss she had endured. Born in 1920, Elaine Stopard became a youthful bride in the early years of World War II, marrying Joe Campbell, an RAF fighter pilot. Only a few months after their marriage, Joe was shot down and killed in a raid over Europe. The young widow, who had been in the British Civil Service before the war, retrained as a Post Office Engineer. Her wartime assignment was to travel around in a little yellow van repairing bombed installations and helping to ensure that telecommunications remained intact.

When the war ended in 1945, Elaine entered upon a nursing career at Guy's Hospital, London. She also staffed at Guy's before training as a midwife, which she completed in 1951.

In February 1952 Elaine travelled to Ireland to meet Mother Mary Martin and to see if her future vocation lay with MMM. She found the Convent in Drogheda strewn with rubble following a terrible fire that destroyed the newly-built Novitiate. She met the novices in temporary shelter in a hotel in Temonfeckin. She could see the needs. She knew she had a lot to offer amidst this kind of crisis.

Professed as an MMM in1955, Sister Campion, the religious name she took, set sail for Nigeria, and became Matron at the Sacred Heart Hospital, Obudu. In 1962, when MMMs were asked to respond to the famine crisis in the Turkana Desert in Kenya, nobody was surprised that 'Camps' would be among the pioneers chosen by Mother Mary for this most difficult assignment.

During her 32 years in Kenya, She worked in Kakuma, Lorugumu, Kataboi, Aror, Kaputir and Kipsaraman. She left her mark in all these places. The Turkana people thought her real name was *Champion*.

During the past six years she bore illness with graciousness, lovingly cared for in Áras Mhuire and freqently visited by her devoted family, who mourn the passing of this inspiring woman just as we do.

BREAK the SILENCE

It is well recognised that around the global issue of HIV and AIDS there is a deafening silence. The 13th International AIDS Conference held in Durban, South Africa in July 2000 was a world wide plea to 'Break the Silence'. This silence results in the stigmatisation of those who are directly infected with HIV or whose lives are indirectly affected by it.

According to Sister Brigid Corrigan, Medical Director of the HIV/AIDS services of the Archdiocese of Dar es Salaam in Tanzania, this silence is to be found:

Within the individual
Between family members
Within the community
Within the church
Within political systems
Between health care workers and patients.
Silence abounds in the whole area of sexuality,
of dying and of death.

PASADA is the name given to the activities and services for people with HIV/AIDS within the Archdiocese of Dar es Salaam. The work of PASADA is integrated with several different health programmes because the staff in each of these programmes face the problems of HIV and AIDS.

The work of PASADA has increased enormously since its beginning in 1992 as a Christian response to the problem of HIV/AIDS in Tanzania's capital city.

PASADA strives to reach the poorest of the poor who are living with HIV and AIDS and provide them with medical, psychological, spiritual, social and material support. The main activities also include support for those orphaned by AIDS and there is a comprehensive educational preventative programme.

In 1994 a dispensary was established at Chang'ombe offering a voluntary counselling and HIV testing service, as well as health care at the dispensary and Home Based Care for those who are too sick to attend.

The centre, whose Executive Director is Fr. Richard Bauer, a Clinical Psychologist, is well staffed with counsellors and social workers. The dispensary and Home Based Care staff, consisting of a Physician, a part time Paediatrician, three Clinical Officers, Nursing Officer, two staff nurses, a laboratory technician, and auxiliary secretarial staff.

During these six years PASADA has registered nearly 4,000 HIV positive people, while the number of people receiving counselling, either pre-test, post test or supportive counselling continues to increase monthly.

Sister Brigid Corrigan

It is up to each of us to do what we can to 'Break the Silence' at whatever level we can. Here, I want to share with readers what we need to do about the 'silence' that we have observed between health care workers and patients.

Most of the problems associated with HIV infection can be dealt with at the primary care level. The shocking fact is that dispensary staff are seeing most of the patients who are HIV positive but neither the staff nor the patient will speak about the problem.

In Tanzania, the contribution to the Health Services by the Churches is of great significance. The question remains as to how the churches are responding to the problem of HIV/AIDS at this important primary care level.

Here in Dar es Salaam, because PASADA is closely linked with the dispensaries of the Archdiocese, we have been in a position to see what care is offered to people regarding HIV and AIDS at dispensary level and try to identify problems.

At PASADA we receive people who come for a variety of reasons, in the first instance. These include signs and symptoms of HIV/AIDS, chronic ill health or recurrent illnesses, death of a partner because of suspected or confirmed HIV/AIDS, counselling and testing before marriage or before certain employment contracts or overseas studies, people wanting to know their sero-status after attending seminars on AIDS, or simply children whose mothers have died from AIDS.

However, the majority of people come for confirmation of a suspected diagnosis of HIV/AIDS.

For some time past, we have been concerned about several factors that point to the silence that exists between Health Care Workers and patients at dispensaries. For instance, some patients arrive with a note that just says 'Refer to PASADA'.

They do not know what PASADA is or the care offered here. They have received no counselling. There has been no discussion that would alert them to the fact that their problem may be due to HIV. Sometimes relatives have been told more than the patient. Referrals from hospitals are sometimes made on the same day that a quick test has been done – with minimum counselling – and already the patient has the result.

During supervision of the dispensaries and collecting of statistics it was clear that AIDS-related illnesses were not recorded, even if the

Clinical Officer may have suspected the diagnosis. There is an increase in the number of AIDS-related illnesses e.g. herpes zoster, skin infections, oral candida in adults etc.

Direct observation of the encounter between Clinical Officers and patients raises questions that must be addressed. After listening to the history of the patient's problems, the Clinical Officer often jumps to the laboratory investigation and treatment without discussing factors which would lead to a correct diagnosis. We have also found that unnecessary investigations are ordered, perhaps to cover a feeling of helplessness. In the case of herpes zoster – where the patient may even suspect HIV – we found cases where the Clinical Officer did not mention any relationship between the two conditions. When we questioned what the Clinical Officer thought may be the cause of chronic illness or loss of weight etc, the answer was 'it may be lowering of the immune status'. Ensuing discussion about whether the patient may have suspected HIV as the cause of their problems revealed that the Clinical Officer may agree with this – but still remained silent. Why?

These are some of the factors which led the PASADA team to study the problem more deeply and consider the implications if this situation continues. We met with dispensary administrators, and with them developed a questionnaire for their staff around the improved management of HIV/AIDS at their dispensaries. This allowed them to raise the problems they faced, including lack of skills, lack of space to ensure privacy, and lack of equipment for sterility and hygiene. Once we knew the needs of the dispensary staff and their willingness to provide the care, we could take steps to address the difficulties.

We recognise that HIV infection reaches across all boundaries – yet it is clear that poverty is a co-factor in the spread of the virus. As the virus spreads relentlessly so too is poverty increased. With the death of the adult wage earner, decreased food consumption, child malnutrition and social marginalisation soon follow.

To stop this spiral, proper health services have to be made accessible and affordable to those who need them. A fragile, poorly trained and under-funded health system has been overwhelmed by the enormity of the HIV pandemic. The policy of 'cost sharing' may prevent the poorest from even attempting to seek health care.

Problem Tree Analysis

So that we could better understand the problems faced by PASADA at this stage of the HIV pandemic and what is likely to happen if new strategies are not found, a staff retreat was held in November 1999, and this was followed by a two day workshop in which we drew up a 'problem tree analysis' for each of the primary aspects of the disease. This included medical care and epidemiology, palliative care for the dying, care for orphans, education for infection prevention and service delivery issues.

Our experience at PASADA is that the vast majority of people with HIV in Tanzania are unaware that they have been infected. This ignorance results in decisions which unknowingly transmit the virus to other sexual partners as well as to the child in mother-to-child transmission.

People who are infected with HIV endure many opportunistic infections and psychological stress when they fail to have the assistance of basic health care to ease the burden of the disease.

According to the Tanzania National AIDS Control Programme, the Dar es Salaam region has reported the highest cumulative number of AIDS cases in the country as well as the highest case rate. Urban prevalence rates are 15 – 20%. With a population of 3 million people in the capital city, it is reasonable to assume that approximately 600,000 people are infected with HIV.

Left untreated these additional infections seriously compromise the quality of life of people living with HIV.

Those who are aware of their HIV status are afraid to seek out medical and psychological support. This is due to the immense social stigma and the fear of lack of confidentiality.

All these facts point to the need to find ways to help people to be informed about their HIV status and access basic medical care.

Progression to AIDS

As the HIV infection progresses to AIDS new issues have to be faced and here again steps taken to 'break the silence'.

Physical weakness and neurological infections often result in the patient being confined to bed and unable to provide the most basic self-care needs, much less attend any clinic for medical intervention. The enormity of the HIV incidence has overwhelmed the traditional systems for caring for the ill. Urban migration results in the loss of family structures which provided such care.

Caregivers suffer from ignorance and fear of contracting the virus through casual contact – as well as burn-out due to burden of caring for people with end-stage AIDS. The stigma and shame associated with a sexually transmitted disease results in marginalisation and abandonment of people in end-stage AIDS. Fear of discussing issues around death and dying result in emotional and physical isolation for both care giver and patient. There is a lack of knowledge both in the community and the church of the benefits of palliative care for the dying. Thus we realised that Primary Health Care Workers need also to understand Home Based Care and the benefits of palliative care. Analysis of the issues involved, the enormity of the problem of HIV/AIDS in Dar es Salaam and the limited capacity of PASADA to respond to ever-increasing demands led us to develop new strategies for the care of people suffering from HIV/AIDS.

PASADA will focus its interventions on the twelve existing dispensaries and their catchment areas, by training programmes specifically geared to upgrading the dispensary staff in skills regarding HIV/AIDS care. Thus we hope to reach 18,000 individuals – but that is only 10% of the poorest sector of those who are infected. We wish we could reach the other 90% too, but we have to work with very limited resources against a massive problem. The 36 parishes of the Archdiocese, will continue to provide a basis for preventative education, social support, palliative care and orphan support.

This article is based on a paper given by Dr. Corrigan last September to the Annual General Meeting of the Tanzania Christian Medical Association.

How we broke the 'Silence' in Addis Ababa

Sister Carol Breslin

We have observed increasing openness about the problem of HIV and a reduction in the stigma associated with the condition. More persons living with HIV are willing to go public with their HIV diagnosis and teach others. Many sick people – and others from the surrounding area – are coming to the Counselling Center on a self-referral basis, or are advised to come by their friends or relatives. These changes are, to a great degree, a result of educational activities, which have created favorable conditions for initiating training activities for voluntary care givers.

In working towards the Center's intention of developing a better climate for home care in one district division for persons affected by HIV/AIDS, we carried out an intensive house-to-house education activity in two 'kebeles' or neighbourhoods. We completed it in February 2000.

It involved the integration of work by the Education, Counselling and Social Services, and Community Development Programs. 'Kebele' officials recruited eight motivators, who were given two weeks' training in HIV/AIDS prevention, communications skills, simple home care, and data collection.

We began by conducting a pre-test survey on knowledge levels, attitudes, practices and beliefs of the community.

A study in 1999 conducted by the Addis Ababa Health Bureau estimated that 300,000 persons, or about 17% of the adult population in the Ethiopian capital, were infected with HIV. This means that more than 1 in 6 adults in the region are already infected with the virus and almost certain to die from AIDS in the foreseeable future. About 12,000 children are also believed to have HIV infection.

The MMM Counselling and Social Services Center was founded in 1992. Sister Carol Breslin, a native of New York, is Medical Director.

The Counselling Program has registered over 1700 clients since it began. Almost all the clients are poor and suffering from various infections. There is little access to drugs in the country for HIV-positive persons. As far as possible the Center provides medicines to clients and their families, and offers alternative therapies such as massage and reflexology.

The aim of all these therapies is to improve the general well-being of clients so they can relax and obtain relief from pain. In the past year 1,735 clients benefitted from the Center's home and medical services.

Family counselling is also offered, with the client's permission. Although it is difficult for most clients to discuss their problems openly with their families, the Center was able to conduct 200 family counselling sessions in the past year.

Hirut is House Mother for six orphan children in one of the Group Homes.

Yewoinshet Masresha is Co-ordinator of the Orphan Support Programme.

The program of Social Services has continued to assist needy families with food, house rent, school fees, and encouraged income generating activities to decrease dependency and a 'hand out' mentality. This involved training in small scale business management.

The Orphan Support Program provided full support for 255 children under 15 years of age in the past year. Of these, 181 are living with extended families, 68 are living in child-headed households, and 6 are in a group home. A total of 443 children received support, including rent, school fees, school materials, medical fees, food and provision of recreational activities.

The Educational Program reached 44,325 people through schools, youth clubs, factories, military rehabilitation camps, parish awareness-raising workshops and other community settings – mixing entertainment with information about non-risk behavior and giving information about HIV and AIDS.

The findings of this survey helped us to identify needs so we could plan appropriate education methodologies. We determined HIV/AIDS related issues that needed greater emphasis. These issues were approached in such a way that false rumors and misconceptions could be cleared up and facts disseminated.

In the 2 'kebeles', we reached 2,920 households with a total population of 10,746. To reach family members who were absent during our daytime visits, we arranged weekend discussions. We also tried to reach a larger male population than we did in previous surveys. This time we reached 4,424 men and 6,299 women.

During the sessions, we helped the community members to internalize the issue of HIV/AIDS and examine their feelings. It was common to see reactions such as fear, anxiety, anger, and worry about their partners having sex with others, or about their own past risky sexual practices. As a result of these discussions, the openness and the attitudinal change towards HIV/AIDS on the part of the community was encouraging. Many people from these 'kebeles' are coming to our Center seeking HIV testing and counselling, home visits and information. The number of requests for voluntary counselling and testing after the awareness activity was very high. For the final evaluation, we conducted a post-activity survey. In comparing the results obtained with those of the pre-test questionnaire, we observed signifcant positive changes in the level of knowledge about HIV/AIDS and in attitudes towards those affected by the virus. This is a good indication for starting similar activities in other 'kebeles'.

During our work, we also came across many bedridden patients who had lost hope from lack of progress in spite of repeated treatments in different health institutions. Some of them who were clinically suspected of being infected with HIV were seen in their homes by the Centre counsellors.

We also found children who had lost their parents from AIDS and we discovered some physically disabled children in bed at home. We referred them to the Counselling Centre for assessment and help.

All of this is the result of our integrated work in the Counselling Centre to fight the epidemic.

Report outlines an ambitious Education Program

The silence and the stigma surrounding HIV can fuel the spread of the virus. The Education Program of the MMM Counselling and Social Services Center in Addis Ababa has undertaken several intervention activities to encourage positive attitudes in the community and safer sexual behavior, and to reach young people and other community members with information and training in different settings. We have used many novel approaches including drama, puppet shows, videos, short plays, contests and competitions, and music.

Our plan of operation for the year was:

To be a resource center for advice, and to produce and distribute educational materials to various groups;

To give AIDS education to 30,000 persons, including students, young people out of school and other community members using various approaches;

To train 300 peer educators in schools, churches and community settings;

To give follow-up and refresher training to 200 previous trainees;

To carry out intensive house-to-house AIDS education to reach 12,000 persons living in 2,767 households in 2 'kebeles';

To work closely with various Anti-AIDS Clubs and support their preventive activities.

NURSE, TEACHER, GUIDE, COUNSELLOR, FRIEND

That is how people described Sister M. Aidan Gallagher, who died at Áras Mhuire on January 7 this year. She was the first Tutor to work at Our Lady of Lourdes Hospital in Drogheda, after it received recognition as a Preliminary Nurse Training School in 1946. Sister M. Aidan was assigned to Clinica Mediterranea in Naples, and later to Clinica Moscati in Rome, which was staffed by MMM for a short time during the 1960s. She was regarded as a nurse administrator of great ability, and a person of enormous integrity. You always knew where you stood with her. All the doctors, nursing staff and students liked that. But in addition, she was approachable, always willing to help – no matter what the problem she would listen patiently and think of something that would lead to a solution. Despite her long final illness, her going has left a great sense of loss.

Any family or community that has experienced the shock of a sudden death mourns all the more deeply, and our community at Mell, on the banks of the River Boyne is no exception. News of the death of Sister Gratia McDermott on March 3rd brought shock and disbelief. She had been downtown in Drogheda that morning and had met quite a few people. Like Sister M. Aidan, she worked in Italy for a number of years before continuing her nursing service in Drogheda. As retirement age approached, she commenced studies in Chiropody, which she practised for some years. She loved being with people. She kept close links with her family, and was known to nieces and nephews as their 'exotic' aunt. She loved art, music, flower arrangement and sewing. It is still difficult for us to believe she has gone, but we know that all our concerns are her concerns still, and we pray to her just as we pray for her.

Brave people who broke the 'Silence' in Arusha

Sister Denise Lynch

People who know they are infected and receive care can break through the denial about HIV/AIDS by talking with family and friends thus reducing the discomfort associated with the subject. Breaking the silence most assuredly can bring a measure of hope and peace not only to those who are ill but also to their families and friends.

Faleti Broke the Silence

Faleti was a long-distance truck driver, travelling between Dar es Salaam, Nairobi, Kampala and Kigali. When he contracted HIV, his three wives were subsequently infected. Between the wives there were eight children. One of them, Emmanuel, was eleven years old when his mother died.

Faleti recognised that Emmanuel and his brother Nelson were highly intelligent. Their father jealously guarded their health and well-being. Faleti had obtained the AZT treatment for AIDS which was very rare here. Sadly, the younger boy, Nelson, died when he was eleven years old. Faleti was heartbroken and decided to discontinue his own treatment. He died in 1994. But before he died he confided in his friend, Joshua, asking him to take care of Emmanuel and keep him at school.

Joshua has six children of his own to provide for. But he undertook to do as Faleti asked as a 'sacred duty'. Thus Emmanuel, with the help of Uhai Centre, successfully completed his Standard VII exams, and was offered a place in the Government Public School for gifted children here in Arusha.

Now twenty years old, Emmanuel is in Form IV which is a crucial year. He has been an 'A' student from the beginning. At the end of Form Six his hopes are to go to University and study Physics, Chemistry and Biology. We at the Uhai Centre are committed to journey with him during the next two years and to help him on his way to the career of his dreams.

The long shadow of HIV/AIDS has been with us for almost two decades and we have watched it grow longer and longer, change shape and reach out long fingers to the most remote parts of the world.

The Archdiocese of Arusha covers an area of 66,830 sq. kms. with an estimated population of 1,235,649 people. The municipality of Arusha has an estimated population of 300,000. 'Uhai' is the Swahili word for 'health' and from the Uhai Centre based in Arusha, the Uhai Team continues to carry out its regular tasks of caring for those infected and affected by HIV/AIDS and AIDS orphans as well as our programme of education for AIDS Prevention.

For the former we offer services which includes pre and post test counselling, palliative care for those already ill with AIDS, nutrition, medicines, household needs, advice and professional help with advocacy rights; trying to ensure that wives and children will be the named beneficiaries in legally drawn wills, so that other family members of the husband will not evict them and leave them homeless and penniless. We also care for orphans by sending them to school, and ensuring that their nutritional status is kept at a healthy level.

In the recent International AIDS Conference held in Durban, South Africa, the theme was very appropriately 'Breaking the Silence'. In Arusha at this time we learn of the deaths of very many young people, and neighbours tell us that they did not know they were sick until they heard the news of their deaths. It is assumed that many of these people die from AIDS-related illnesses, but after their death it is too late for anyone to offer help to improve the quality of life, reach out to them or give them hope and help the family.

Richard and Mary Broke the Silence

Richard came to the Uhai Centre seeking help and told us he wished to return to his home place in the far south of Tanzania, to die. He died in 1992 leaving his wife, Mary, to care for their two small children Ezekiel and Joyce. Mary was also infected but she maintained good health for many years and only visits Uhai Centre occasionally when she is sick. Now she seems to be losing the battle but is determined to stay as healthy as possible to watch over her young family.

Ezekiel did well at Primary School and on graduating was offered a place at the Arusha Government School for gifted children. He is now fifteen years old and is in Form II maintaining a high record of 'A' grades. We hope he will have the opportunity to continue his education until Form VI.

Joyce is now thirteen years and after successfully passing her Standard VII examination she was selected to go to Arusha Secondary Day School in the Municipality. This was a great relief to Mary who has great determination to survive to see them through school so that they will have an opportunity to be educated and so that life may be easier for them in the future.

Samson Broke the Silence

Samson was a driver with a tour operating company in Arusha when he was told he was HIV positive and his wife Maria was also infected. Samson died in 1993 and Maria died in 1995. Before they died, they had discussed their plight with a neighbouring family. Samson was able to set up a small trust fund with the

The latest statistics published show an alarming rise in the number of those infected with HIV – 34.3 million people worldwide. Of these, 24.5 million live in sub-Saharan Africa. In 1999 5.4 million new HIV infections were reported and 2.8 million people died of AIDS in that year.

It is the children we are most concerned with at the moment as we prepare many of our AIDS orphans to return to school, ensuring that they have all they need. At the end of 1999 there were 12.1 million children orphaned by AIDS in sub-Saharan Africa, of whom 1.1 million were Tanzanian.

In our Uhai Centre programme in Arusha we have 330 orphaned children who live in and around the Municipality; we have no figures for those who live beyond the perimeter of the town. Eighty-two of these children are infected with HIV/AIDS. Over the past eight years our programme has assisted orphaned children with school fees, uniforms, text books, desk fees, nutrition and medication. Many of the children have successfully completed their Standard VII exams at Primary School and some have gone on to vocational training schools. We have also good news about other children who have successfully completed their Standard VII examinations and have been called to the Government Public School for gifted children.

help of the Uhai Centre. Their eight children, six girls and two boys were left in the care of these good friends. All the children did well at school. After Standard VII the twin boys, Richard and Godfrey, were both selected to go to the National Technical Secondary School in Moshi, Kilimanjaro Area, which is the main technical school for the whole country. Both boys are performing well and liking their studies there. Joyce, the eldest girl completed her Form VI examinations and studied for hotel management. She is now employed by one of the major tourist hotels. The second girl, Neema, finished Form IV and is studying computer technology; Susanne and Rightness are both at Vocational School following a tailoring course. Jane and Rose are studying Nutrition and Cooking.

All eight children completed their basic education with honours and their guardians are extremely proud of them.

We, too, at Uhai Centre rejoice that so many of the children we have helped through the years have been successful. We could not do this without the help we receive from our donors and all the generous people who give to us. We praise and thank God for all of you. We live amidst great suffering and helplessness and we continue to walk with Christ and our people in the sure and certain hope of the resurrection.

Sister Petria Whelan

Sister Petria gave up her job in the Bank to become an MMM in 1950. She got first place in her final year in Medical School and loved being a doctor – most of all caring for mothers and tiny infants. She did this, tirelessly, from 1958 until 1993, after which illness overtook her. Sister Petria served in Nigeria at Anua, Urua Akpan and Ondo; in 1961 she pioneered MMM's work in Taiwan and remained there until 1975, then returned to Nigeria for a further three years. After that she was then asked to go to Tanzania, and served in Dareda, Makiungu and Kabanga hospitals. She loved walking and swimming, and an evening game of 'scrabble'. Sister Mary Swaby, who lived with her in Dareda, remembers: "It was no trouble to Petria to knit, listen to music and play 'scrabble' at the one time and still get the highest score! The knitting was usually a warm vest or blanket for one of the premature babies so dear to Petria's heart." That personal touch was complemented by a wealth of knowledge and experience. Sister Petria bore her very difficult final illness with enormous courage and grace. She welcomed the moment when death would finally approach, believing it was the gateway to a new Life with the God she had served with such generosity. That moment came on March 16th. With her sisters Ann and Kit, her brothers Dermot and Brian and all her family we miss her very much.

Alone, and sometimes lonely
living a life of uncertainty
in a country and a church that
brings confusion and hope,
shuts doors and opens doors
in fear and in freedom.

Sad, but not despairing
as AIDS cuts down people as swiftly
as a harvester cuts his maize.

Anger, that brings energy
to keep reaching out
where those who 'dare not'
turn the other way.

Part of the problem
and part of the solution
as I struggle with my own shortcomings
and my unrealistic expectations
of others.

Like a ship without a rudder
adrift in an open sea,
Some sing, some cry
and some just hanging on.

Deep peace, in a shared struggle
to be who I am.

Hope in a future
where the only thing I can be certain of
is that I will never be certain.

This reflection was sent by Sister Mary Dunne in Kenya to a meeting of MMM Leaders who were reflecting on the demands the AIDS pandemic puts on all those whose vocation is to care for those in need.

Those Martin Girls

From a portrait by Céline in 'A Little White Flower' Burns Oates & Washbourne 1925

Marie Françoise Thérèse Martin in 1884

Marie Helena Martin in 1905

THEIR DATES OF BIRTH were separated by only 19 years. Marie Françoise Thérèse Martin would never know of Marie Helena Martin, at least not on this earth. But she was destined to have a major influence on the life of Marie Helena – the woman who would one day become the Foundress of the Medical Missionaries of Mary.

Marie Françoise Thérèse was born on January 2, 1873, the youngest of nine children of Louis Martin and Zélie Guérin of Alençon, France.

This devout couple had known great loss. A little daughter named Marie Hélène had died at the age of four and a half. Another, Marie Melanie Thérèse died when only three months old. The couple dearly desired a son who might become a priest and a missionary. For this they prayed fervently. But their only son, Marie Joseph Jean Baptiste, died at the age of 5 months. Another son was born, and they christened him Joseph too. But he flew off to heaven at the age of nine months.

When they brought their last baby to be christened, they could hardly have imagined that one day she would announce that she wanted to become a priest. But that was an idea the church would find difficult to accept.

Sorrow was never far from the Martin household. Zélie developed cancer. She bore this suffering for years until her death, on August 28, 1877. She was 47 years old.

Little Marie Françoise Thérèse was not yet five. She later wrote about the loss of her mother: "My happy disposition completely changed, I became timid and retiring, sensitive to an excessive degree..." Attacks of scruples and anxiety would come later.

Louis Martin, felt the heart had gone out of their Alençon home. He moved the family to Lisieux.

When Marie Françoise Thérèse was eight, her father enrolled her as a day pupil in Benedictine Abbey in Lisieux. She hated the place and classes bored her. The nuns realised her intelligence was above average and put her into a class with fourteen-year-olds. She was still bored. Her father finally removed her from the Abbey and provided private tutoring for her.

When she was nine, Thérèse suffered a prolonged serious illness. No treatment helped. One day she turned to a statue of the Virgin Mary near her bed, and prayed for a cure. "Suddenly", Thérèse wrote, "...Mary's face radiated kindness and love." She knew she had been cured. The statue has since been called *Our Lady of the Smile*.

The story of how Thérèse wanted to become a Carmelite – but was too young – is well known. In 1887, when her father took her and her sister, Céline, on pilgrimage to Rome, she defied all protocol. During the audience with Pope Leo XIII, she ran to his feet and cried out:

'Most Holy Father, I have a great favor to ask you!... in honour of your jubilee, permit me to enter Carmel at the age of fifteen."

"Well, my child,", the Holy Father replied, "do what the superiors tell you"

Resting her hands on his knees, Thérèse made a final plea. "Oh, Holy Father, if you say yes, everybody will agree!" She later wrote: "He gazed at me steadily speaking these words and stressing each syllable: 'Go – go – you will enter if God wills it.' The guards had to lift her and carry her to the door. On New Year's Day, 1888, the Prioress of the Lisieux Carmel advised Thérèse she would be received into the monastery the following April.

Thérèse perceived her life's mission as one of salvation for all. She would accomplish this by becoming a saint. She enjoyed playing the role of Joan of Arc in a play she wrote for a feast-day performance in Carmel. She thought of herself as the new Joan of Arc, dedicated to the rescue not only of France, but of the whole world. Her spirituality was grounded in love, and in a deep faith that what God wanted was never impossible. *"O my Jesus! Thou dost never ask what is impossible..."* she wrote in her autobiography.

Marie Françoise Thérèse died on September 30, 1897, having suffered greatly from tuberculosis. She was only 24 years old. She was canonised on May 17, 1925 by Pope Pius XI. She was named Co-Patron of the Missions in 1927 and became the third woman Doctor of the Church in 1997.

In Dublin, Ireland, Marie Helena was born on April 24, 1892, the second of twelve children of Thomas Martin and Mary Moore who lived in Glenageary.

Marie Helena and her younger sister, Ethel, were sent to the Sacred Heart convent, Leeson Street, to prepare for First Holy Communion. But Marie developed rheumatic fever in 1904 after a drive home from Leeson Street on an outside car during a snowstorm. This was to leave her with a legacy of heart trouble and ill health that dogged her throughout her life.

This Martin family also knew sorrow. On St. Patrick's Day in 1907, when Mary Martin was pregnant with her twelfth child, her husband, Thomas, died from a gunshot wound, believed to be accidental. The bond between Marie and her mother grew even closer after that. Mrs. Martin sent her two eldest daughters as boarders to the Mercy Convent in Edinburgh, but had to bring them home again because 'Marie was so homesick'. In September 1908 they were sent to the Holy Child convent in Harrogate, England. But after the Christmas vacation of 1910 Marie did not return. The resident German governess in the Martin home recommended a finishing school in Bonn. Mrs. Martin travelled with her daughters to check it out, but Marie only stuck it until the end of the year, after which she accompanied her Uncle Charlie on a cruise to the West Indies. Few nineteen-year-old Dublin girls of that period were so widely travelled.

When war broke out in 1914, Marie trained for the Voluntary Aid Detachment, and was posted first to Malta and later to France. She was nursing wounded soldiers, when on December 27 1915, news came that her own brother, Charlie, was missing, reported wounded and captured. Months of anxiety followed until it was confirmed at the end of June that he had been paralyzed by his wounds, on December 8, and had died two days later.

That was just one week before his 21st birthday.

When the war was over, Marie Helena returned home, matured by the things she had seen. In 1921, at the age of 29, she went to Nigeria as a lay missionary. The situation she encountered quickly convinced her that single-handed she could do little. To make any impact, she would have to establish a Congregation of committed religious women, trained in medicine, surgery and obstetrics.

But that was an idea the church would find difficult to accept. Besides, few Universities would allow women into Medical School in the early 1920s. These obstacles did not cause her to doubt her calling. She was guided by a deep belief: *"If God wants the work, God will show the way."*

Yet, in 1927 it seemed impossible that the calling she felt so deeply could be followed in her lifetime. Mindful of the missionary role of the recently canonized St. Thérèse, she thought she might follow the way of Carmel instead. She sought admission to the Carmelite convent at Hampton, Dublin. Although she received all the votes of the community, the Prioress, Mother Dympna, was convinced that her vocation was not to Carmel.

Marie Helena had to wait until 1936 before the church acknowledged the value of religious women in the practice of surgery and obstetrics. When she made her vows on April 4, 1937, she was gravely ill in a government hospital in Nigeria. She took the name *Mother Mary of the Incarnation*. When well enough, the doctor advised that she take the first ship back to Ireland.

In 1949, she made a visit to Lisieux, where she told the prioress, St. Thérèse's sister, Pauline (Mère Agnes) about the history of MMM with its many ups and downs. Mère Agnes promised 'to see to it that my holy Sister Thérèse will answer all your petitions and the intentions of your friends and benefactors, and obtain all that your Congregation needs.'

Mère Agnes presented Mother Mary with a stone from the wall of the convent infirmary where St. Thérèse had died – a gift to be used as a foundation stone for the new hospital which Mother Mary hoped to build in Drogheda. Mère Agnes added a prayer that the Saint would adopt the entire MMM congregation, 'showing herself ever a sister to the MMMs, labouring in and through them, and spending her heaven doing good with them on earth'.

These Martin girls were women of their time. Their writings and spirituality were informed by the language and theology of that time. To the mindset of today that can appear out of date. But the courage of these women in overcoming personal difficulties and external obstacles does not become dated. Their determination to follow their dream no matter what the cost, will inspire people in every age.

At 2 pm on Sunday May 20, 2001, the Reliquary of Saint Thérèse will arrive at the Motherhouse of MMM in Drogheda, where it will repose until noon on the following day. When it leaves, en route to the Cathedral in Cavan, the cortège will pause for just a moment at the entrance to St. Peter's Cemetery. In the hospital, two hundred yards to the left will be the stone from the Infirmary where Thérèse died.

Two hundred yards to the right, will be the tomb of Marie Helena Martin, who died on January 27, 1975. We can surely depend on abundant graces from heaven at that blessed moment.

'Les Buissonets' (The Hedges) Lisieux

'Greenbank' – the Martin home in Dublin

Fifteen Fools in '54

An extract from an article written by Sister M. Augustus Doyle, first published in the September 1959 edition of our magazine.

Sister M. Augustus was born in Salthill, on the shores of Galway Bay in 1912. She graduated from the Medical School at UCG in 1936 and held posts at Galway Regional Hospital, in Dublin at St. Ultan's and Cappagh hospitals and the National Maternity Hospital, Holles Street. She spent all the years of World War II in England, working in General Practice in Burton-on-Trent. After the war she returned to Ireland and did post-graduate studies in Public Health at UCD, following which she worked in Donegal until joining MMM in 1954. Immediately following her first Profession, she went to Kitovu Hospital, Masaka, Uganda, and remained there until poor health forced her to retire in 1980. Sister Augustus died peacefully at Áras Mhuire, attached to our Motherhouse, on May 22, 2000. May she rest in peace.

We came from everywhere. We were all sorts. Some young, some not so young, some almost old, but not quite. Some had just finished school. They came holding out as their offering the 17 or 18 gloriously happy years of their life and in addition all the truly wonderful things they thought life had in store for them – they knew nothing of the darker things that life can bring. What a truly wonderful offering is theirs.

Others had tasted the joys of independence in office or hospital or schoolroom. Having tasted them they bravely gave them up while the flavour was still sweet and the willpower strong.

Others tarried longer. They knew the great joys of the world – the thrill of achievement of ambitions – knew something too of life's sorrows. And still they realised that there is a deeper craving; and so they too at last listened to the call – "Come follow Me".

Well, never mind the differences; we were all in the same boat now.

For the next six months we set about proving to our Superior what we had already proved to ourselves – that we were ready to surrender all for Christ. To be fools. Very easy to write these words – translation into action difficult. It was a task to fill every minute of each 24 hours of that six months. During that six months we learned to pray the words of Father O'Connor:

'Let us not waste Thy splendid gift, O King,
Or barter it for all the world's poor price;
Make of our youth, O God, a holy thing,
Make of our hearts, O Lord, Thy Sacrifice'.

Youth is an infectious complaint and those who were young among us soon passed the contagion on to the older ones. The incubation period is about 10 days. The symptoms of youth are – tireless energy, boundless enthusiasm, ability to recover quickly from innumerable reprimands (surely I did that job as well as anybody could). Watch the way youngsters recover! Two more symptoms of the youth complex – a healthy appetite and the ability to laugh heartily at the end of the day at all the foolish things you had done.

WHY DID WE STAY?

Did the world not lure us any more. Why did we stay? Ah! Yes, there were many lonely moments when the thought of family and home played a lively tattoo on the imagination. More perhaps at Christmas, that feast of happy home-comings or at Easter when nature calls to all to come out and enjoy the glorious freedom and the rebirth of all nature.

However, families of all called in gleaming cars to see these loved ones and to give them the chance, if necessary, to come back; but they returned home as they came. The love of God was stronger than all. It took a strong love to prefer the loneliness of convent life to the happy family circle, dull clothes of the postulant to the glamorous apparel of the modern girl – dull drudgery to pleasant days by the sea or lake or tennis-court – but to those who knew the love of God, there was, beyond the loneliness, the wonderful feeling of being close to God and working directly with Him.

One wondered would one be allowed to take the first high jump – would one be received into the Congregation on the official Reception Day. One prayed and hoped and redoubled one's efforts. One asked if anyone had ever been sent home and of course the 'Job's comforters' knew several who were. At last the suspense is over. We have started the Retreat prior to Reception. The Retreat ended gloriously with our Reception into the Congregation. We thought we would never see another unhappy day! Are still fifteen? We are – still fools prepared to be treated as such for Christ's sake.

The emphasis in training now swings from physical endurance to moral. It is hard – sometimes it feels almost too hard. Almost; but one could never go into the Oratory and say, "No, I won't do that for You". Instead one said, "I'll try again"; and then what seemed hard now became easy.

WONDERFUL NEWS

Thus the two years pass. Once again we wonder. Will we make it? Have we measured up? Wonderful news.
We are all accepted for Profession.

Comes the great day; the day of Profession. Yes, Thank God, we are all there. What a wonderful day. There are no human words to describe it. Fifteen humans giving the only thing a human can give to God – her life – her will – and God stoops graciously to take the offering. Did any one of us consider we had paid too big a price?

These years of preparation, and above all, the superb moment of offering, have made a bond between us fifteen, that will last to the end of our lives.

Good. We have reached the sublime moment together and now we separate. One goes almost at once to the goal – the mission field in Africa. Another, a secretary, follows in a short time. Yet another, an accountant, is given the challenge to take us 'out of the red' in a growing mission hospital.

The remainder, according to their aptitudes, commence professional training – some get on their bicycles again and start Medicine in University College, Dublin. Another's goal is Dietetics, another Pharmacy, a third Radiography, the majority are together again on the benches of the Nursing School in the International Missionary Training Hospital.

The need for them in our missions is great and urgent. Times have changed. The world is moving fast everywhere, alarmingly fast.

LONG JOURNEY

Recently the writer undertook a journey across two African countries to see how the mission work was done in other places. The journey was a revelation of how tough a missionary needs to become. The trip was taken at the fastest possible pace over terrible roads. We were fortunate that one of the missionaries with us was a really expert driver. Long stretches of about 200 miles were taken at a time from one mission to another. Stops were only long enough to get food from the car, carry it to the mission refectory table and while eating the cold tinned meal, lightening speed conversation was carried on with the resident missionaries – a mixture of good-natured leg-pulling and serious comparison of progress at the mission. Conversation was carried on in French, Dutch, broken English or German as different missionaries gave their views. Meals – if they could be called such – were soon over, the flasks replenished with water, and then off bumpety-bump to the next mission.

MUCH WORK FOR FOOLS TO DO

Miles now over 600, and we arrived at our destination covered in red dust, feeling terribly dirty inside and out, every joint in the spine apparently fixed in one position never to change again. But I had learned a lot! I had learned that there is no place in a missionary's life for comfort or for self. I was amazed at the number of "necessary" comforts these missionaries were able to do without.

The more they had to do without, the more cheerful they became. Every day full with a thousand tasks. Yes, there is still much work for fools to do.

Kitovu Now

MMMs went to staff Kitovu Hospital, Masaka, Uganda in 1951. We have seen much development of the complex during the decades in between, as one department after another was added to meet the growing needs.

The past year saw the beginning of the implementation of a plan drawn up over the past five years, in which all the hospital staff were involved. The plan was made to secure good long-term management for Kitovu Hospital. A local Congregation of Sisters, called the 'Baanabikira' or Daughters of Mary, came to take over responsibility for the hospital from MMM. Initially four Sisters came, and the majority of the MMM community moved into a new house in Masaka town.

However, for the present Sister Maura Lynch remained on as Senior Surgeon, Sister Mary Teresa Reilly remained as Complex Administrator to ensure a smooth transition in the longer term, Sister Monica Prendergast remained on to continue to meet the very large demand for social and pastoral services at the hospital. And Sister Davnet O'Kane, who established the Regional Blood Bank and runs the school of training for laboratory technologists, also remained.

Sister Monica Prendergast was among the long-term staff of Kitovu who were presented with a framed certificate for 25 years of service to the hospital. She is pictured here with another long-term staff member, Mrs. Kate Nalumaga.

The area served by Kitovu Hospital is inherently poor. The impact of HIV/AIDS has created significant levels of need and has had a profound effect on the health status of the people of the area. Masaka and Rakai Districts, because of their location on trading routes between Tanzania and Uganda and also because these routes were used for movement of troops during the war, were the first places where AIDS was diagnosed in the early 1980s. Because of this long history of infection the area continues to have very high rates of HIV/AIDS. The estimated average life expectancy in the area is only 40 years now.

At the request of the Banabikira Sisters, MMM will continue to work with the Home Care Programme, which was initiated in 1987 to address the psychosocial and economic consequences of HIV/AIDS. The programme's activities include home care for persons with AIDS, orphan care including a farm school and skills training, income generating activities for guardians and families, house construction and repair for needy families. HIV/AIDS preventive education including a behavioural change process is provided in all targeted communities, counselling for those infected and affected and HIV testing as requested.

The MMMs who moved out of Kitovu are now free to devote more time to the outreach work in the fields of hospice care for persons living with cancer, the coordination of counselling services, and other social needs of the people of the growing town of Masaka.

Sister Davnet O'Kane with laboratory trainees.

Poetry of Remembrance

Drogheda-born poet, Susan Connolly, can trace her love of nature to childhood walks with her father along the River Boyne, with its estuary at Mornington. Youngest of the five children of Gerald and Mary Connolly, she and her sisters, Fiona and Rosemary, and her brothers Stephen and Timothy, were brought up on an outdoor life – their Dad's hobbies included fishing, model aeroplanes, go-carting, canoeing and sailing, as well as those rambles in the Boyne Valley.

Dr. Gerry Connolly was born in the Cavan heartland. He graduated from the Medical School of University College Dublin in 1940. Having read about Nigeria's need for doctors, he volunteered for medical work in St. Luke's Hospital, Anua, the first hospital run by MMM.

War was raging in Europe. In 1942 he travelled in a troop ship sailing in convoy. He loved Nigeria and its people. But Mother Mary Martin asked him to return home and prepare to become a Consultant Obstetrician. For MMM, care of mothers during pregnancy and their newborn infants was always a special priority.

In April 1945, Dr. Connolly left Anua for Drogheda, exchanging places with Sister Margaret Mary Nolan. He was awarded his MAO in 1948. In the same year he and Dr. Mary Lyons were married.

Dr. Connolly particularly encouraged young African students in Drogheda. From the Cape to Cairo, you'll find doctors and nurses who learned their skills in obstetrics in Drogheda under Dr. Connolly's mastership. He retired in 1982, and the following year was awarded the Papal Honour, Knight of St. Gregory.

As his health failed, MMMs felt it was very fitting to have this great friend and co-worker among us once again in Áras Mhuire. When he died on March 17th this year, we knew his work was finally done, and done so well. To Dr. Mary, their children and eleven grandchildren, we offer our sympathy and prayers, as they come to terms with the loneliness his passing surely leaves.

'Mornington' is from Susan Connolly's book of poems *Race to the Sea.* Among her other works is an exploration of sacred and secular wells of Co. Louth, co-authored with Anne Marie Moroney, entitled *Stone and Tree Sheltering Water*. Susan is currently working on a literary map of the River Boyne.

The young child's mother
was pregnant again,
brim-full of energy
and exuberant
as her firstborn.
All July and August,
in the evenings –
they cycled out of Drogheda
to the beach.

Smoke
from a factory chimney
indicated
a west wind –
and he, strapped
to his carrier seat,
sang, then suddenly
fell asleep.

While she leaned
her bicycle
against an iron girder
he ran away up the beach –
knew she would follow.
And though she welcomed
the creature in her womb,
she knew
nothing could
outshine him.

At the seaweed's
shore lip
he stood, entranced
by the waves
till they lapped
round his ankles,
chilling him –
like some cold shapeless
thing out of a dream –
and he broke away
from that dream
to hear her
calling him.

As beacon lights
switched on
the sky became deep red
and they cycled home,
racing the dark
along the river Boyne.

They saw fishermen
old as the river.
Two stately homes
faced each other
across the river.
From islands of eelgrass
a curlew cried.

One night,
darkness
overtook them.
The factory's hum
changed into
a terrible screaming
heard only in war.
Frightened, he clung to her.
Imaginations raced.

Later,
while she slept,
a child drew closer
to birth;
the river ran past her head,
upstream;
the calm of summer
gave way
to a September birth.

But as she cycled
beneath
the Viaduct
spanning the river,
back to the heart of the town,
her child wide-eyed
in the dark –

nobody
could tell her
that an invisible
blue mantle
would be lifted
from around them
as soon as the new child
arrived, causing
their first separation
since that earlier September:
the warm evening of his birth.

Susan Connolly

Saviour

Restoring health, he scandalised
Breaking the Sabbath law.
Healing on the morrow
None would he offend.
Eighteen years a-suffering
Gladly would she wait
But he would not have her wait.
What manner of man is he?

Lines from Sister Maura Forkan's poem ***Saviour*** challenge us to take time with the Gospel stories of Jesus' healing ministry. They invite us to allow these stories to shape our lives. They reveal how deeply Sister Maura was immersed in the MMM vocation and mission to heal the world's pain.

These and other poems of Sister Maura will continue to inspire and renew us, now that she has gone. Writing poetry was an activity of her later years. The honing of the spirit that guided her pen, whether in poetry or prose, began much earlier.

Maura was thirty-five years old when she left her Co. Mayo home in 1961 and came to MMM. Her health had never been robust. Although she did not go overseas herself, she seemed to know every mission as intimately as if she had worked there. During her final illness, she offered every day, whether it brought pain, weakness or other suffering, for each of our overseas missions in turn. This made her day worthwhile because she believed her offering would make a difference.

A widely read and cultured person, she enriched community life at our Motherhouse for almost forty years, until her death on October 8th. In word and deed as well as in her creative writing she shared those "Thoughts, ideas, images, memories, imprisoned in my brain...write I must – for their liberation – A jailor I would not be."

Copies of Sister Maura's poems 'Thy Presence My Light' are available from MMM Communications, address on p.2

Congratulations and Celebrations . . .

This year's Golden Jubilarians

Sr. Florrie Goold, Sr.Veronica Hanratty and Sr. Ita Barry

Sr. Mary Jones

Sr. Maureen O'Mahony

Sr. Marie Conlon

Sr. M. Jude Walsh

Sr. Mairead O'Kane

Sr. Adalberta Simakova

Sr. Mary Mel Brady

Sr. Zita Twomey

Also Sr. Ann Ward – see page 32

Oh, the days of the Kerry Dances!

On the back of a pick-up truck, returning home from a busy Outstation in Nigeria or Angola, Sister Frances Cronin would reach for her accordion. Soon the lilt of the 'Kerry Dances' would waft through the plam trees on the tropical evening air. The weary health care team would forget the bumpy road, sit back and relax. The medley would continue with 'The Rose of Tralee' – the town she loved so well! She was born there on June 2, 1906, Ellen Nora Costello. In 1930 she married John Cronin. Sadly, the killer-disease of those days, tuberculosis, struck John. They had no children. She told him she would never marry another, but might join a convent.

After John died in 1937, she went to Erinville Maternity Hospital in Cork to train as a midwife. A friend told her that the foundress of a new religious congregation, would be speaking at a Missionary Exhibition in the city. She met Mother Mary Martin, took a course in Tropical Medicine for Missionaries, and joined MMM on 15th August 1938. She took the name of Frances, after St. Jane Frances de Chantal, who had trodden a path similar to her own.

When she sailed for Nigeria early in 1942, the seas were mined, the troop ship on which she got a passage was part of a convoy and the journey lasted thirteen weeks. The captain allowed those on board to send messages home, but for security reasons the address had to be "Our Hotel".

In Nigeria she developed great skill at making ointments and injections. There were no antibiotics then. One of her treatments in great demand was what the patients called her 'injection of health'.

In 1955 Mother Mary asked Sister Frances to go to Angola. It meant learning Portuguese and a native language. Sister Frances loved people and that made her a great communicator.

The Sisters who were with her in Angola remember a certain patient who had to remain hospitalized for some time after her baby was born. The mother was still very weak, so every night when Sister Frances went into the ward, she would pick up that baby and carry her up and down the ward as she did her round, singing to the baby "bumpety bump, bumpety bump"
and then, when the ward round was finished, 'bumpety bump" back into her cot .

Many years later a young pregnant woman came into the Out-patient Department of the same hospital and asked for "Madre Francesca". She was told Madre Francesca had returned to Ireland some years earlier. When asked how she knew her, the young woman replied: "My mother told me to come to this hospital when I was ready to have my baby and to look for Madre Francesca. I'm Bumpety Bump."

When age and ill-health forced Sister Frances to return to Ireland, she always made a point of getting to Kerry for the Rose of Tralee Festival. At our Motherhouse she could be seen with paintbrush in hand keeping the garden furniture in good condition. She lived into her 94th year. The day God called her to heaven, 27th January this year, was the 25th anniversary of the death of Mother Mary Martin.

The Extended Family of MMM

On 9th September 2000, Eamonn and Moira Brehony made their Covenant as MMM Associates, at a very moving ceremony during the annual Assembly of MMMs in the north-eastern Area of Tanzania. They are the first married couple to join the MMM Extended Family in this way.

Moira says the children, Peadar and Aishling, settled in well to the International School in Arusha and love it. She notices that they "have added a new dimension to community life, which is spontaneous and challenging at times!"

In sharing his thoughts on the development of the Associate Membership of MMM, Eamonn throws out some ideas to stimulate discussion and critical reflection. He asks: "What unites us all as Medical Missionaries of Mary?"

"Our belief in the gospel of Jesus and the way of life he has left to his followers, unites us with all Christians. But beyond this, Eamonn writes:

"We are united in the way Mother Mary Martin viewed the problems of the world and the long term contribution she and her followers could make to solve these problems.

"We are united in our commitment to carrying on the work Mother Mary began. We share her vision and mission for the world."

Eamonn goes on to address "the key question that we now need to tease out", i.e. what does that mean in practice?

This question is one we must live with for the present. It will only be answered when we have had time to test and evaluate various initiatives taken by MMM Associates around the world.

The Narrative containing the full text of contributions from MMM Associate Members can be obtained from: Anne Marie Kenny Bull, 410 South 67 Street, Omaha, NE 68132, USA, or can be read at www.medical-missionaries.com

MMM ASSOCIATES IN ENGLAND, IRELAND AND SCOTLAND:

In the MMM Community at Ealing, London, the first English Associates made their Convenant of Membership on 12 November.

Mary Bradley (top) has known MMM for a long time, having worked as a Nurse Tutor in Drogheda. She is now back in England.

Samantha Keane, Customer Services Advisor for a London property consultancy says: "Mother Mary Martin, her faith, ideas and determination are a great example to me."

Rosara Larkin pictured with husband Dave and baby Amy Nichola, says she is "warmed by Mother Mary's initial difficulties in establishing MMM…When a group of people come together with a common dream, nothing is impossible."

Phena Doran (left) has been a long-time supporter of MMM missions, and made her Covenant in Dublin on 11 November.

Two MMMs from Dublin and two from London witnessed the Covenant of Rev. Mhorag Macdonald (right) who shares an ecumenical ministry with Sister Aideen O'Sullivan in Glasgow.

Mary Egan is an Associate MMM living in our community in Marcala, Honduras. Her article Are you listening? published in *The Narrative* tells of her work as Coordinator of the *Maestro en Casa* (Teacher at Home) literacy project on the parish radio station that plays a pivotal role of the work of the parish and of MMM in Primary Health Care in Honduras.

IN USA . . .

In June, at the reunion to mark 50 years of MMM in the United States, three more women became Associate Members. Sister Joanne Bierl writes:

'One of the highlights of the week was the Associate Covenant Ceremony when Marianne Grisez, Lucille Shepard and Kathy Velekkakan made their Covenant. This bring the total of Associate MMMs in the US to five and is a source of new life and energy to all of us. A moving ceremony, it encouraged each of us to renew our own commitment to the Lord."

Unfortunately, neither Nancy Hinds nor Anne Marie Kenny Bull (left), who made their Covenant a year ago, could make it to Rhode Island for this memorable occasion.

This Year's Graduates

Sr. Monica Ndege from Tanzania took a MSc in Pastoral Counselling at Loyola University

Sr. Charity Munonye from Nigeria, Administrator at Makiungu Hospital, Tanzania, received a Management Diploma for Senior Church Administrators.

Sr. Cleide da Silva qualified as a Registered Nurse in Brazil

Sr. Jacinta Akonaay SRN Community Health Diploma

Sr. Regina Reinart B.A. in Theology

Sr. Mary Mwalla Assistant Medical Officer

Sr. Justina Odunukwe Masters in Business Administration

Sister de Lourdes Gogan

There were only twenty-something MMMs in 1939 when Chrissie Gogan first met Mother Mary Martin. Already trained in general nursing, she had much to bring. Taking the name Sister de Lourdes, she was one of the founders of the work at Ogoja in Nigeria. More than 47,000 people were suffering from the dreaded Hansen's disease when she took the first Out-patient Clinic on Easter Monday of 1945. Sister de Lourdes became one of the 'stars' of the documentary film *Visitation*. The film gives us a glimpse of her empathy and compassion among people who endured the most awful suffering and disfigurement. They were outcasts who never knew what it was to have a wound dressed, or to meet someone who was concerned with all the aspects of their lives – whether their need was a good meal or shelter, or hope that one day some new medicine would help restore them to a normal social life. Was this more or less difficult than her later task – as Regional Superior during Nigeria's civil war? She never complained that anything was difficult, she just did it. Her reward came on May 8th, in her 92nd year. We can lean on her prayers now.

Sr. Helen O'Brien B.A. in Theology

Not so long ago it was "back to school" for *fourteen* MMMs, but now it is "back to work" for those who successfully completed their studies.

Sr. Ursula Sharpe M.A. in Psychology

Sr. Cecilia Azuh, Bachelor's Degree in Nursing Studies

Sr. Itoro Etokakpan B.A. Social Science

Sr. Fidelia Adigo, SRN Hospital Management Cert.

Sr. Alice Ashitebe, SRN, M.A. Hospital Management

Sister Ann Ward

‘Teach My People Compassion’

‘The arch-enemy of compassion is pity.’ Sister Ann Ward looks you straight in the eye when she says this, and you get the feeling that she knows a thing or two about the subject.

‘Pity puts distance between you and the person you are pitying. Compassion puts the two of you on the same level, enabling you to work together to change the situation, or at least to make it more bearable.’

A deep sense of compassion is what drove Ann Ward to leave her Donegal home more than fifty years ago, when she joined MMM. The same desire impelled her as she entered Medical School in Dublin, and later when she pursued her post-graduate studies to obtain her Master’s and her Fellowship in Obstetrics & Gynaecology.

Two years ago, Sister Ann was honoured by her peers at University College Dublin, who presented her with the *Distinguished Graduate* Award for outstanding achievement in the field of medicine.

‘If you found yourself in the same circumstances I work in’, she told the professional gathering at UCD, ‘you would have done just as much as I have done.’

Sister Ann had previously received international recognition for her *‘outstanding contribution to women’s health’*. She is frequently invited to prestigious medical schools or conferences to present papers, or to demonstrate the surgical procedures she has pioneered. But Sister Ann shuns publicity.

‘Please don’t write about *me*’, she protests. ‘The focus needs to be placed on the women who suffer this terrible condition, and on the services that need to be put in place to bring relief and proper treatment.’

Nonetheless, she reluctantly agreed to speak to us for this *Yearbook*, in between packing her bags to return to the place where she most wants to be.

That is in Itam, in south-eastern Nigeria, where more than 3,000 women have now been successfully treated from what is surely one of the most distressing of all illnesses a young woman can have inflicted upon her.

Sister Ann’s patients come to Itam because of a condition known as Vesico-Vaginal Fistula (VVF). The condition develops from prolonged and obstructed labour. Usually the infant is dead upon delivery, and the mother is left with severe internal damage, leaving her incontinent, in acute pain, and with great difficulty in walking.

Added to this there is the terrible stigma and the ostracisation – because of the smell, and the fact that she has no child and is not very likely to be able to have a child.

In communities where women’s rights are not properly valued, she can even be driven from her home or her village.

‘The sad part is that, today, most of the patients are teenage pregnancies which have gone wrong. They are schoolgirls that have messed up their lives. Unfortunately they never get back to school again, because their parents have been let down, and the money that was put aside for their schooling is often swallowed up on their treatment instead.’

‘Teach my people compassion.’ This was the request made to us, so graciously and so humbly by the great African leader, the late Julius Nyerere, when he visited our Motherhouse twenty-five years ago, while he was President of Tanzania.

These words were recalled during a recent interview with Sister Ann Ward, founder and medical director of the Family Life Centre at Itam-Mbirit, in south-east Nigeria.

At Itam, the charge for treatment is kept to an incredibly low level, and nobody is ever turned away for lack of the ability to pay. But, unfortunately, before women discover what is available in Itam, they may have spent all the money they can manage to scrape together elsewhere.

‘Unfortunately, the problem of VVF is growing’, says Sister Ann. ‘When I started this work, I thought I would work myself out of a job and that VVF would be unheard of by now. But sad to say it is on the increase.

‘Not only that, but the cases coming in seem to be much worse now, much more difficult, the girls are much younger and, consequently, they are much more damaged. The majority of them, sadly, are damaged for life.

‘Another thing we have noticed is that young women from the same family are becoming inflicted with VVF. Girls that were here looking after their sisters when they had it, are back in with us now with the same problems. It shows the terribly

low standard of living, and of healthcare in the villages. Life is so difficult for them, there is no transportation to get to hospital in their hour of need, or else the hospitals are in such an appalling condition there is nobody to attend to them, or they haven't the money to pay for the treatment.

'Compassion puts the two of you on the same level enabling you to work together to change the situation.'

'I just don't know what the future holds, because the medical facilities in the country are so bad. If the salaries of staff in medical facilities are not guaranteed and paid when due, you cannot expect commitment from them, you cannot expect them to give proper service without demanding payment from the patient. What the country needs – maybe what the whole world needs – is a renewal of commitment within health care.'

Many specialists from overseas want to spend a short time at Itam to get experience. But this is not a solution to the Nigerian problem.

'They ask me to let them come and to keep the easier cases for them. But I have to tell them there are no easy cases. They are all difficult. And there is no point in coming to learn just the surgical techniques. The post-operative care is critical. You have to be able to stay with these patients and you have to be here for the long haul.'

Luckily, Sister Ann can rely on excellent Nigerian women as Senior Nursing Officers at Itam, to ensure that good post-operative nursing care is provided.

'With an illness like this, you have to have somebody that has compassion', repeats Sister Ann. 'There is no other way it can be done.'

Sister Trinitas McMullan

Another MMM from Ireland, Sister Trinitas McMullan, is administrator of the Family Life Centre, and a Nigerian MMM, Sister Therese Jane Ogu, as well as being a Senior Nursing Officer, is responsible for the Hostel where the young women live while awaiting their surgery.

Most patients need several operations to repair the internal damage done during their obstructed labour, and this can take up to a year.

The Hostel is a cheery place. It is part of the large, leafy, compound. Sister Therese Jane also tries to interest the residents in poultry and produce from the land. A recent donation from friends in Canada has made it possible to buy new sheets and coloured plastic chairs and to have the whole place painted in bright colours.

'It is very hard to know what is the best way to keep the young women occupied while they are in the Hostel', according to Sister Ann. 'They make their own fun, they are glad to be this far on the road to their eventual recovery, even though there is still such a long way to go.

'In some ways the Hostel resembles a second-level boarding school. UNICEF gave us desks, blackboards, etc., and paid a teacher, but it is hard to know whether this is the right time for these young women to be at school.

'Their only interest is having their operation. But, of course, we believe the best rehabilitation they could have is education.

'In countries that are better off financially there is much talk of rehabilitation after VVF, but for our young women the rehabilitation they want is to be able to return home and become integrated in society once again, to be able to work on the farm, or to sit in a bus, or go to the market, or to the church, without stigma.'

While the situation looks bleak enough, the MMMs and staff at Itam do what they can to make a difference. 'As part of the Primary Health Care programme, women who are healed from VVF are trained as ambassadors to go back to their villages and explain to the women there how they may get into difficulty in childbirth and the consequences if they don't get help in time.

'Many women still feel that their difficult labour is due to witchcraft. But hearing those who have been cured speak about their experiences reveals to them that it is not due to witchcraft, but due to a medical and mechanical difficulty they ran into. It brings them the greatest relief to be freed from their superstititions and to know that they are not bad people and not the victim of some curse.'

Clearly, the work is hard, but the need is great.

Sister Therese Jane Ogu

'I don't suppose wild horses could hold you here in Ireland?', Sister Ann was asked. She laughed and shook her head.

'No, no way! No matter what conditions are like, when you are working with someone who is suffering from VVF you can see you are restoring life and dignity. And as long as you can put a smile on that young person's face it is worth it.'

PSALM from Bahia

Sister Siobhán Corkery

Plebiscito – Referendum

The National Bishops' Conference, together with other churches and other social / pastoral groups, have organized a referendum to consult the people of Brazil about the weight of the external and internal debt on their daily lives. Although Brazil has paid back what it originally borrowed several times over, because of the outrageous 50% interest rates being charged it still owes $235 billion. In 1999 64% of the Federal government's budget went towards paying the interest on this debt. It is hoped that the referendum will send a strong message to the Government of Brazil and to the world.

Saúde – Health

We work with a team of twelve local women from the town of Capim Grosso. Our focus is preventative rather than curative. We train our leaders in the following areas: basic hygiene and sanitation, nutrition, herbal medicine, safe drinking water, environmental awareness and how to influence the public health system.

Because the psalms resonate with the daily lives of our people we have chosen to use the acronym PSALM to present our story.

With our leaders we target six of the poorest rural communities each year in our outreach program. We travel to these communities and present workshops. Our aim is to help people take control of their own health care and to value the tried and true natural remedies which are a part of their culture. We work to combine their knowledge of herbal medicines with a safe and reliable means of producing these natural remedies. One example is the use of grains, seeds, leaves and eggshells to produce a cheap natural food supplement, high in fiber, protein and minerals.

Água – Water

Our planet, like our body, is 70% water. 97% of the planet's water is salty leaving only 3% fresh water. Here in Bahia, it is semi-arid and it often does not rain for months on end. However Brazil has 8% of the world's fresh water, so our lack of water in the Northeast is due mainly to a lack of political will on the part of our State and Federal leaders to bring water to our area. We work to mobilize these rural communities in the fight for water.

We also help them to secure resources, to build cisterns to collect rain water from the roofs of their houses during the short rainy season, as this is one of the few reliable sources of safe drinking water in our region.

Luta – Struggle

The residents of Planaltino where we live, have for the last three years petitioned the Mayor to do something to control the speed of traffic on the main highway that separates this neighborhood from the rest of the town.

In December 1999 a grandmother was killed on this stretch of road and in January a 12-year-old boy died. When, in March, a five-year-old boy was killed instantly the people had had enough and took matters into their own hands. They dug up the road in the areas where they believed speed bumps (called 'sleeping policemen' here) should be placed. No traffic could pass and the police and the Mayor tried to reopen the road. Since in the last seven years the lives of 28 people have been sacrificed on this stretch of road, the people refused to be ignored this time.

Eventually the authorities sat down to negotiate with the residents and were ready to listen. The result was the construction of two speed bumps and the placement of warning signs.

Mulher – Woman

This year we started working with a national movement for women farm workers – the *Rural Working Women's Movement*. These women have remarkable resilience and are willing to work hard at personal development as well as tackling problems to improve their communities. We are helping these women become aware of their rights as farm workers, assisting them to secure personal documents, and to explore income generating projects. On March 25th several of the rural communities celebrated the *International Day for Women*. They came by every type of transport conceivable – they walked miles, drove horses and carts, peddled bikes, hung onto motor cycles and hitched transport from passing cars and trucks in order to participate. Using the back of an open truck as a platform, they shared their stories and concerns and ideas to bring about change.

MISSION TO BRITAIN

This was the title of the Keynote address at this year's AGM of the Catholic Missionary Union in London. The speaker, Fr. Donal Dorr, based the address on his latest book *Mission in Today's World*. He interprets the message of *Redemptoris Missio* – the encyclical of Pope John II, to affirm that those who have worked as a missionary abroad, in a culture not their own, can remain life-long missionaries when they return home – provided they continue to have a frontier mentality and seek out frontier situations in their home church situations.

"This interpretation fits in well with the encyclical's insistence that one can answer the call to mission *ad gentes* (to the nations) not only in distant lands but also in social or cultural 'zones' or 'worlds' near home – situations where Christ is not really known and the church is not truly present. Committed Christians who spend some significant period of time working in foreign mission situations and then return home, bring with them a missionary vision, energy and attitude."

Donal Dorr ends his book* exploring the contribution which this group of missionaries can make in the home churches.

*ISBN 1-85607-292-4

SERVING THOSE WHO SERVE

Sister Maureen Clarke is the newly-elected Area Leader for MMM in the UK. A Social Worker by profession, Sister Maureen also works for the Counselling Service provided at the parish of Ealing Abbey, where MMMs have been living since 1973.

Sister Eileen Morrison has spent many years in a number of African countries, training MMMs in accounts and administration. She is currently based in London, and still available to answer the many calls for assistance made upon her elsewhere.

Sister Mary Canty was delighted recently when news reached her in London that she had been granted the Alanu Fund Special Humanity Award for services to Medical Social Work at University College Hospital, Ibadan, Nigeria. This was well deserved recognition of the many years she had devoted to the people of Nigeria.

Sister Marie Therese Roberts, lives in Birmingham where the inspiration of the great Cardinal Newman is still felt. Sister Marie Therese is Secretary and Treasurer of the Catholic Biblical Association, which publishes *Scripture Bulletin*. She has become well known to a wide circle of elderly people who have prevailed upon her to organize holidays each year, in May and October, at one or other coastal resort. She first did this as part of a social work post she held in London some years ago, but obviously her reputation as an organiser had gone before her to Birmingham!

Sister Clair O'Leary is Manager of the Catholic International Students' Hostel at Mill Hill in London. Students of all religions – from Asia, the Middle East, Africa and mainland Europe – can find at Mill Hill an understanding welcome from someone who has devoted her whole life to young people. Sister Clair says: "As a Nurse Tutor I have always been working with young people." She is pictured here with Helena Guaderon, a drama student from Switzerland.

Sister Margaret Ann McGrath is concerned with the ecumenical dimension of mission. She is a member of the Overseas Health Care Advisory Forum of the Churches' Commission on Mission and the Evangelical Missionary Alliance.

Sister Máiread Butterly's missionary frontier is found as Co-ordinator of the Refugee Project of the Diocese of Brentwood. This Project provides services to asylum seekers in East London and Essex County, and networks with many other agencies in Britain.

Sister Maura Magner is currently engaged in providing awareness of the missionary needs of the church worldwide in the English deaneries assigned to MMM. She also finds time to volunteer her services in a facility for the care of the elderly in Romiley, Cheshire.

When **Sister Rosemary Mohan** finished her term of office as Central Business Administrator for MMM, she studied for her Master's in Pastoral Studies at Loyola University in Chicago. A back-ground in pastoral care is useful in her present role as Financial Manager for the Kairos Community Trust which manages thirteen London properties. This is part of the Trust's response to the crisis of homelessness in London. Kairos tries not only to provide shelter, but to get to the bottom of the problem of its clients – whether poverty, crime, drugs, unemployment or family breakdown. It seeks to address "the need of people at the very bottom rung of society's ladder". Once you step inside the door of a Kairos home, you can feel the spirit of hope and friendship that pervades. The services of dedicated professionals gradually replace hopelessness with courage. As one client put it: "Kairos gave me a chance to live my life to the full where before I went to bed every night hoping not to wake up."

If you don't have a telephone, try bouncing your messages off the ionosphere. That's what the MMMs do at Loolera and Kabanga, where they found the best solution to urgent communications is

e-mail by radio

When Sister Joan Grumbach, a native of Connecticut, was elected Area Leader for MMM in north-eastern Tanzania, she was given a mandate by the Area Assembly to improve communications. Quite a challenge, since she is located in Loolera and belongs to that half of the world's population who live more than seven days' walk from the nearest telephone line.

She sat down and wrote to the Loyola Foundation in the United States, applying for a grant for a radio-telephone, inverter, wiring, computer and printer. They very kindly obliged.

She knew she could depend on the help of Fr. Pat Patten CSSp of the Arusha-based Flying Medical Service to do the rest. He explains:

"Our Bushlink e-mail system works by way of a special high frequency radio modem and radiocall connection, instead of a telephone line. High frequency radio signals can follow the curvature of the earth. They do this by being reflected off the ionosphere – a charged layer in the atmosphere which varies greatly in density and height above the earth, according to solar activity.

We use this reflective property of the atmosphere to bounce the signal from virtually any remote spot on earth right here to Arusha – or from Arusha back to any other place. This can be done with relatively inexpensive radio equipment. It can also be done with relatively little power. So we can use, for example, two small solar panels to power the computer, radio, modem, and printer in the most remote areas.

"The remote hospital uses a computer to send and receive e-mail as usual. However, instead of the link from the computer to the internet being by telephone line, it uses a radiocall. The radiocall, which can operate on any one of several widely-spaced radio frequencies (depending on the height of the reflective layer in the atmosphere), automatically contacts our radio e-mail node in Arusha whenever the user wants. That node is permanently connected to a local Server which uses a stationary communications satellite to connect to the Internet. Mail is sent and received in this way. It is totally automated and operates 24 hours a day."

The Flying Medical Service started in 1983 as a result of the border closure between Kenya and Tanzania. This closure deprived large areas of north-central Tanzania of medical services which were then being provided by the Flying Doctors from Nairobi.

As well as medical emergency flights throughout East Africa, they provide a consultative medical service via radio and e-mail to hospitals and health centres throughout East Africa, allowing them to have access to the latest medical information available on the Internet.

The Flying Medical Service is a non-profit volunteer organization. Services are provided to anyone in need, regardless of religious affiliation, ethnic origin or ability to pay. Their focus is on the poor and the marginalized. Their commitment is primarily to them.

Tanzania is populated by 32 million people. It has a ratio of one doctor for every 23,000 people – in contrast to USA which has one for every 460, Belgium with one for every 384 and Austria with one for every 365.

Most of Tanzania's doctors are concentrated in large towns where 80% of the government's expenditure on health is allocated. However, only 20% of the population lives in urban areas. The Flying Medical Service tries to fill the gaps by focusing on the rural areas.

In 1999 alone, their aircraft flew a total of 668 hours while doing 1,364 flights. They treated 2,705 patients in their own villages, vaccinated 8,243 children against diphtheria, whooping cough, tetanus, measles, polio and tuberculosis. They provided 2,747 pregnant women with health education and treated 86 TB patients. They evacuated 88 seriously ill patients from their villages to local hospitals, and did 55 emergency flights outside of normally scheduled clinics. They served a total of 13,924 patients for the year – an average of more than 38 patients per day!

They have provided medical and teaching specialists such as general surgeons; orthopaedic, plastic, eye and reconstructive surgeons; gynaecologists; radiologists, paediatricians; TB specialists; lab technicians; theatre nurses and other support staff to 34 remote hospitals throughout Tanzania.

The Flying Medical Service also produces health education videos in Swahili and Maasai languages. With portable equipment which can be carried on the aircraft, these videos are shown in clinics as part of the health education component.

All the above work – flying, administration, video production, most of the aircraft maintenance, installing and maintaining medical communications radios – and more – is done by three full-time and one part-time volunteer staff with two aircraft.

Needless to say, MMMs in Tanzania rely greatly on this invaluable service!

But hang on a minute! Don't the mountains get in the way?

"Microwave relays, such as those used for long distance phone services, and Very High Frequency signals such as those used for television or for FM radio broadcasting, are indeed affected by obstructions and are basically line-of-sight signals. AM radio signals, on the other hand, have a far greater range. You will notice this later in the evening and at night where you can receive stations from all over Europe, whereas during the daylight hours the range is more limited. That is because of the reflection of the signal off the ionosphere. Very high frequencies such as FM and TV penetrate it and are not reflected.

"Low frequency signals such as standard AM radio broadcasts are reflected very steeply during the day and less steeply at night. Thus they travel longer distances at night as the reflective layer is effectively higher up. So, in one bounce, the signal goes farther. Even when the charged reflective layer in the atmosphere is relatively low during daylight hours, it is still far higher than a mountain; so the signal just bounces right over it. It is, in effect, as if the radio transmitter were in the sky.

"What our system uses are in-between frequencies in the High Frequency radio spectrum – not so high that they penetrate the ionosphere, nor are they so low that the reflected distance which they cover is relatively short. By choosing the proper frequency for the particular time of day or night, the skip distance can be varied."

Is there a limit to the distance between the remote mission and the Server?

"No. There is no real limit. We have stations in the Congo which regularly connect with us over a distance of more than 1,600 kilometers."

Can users write unlimited messages off-line or is there a limit?

"There is no limit. But they are charged per kilobyte sent and received for use of the radio space. So it costs about 15 US cents per densely-typed page. We do not encourage sending rich text files, file attachments, or pictures, as these take up enormous space. A one-page densely-typed document using standard Word Processing software could take up about 35 kilobytes of space and would cost about $5.25 to send or receive. A simple one-page (ASCII) text file such as you can get in e-mail software would only cost 15 cents.

Why does Sister Joan say she collects her mail around mid-day because that's the best time to 'get a line'?

"Right now we only have four active radio channels for transferring the e-mail. They can get quite crowded during certain times of the day, much as phone lines can be busy. So Joan chooses a less crowded time. We're in the process of adding more channels."

For further information contact Fr. Pat Patten by e-mail at: FMS@habari.co.tz

Sporadic rainfall

resulted in crop failure in Loolera again this past year. Some people tried planting maize – even up to three times – but received no harvest. One area, about four hours away, had a good harvest. The radio-controlled lorry recognized on the airwaves as "Mobile Blue" went there to bring in maize, which was stored in the godown in Loolera – part of the well-tested famine prevention strategy.

Sister Joan Grumbach writes:

"Our mobile Mother & Child Health Clinics continue to be held twice weekly. Our target group for upgrading and ongoing education this year has been the Traditional Birth Attendants, who still do most of the normal deliveries. They call us for any complications and the newborn babies are brought to the Child Welfare Clinic for vaccination. We participated in the district polio campaign for the fifth year, and all children of five years and under have been vaccinated.

The nursery school has 38 children and we are into our second year now, giving them a basic foundation of learning prior to entering the local primary school.

Maasai compound visits for health education, nutrition and hygiene have also been a priority. AIDS education to the school children and among the Maasai warriors has been effective and is keeping this deadly disease out of Loolera so far. We hope to have the Diocesan AIDS team visit later in the year to provide more input.

The new Loolera church was officially opened and blessed on October 15, replacing the old one, that was open to the skies!

Annual Report 'takes the biscuit'

Sr. Patricia Byrne, Hospital Administrator, with Mr. Evaristi Bavuma

Once again, Kabanga Hospital in western Tanzania has produced an Annual Report that leaves the rest of us wondering how they do it! Fifty-three pages of facts, photographs, a month-by-month diary, charts and tables showing comparative figures for the previous four years. It leaves nothing to the imagination! From such a remote location, where they face difficulties undreamed of in more developed parts of the world, this is no mean feat. And the comprehensive financial reports show a modest surplus both for the Hospital Complex and for the Training Institute.

The hospital has 155 beds and ten cots, one major and two minor operating theatres, and a new one under construction. A total hospital staff of 144, and a Training Institute that provides the only nursing and midwifery education in Kigoma Region, makes this quite an administrative task. With 5,694 admissions, and 26,575 out-patient visits, 714 babies born, of which 29% were abnormal deliveries, it was a busy year for every department. In addition there was the outreach services for Mother & Child Welfare – 10,310 women attended for antenatal care, 68,501 attendances at Well Baby Clinics and 10,191 sick children were treated.

The Report outlines the difficulties, disappointments and challenges as well as the achievements. It thanks all those 'partners in mission' – those who donated in any way, a list that 'cannot be exhausted'. And it expresses appreciation for all the hospital staff "for their goodwill, dedication and self-sacrificing work in order to accomplish all the good things that happened. And for the 'not so good' things, we were together in trying to find a solution that benefited everyone concerned."

One Year down the Road . . .

Sister Ekaete Ekop is the MMM doctor at Zaffe

The new millennium had just dawned when the first all-African team of MMMs set out to establish a new mission in Zaffe. And what a year it has been at the ***'Soins de Sante Primaire et Programme de Developpement'.***

As soon as we had equipped and furnished the Clinic with the things we needed to start with, we began our health services in Zaffe. Of the seven rooms in the Health Centre, we are using just four. The other three are yet to be furnished and equipped.

As we intend this to be a community-based Health programme, with the ultimate aim of making the people responsible for their own health, we have done a short formation course for Health Volunteers. We had twelve candidates in all – with representatives from every village. The course lasted twelve weeks, two hours every week.

The Volunteers were trained in the first-aid care of common illnesses in this area. Now they are working in their different villages with the people, giving health education and first aid care, and also providing an important link between us and the local people.

To provide water, which is so necessary for the services we give, we have sunk a borehole and are in the process of building an overhead tank. We are still planning to get an electric pump which will be run by our generator. There is still no electricity in the area.

The plumbing work in the Centre is yet to be done. We are in the process of negotiating for that. This is all very expensive. To cut down on costs, we split up ths venture and gave it out to different groups – sinking the borehole, building the overhead tank, buying the pump and doing the plumbing.

We have also started a Nutrition Centre, to attend to the needs of the many malnourished children we come across during daily consultations and social visits in the village. We hope, through the services of this unit, to teach mothers how to use the available foodstuff to the greatest advantage of their children. At the start of the next rainy season we hope to initiate demonstration farms, to sustain the Nutrition Programme in the different villages.

At the beginning of June we began outstation visits to villages which are not so close to the Centre. During these visits, we give curative services, health talks and demonstrations. We also use these opportunities to visit the homes of the local people and see the conditions in which they live.

The patients come from far beyond our catchment area. We had initially started out with seven villages, but now we receive patients from over twenty villages. We will need to visit these villages, study their environment, educate the people and establish measures to prevent some of the illnesses we see each day at the Health Centre.

Nutrition Unit under construction

The lot of women here is pathetic. We have gleaned from some of their stories that the root of this is the low literacy level. Increasing their literacy level would heighten their awareness and empower them to resist some of the injustices they have to endure and take their rightful place in society. We hope you continue to keep us in your prayers.

Where exactly is it that you work?

For the first time in years, Sister Sheila Devane, can answer that question now. For the big news in the Mental Health Programme she established in Arusha four years ago, is that they now have their own space – at last!

Until now they had the use of the hospital library for out-patient clinics. A very small office space was available in the Chancery for some administration.

Architect David Mahando starts to make the plans

Civil Engineer Thomas Shaibu checking levels

Yakobo has a hard job, but it has to be done

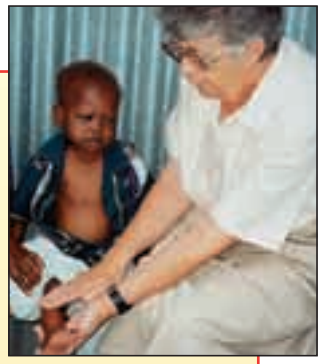
Despite, this they managed to provide no fewer than 1,216 mental health consultations to clients in the first half of this year.

Sister Sheila says: "The most difficult question for me was not 'can I see you', but rather 'where can I see you?'" But, that is all over now. "Earlier this year we managed to get a ward in the government regional hospital. With the help of the Danish funding agency, DANIDA, and some other donors, we have transformed a long ward into a beautiful mental health out-patient unit. There are bright colours everywhere, private counselling rooms, a spacious resource centre, a welcoming reception area, a good-sized multi-purpose room where children can be assessed and treated among many other possible activities.

This building will function as a therapy centre for many and as a drop-in centre for people with more chronic and long-standing illness. People interested in mental health can sit and read. Worried relatives can come and talk. Groups with the same problem or their relatives will have a place of their own in which to meet and share.

For us, the staff, we will now at last have a definite space to hang our bags! Having a premises of our own will indeed transform and extend our services. We will be busier, but we hope that our clients will enjoy the building as much as we have enjoyed making it possible for them."

True Love Waits…



The staff and MMMs at Mukuru Health Centre, in a large Nairobi slum are victims of their own success! The increase in the number of people attending every day can be put down to the fact that the Traditional Birth Attendants trained in the programme, are now educating and motivating mothers about the importance of the clinic to the health of their children.

Many of these families have been driven out of rural areas because of drought. But when they reach the city, life is even more harsh for them.

Sister Kathleen Donnelly writes:

"Many, when they come from the rural areas are very undernourished. With nutritional advice and food supplements, they are very quickly back on the road to health.

"We have been able to help a number of people with HIV or AIDS with small income generation projects. This enables them to pay their rent and feed their children. It gives them a sense of independence and has a positive effect on their own health and lifestyle.

"We continue with HIV / AIDS education in the schools and factories. Many people are beginning to change their behaviour. In some of the schools there are very active youth groups promoting a campaign they call *True Love Waits."*

Ministry at 7,000 ft. above sea level

Sister Patricia Hoey works up high on a plateau and way down into the surrounding valleys near Eldoret in Kenya. Her job takes her to a cluster of villages that are scattered in all directions, climbing the hills and walking the valleys.

"Each day brings new surprises", she says. "These communities are poor. I work from rented rooms in Munyaka, a settlement on the plateau that has become home for the unemployed and school drop-outs.

Many of the families are victims of tribal clashes, forced to flee and seek new territory. I do a regular clinic two days a week. Other days I do home visiting. Among the homes visited I've found epileptics, deformed children, blind people, some very old... My main concern is for people with HIV and their families. The University Hospital in Eldoret refers people to me when discharged to this area. It is a privilege to be able to provide ongoing treatment and care, to relieve pain or hunger."

Fostering the Gentle Power of Women

Bellitu Eshetu

Sister Mairead Gorman, who has been coordinating Women's Development in Awassa Diocese, for two years, writes from Ethiopia:

"Our aim is to help women identify their role in society, and to help them develop skills to fulfil this role to the best of their ability.

Often, women don't have rights within the family, nor in the community. They are not invited on to committees where decisions that affect them are made. Many women wouldn't have had schooling. If a family has money for school, the boys are sent.

At each mission within the diocese now there is a lot of emphasis on promoting the education of girls. Attitudes only change very slowly. Our work is among four tribes, and we notice that they are beginning to value education now, especially among the Sidamo tribe.

There will not be a lot of change until women get basic education. When I go to a house I notice the difference. Girls who have finished primary school demand more. They have shoes on, they keep children better, keep their houses tidier, you can see the difference a good foundation makes. I think it has something to do with the discipline of being in class, and the exposure of meeting different people.

Education of women used to be considered a waste of time. With the younger generation this is changing. Some husbands who have been to school themselves encourage their wives to continue education after marriage.

To initiate a change of attitudes, we invited gender experts to come and give talks to the sisters and staff running various diocesan programmes. It was not easy to gain support for these 'new ideas'. People are used to a man being the sole authority figure in the family.

We found women will not attend a health class on hygiene or child care, unless there is some skills training going with it that will help them generate a little income. We set up a small revolving fund to help women get sewing machines, for which they can pay back gradually.

All but two of the parishes in the diocese are rural. There are twelve 'Women in Development' centres. The women attend once a week, with separate programmes for girls, and adults, including sewing, knitting and other crafts. Getting sales is a big problem, but the National Coordinator investigates outlets. That is a very hard task, made more difficult by the fact that people can buy cheap second-hand clothes which are imported from overseas.

We were delighted when Bellitu Eshetu, one of the staff from the diocesan Development Office, was sponsored to take the Development Studies course at the Kimmage Institute in Dublin. Bellitu is back in Awassa now and I have passed the coordinating work over to her. That leaves me free to return to our MMM mission at Dadim, which is at the southern end of the diocese.

Sister Kathleen Crowley first went to Kenya's Turkana Desert in 1973. For the past nine years she has been Diocesan Coordinator of Women's Development covering the fourteen parishes of the diocese of Lodwar. Her work with womens' groups involves a lot of travel, from Kalokol on the shores of Lake Turkana, northwards as far as Lokitaung and beyond, or southwards to Nakwamoro.

Sister Kathleen administers a revolving fund, to help with income generating activities. With financial support from Germany they got six boats for the women's groups involved in fishing on Lake Turkana. Selling fresh fish would bring more money, but with transport as it is, they find it is wiser to dry and smoke the catch.

Weaving laundry baskets, shopping baskets, every kind of basket you can think of is another source of income. The women pick the doum palm, treat it and get to work on the variety of patterns they have developed over the years. Securing overseas orders for these high quality baskets has been an important part of Sister Kathleen's work. She says: "Women are still very vulnerable, despite advances like the irrigation scheme from the Turkwell river that waters the drills where they have planted seeds. You think you are getting places, then drought comes and famine stikes again."

Wide range of Skills Training in Tanzania

It has been a busy year at the MMM Training Centre opened at Ngaramtoni, just north of Arusha, Tanzania towards the end of 1999. Courses on offer range from Project Planning and Management to Facilitation and Mediation Skills. These are available, both in Swahili and in English.

Gradually news is spreading about the holistic healing therapies on offer. These include Reflexology, Bio-energy, Mora Therapy, Bio-oscillator, Magnet Therapy and Acupressure. The growing demand for these services of 'complementary medicine' seems to work on the basis that everyone who has a treatment brings along someone else the next time!

Sister Helen McKenna, who works closely with Moira and Eamonn Brehony, says:

"Therapists do not heal. The body heals itself. We know this clearly, in the case of a broken leg. Once it is immobilised and rested then natural healing is enabled to take place.

"Sometimes there is an obstacle preventing healing. With the use of Bio-testing, these obstacles – if they are toxins – can be identified. They can then be cleared from the body using combination homeopathy. This is where the therapist comes in – enabling the body to heal itself.

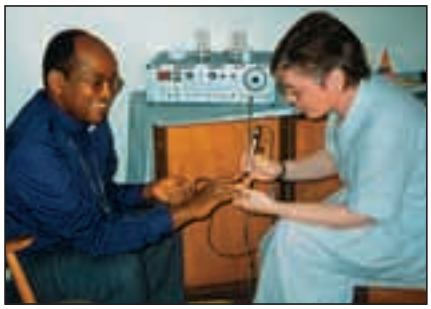
An important part of our service is caring for the carers. This includes those in the caring ministries and also exhausted mothers of chronically ill children.

More and more people have expressed an interest in learning about this healing dynamic for themselves. Providing therapies without education is like giving a person a fish without teaching them how to fish. You may solve their problem for now but without education in the ways of natural healing they may not be able to prevent further problems or be able to heal themselves next time.

With the light dawn on them and bringing their healing process to consciousness they will be able to take control of their lives. That is why we have named our Training Centre *Mapambazuko* – the Swahili word for Dawn.

A group of eleven Reflexology students, all Staff Nurses at Dareda Hospital, are now ready to take their examination at the end of a year-long course. Although still only students, they are gaining great results from treating chronically sick neighbours and family members. We will have another similar Reflexology course beginning in 2001.

Since we began, a high priority has been the Project Planning courses. In the past year we also offered a course in the care of those who are house-bound with AIDS, a Body Awareness Workshop and an Introduction to Healing – integrating body, mind and spirit.



Sister Helen uses Mora Therapy on Archbishop Josephat Hebulu of Arusha.

The brochure for 2001 has an ambitious programme, including Psychosynthesis Workshop, Facilitation and Mediation Skills, Project Planning and Management, Organizational Development, Reflexology for Home Use, Reflexology for Practitioners, Care of the House Bound, Proposal Writing for Donors, Participatory Planning Techniques, Natural Health Care, Indigenous Plants as Food and Medicine, and Mediation & Conflict Management.

'I hear Miss Heaney is leaving…'

Paddy McGahon had a Pharmacy in Dundalk, Co. Louth. In the early months of 1961, customers would come in and say 'I hear Miss Heaney is going off to join the Medical Missionaries', and he'd reply. 'I just don't know what I'm going to do, she's been here for the past 25 years...' Sixty years ago, pharmacists trained through apprenticeship, only going to College in the final year for lectures and exams leading to the Membership of the Pharmaceutical Society. Peggy Heaney did her apprenticeship with Paddy McGahon. Sometimes she went to New York, where her mother lived, for six months at a time, but she had always come back. This time, in the Dundalk Pharmacy, everyone knew it could be a while before they'd see her again.

Sister Moninne, as she became, was greatly loved for her wisdom and her wit. She could easily diffuse a situation that was 'boiling over' by seeing the funny side of it. She devoted all of 32 years to the Hospital Pharmacy in Kabanga, Tanzania. By coincidence, another MMM pharmacist, who is still in Kabanga, Sister Pacelli Ward, also worked in McGahon's in Dundalk. When Sister Moninne died on February 28 last, Mrs. Jo McGahon, Paddy's widow, together with Sister Moninne's loving family, mourned with us as we laid this great missionary to rest.

Sister Úna Ní Riain

New Hospital in Ethiopia an International Effort

Sister Úna Ni Riain arrived at Wolisso, Ethiopia, on September 5, on a new and exciting adventure. She is part of an international team of missionaries staffing St. Luke's Catholic Hospital and College of Nursing. The team staffing the new hospital includes four Ethiopian sisters, one missionary from USA and one from Canada, two from India, one from Italy, one from England and two from Ireland. Most of the foreign missionaries have had several years of experience of working in Ethiopia.

For Sister Úna this is yet another step into new territory. She first went to Africa in 1958 and has worked as a Nurse and as a Tutor for many years in Nigeria and Malawi.

Sister Mary Molloy

Wolisso is a medium sized town in the Western Shoa Zone. This health project will serve a population of approximately 346,000 in one hundred and six neighbourhoods. Ninety percent of these people live in rural areas.

The hospital is owned by the Ethiopian Catholic Church, working in partnership with the International College for Health Co-operation in Developing Countries (CUAMM). This is a lay missionary initiative of the Diocese of Padova, in Italy, which sees its main purpose as promoting the health status of people living in rural areas. Working in partnership with the local Church, CUAMM has been mandated with responsibility to manage the funds of the new hospital.

The Hospital was planned with the intention of offering curative services and collaborating with the existing public structure for the prevention of disease and the promotion of community health.

The need for a hospital in Wolisso has been voiced by the local people for many years, and has been seen as a pressing issue.

The administrative district of Wolisso is densely populated and had only a Health Centre which was extremely overburdened.
The local people showed keen interest in collaborating and contributing their share in the realisation of the dream to have a hospital strategically located – enabling easy access to other neighbouring districts and with access to transportation.

The new hospital has a capacity for 120 beds, covering medical, surgical, paediatric, gynaecology and obstetrics wards, with out-patient and maternal and child health departments. It also provides services such as X-ray, drug dispensary, malnutrition unit, and mother waiting unit.

Sister Úna works in the College of Nursing, which has a yearly enrolment of 30 students.

The new venture was a challenge of a different kind for another MMM, Sister Maria Goretti O'Conor who works in the Health Section of the Catholic Secretariat in Addis Ababa. Like Sister Úna, she had pioneered MMM work in Malawi before going to her present work in Ethiopia. She had two knock repeatedly on many doors around the world to find staff for Wolisso and then deal with mountains of paperwork to get the visas for the new arrivals and the recognition of their respective qualifications.

Sister Maria Goretti O'Conor

Sister Mary Molloy is an MMM surgeon who will work with several other doctors recruited by CUAMM.

Sister Mary's missionary experience to date has been in Nigeria and Angola. She was in Ethiopia briefly once before – to attend a course in Reconstructive Orthopaedic Surgery in Addis Ababa. As she packed her bags at our Mother-house in Drogheda, she looked forward to seeing again "this magnificent country and lovely people".

When she eventually got news that her visa for Ethiopia had been granted, it was quite a rush to get everything done in time to meet the deadlines.

Did she find it a little daunting to be heading out into another new culture and starting off all over again?

"If I had time to think about it", she said, "I suppose I would find it an overwhelming challenge."

Why Tijuana?

Sister Mary Ann MacRae

Tijuana is now home to two million people and is the fastest growing city on the west coast of the Americas. Fifteen years ago most of the population of Tijuana had lived all their lives here. Now, with the migration from the south and from other Latin American countries, I am surprised when occasionally I meet someone under 15 who has lived all their life here.

This means we are journeying with a very mobile migrant population who have or had great hopes of a better life. It is also a people that is afflicted with a lot of everyday violence. This makes for considerable stress in their lives and stress leads to illness, feelings of isolation and alienation.

The most basic thing here is to get to know the people in whatever community they live. This means visiting them and getting them to know us, in order to build up a level of trust so that other things can happen.

When I walk around the neighborhoods, I see doctors' offices, clinics, hospitals. There are a lot of health care providers here, the majority are in private practice. But here the doctors don't make much money and some have to hold down two or three jobs, working morning in one clinic and afternoons or nights somewhere else. But even at the poor wages that they make, often the cost of consultancy, tests, and prescriptions are beyond the means of the poor.

Holistic care

I work as a doctor in a clinic that serves the poor. One patient has a husband who has full-blown AIDS. He has a visa for the USA and is currently in Los Angeles getting the latest antiretroviral treatment. But my patient will never be able to avail of that kind of

treatment as it would be very difficult for her to get a visa. Her relatives in Los Angeles are telling her to be sure to start treatment pronto! This brings home to me just how different life is, depending on which side of the border you are.

The border also gives rise to the whole phenomenon of border culture. This is a culture that is neither of Mexico nor of the USA – a mixture of both and identified with neither. It can be a culture of ambiguity and of the proverbial love-hate relationships.

So I see a great need to be with people and to serve them through a more integrated, holistic health care approach. I mean a health care that encompasses not only the body, but the mind, spirit, soul and emotions and helps people to cope with the stressful situation in which they find themselves. This is in addition to our traditional western health care. Included in this is acupressure, massage, body movement such as Tai Chi, meditation, reflexology, herbal medicines, nutrition, and support groups. The people seem at home with many of these approaches. Moreover, there are persons with knowledge of alternative types of health care in Tijuana who are happy to help by doing some volunteer work with us.

Challenges

If we are to make any impact we must network with others, seeing what can be done together. Networking is messier and less well defined than running a project or program where you are in charge and it is organized from the top down. But in the long term, our hope is that our work will be effective for people at the level of the grass roots.

It is not easy to find solutions in a urban environment where the population is increasing more rapidly than the infrastructures.

We have to face the fact that there is an increase in violence due to narco traffic – Baja California, the State that Tijuana is in, is considered to be the most dangerous state of Mexico. Because of *Operation Gatekeeper*, more of the 'narco trade' remains on this side of the border, leading to a higher incidence of drug addiction and growing HIV/AIDS incidence and prevalence here.

The geographical location of Tijuana on a peninsula makes it the 'step child' of Mexico. Often there are claims that Tijuana does not get a fair share of government resources.

The North American Free Trade Association (NAFTA) has given rise to foreign companies who often take advantage of cheap labor and lower environmental standards.

Perceptions of Mexico as having good economic growth rate makes it a less attractive country for funding by donor agencies.

While fluency in the Spanish language is essential to work here, close proximity to the USA makes it more difficult to be completely immersed in the language for learning purposes.

All the problems encountered in any city are here – domestic violence, alcoholism, loneliness, isolation and poverty.

So, why are we three American MMMs in Tijuana?

First, we believe in the Gospel values of being part of a suffering peoples' journey and struggle – being part of a migrant people that have to live in the messiness and uncertainty of 'who knows tomorrow'.

Secondly, with many unjust structures that affect the most vulnerable in society, we hope we can help people to identify their needs and to find solutions.

Thirdly, we hope to bring a peaceful healing presence in a violent place. Culturally the people here are open to alternative ways of healing.

That is our dream, that is our prayer.

Rosedale: a Home from Home

"It was a moving and sad occasion for the people of this parish as they turned out in great numbers to honour the departing nuns…". So wrote Kathleen Laffan in her *History of Kilmacow*.

She was referring to the concelebrated Mass, on June 25 1986, when the Presentation Sisters withdrew from the convent and school where they had served the parish since 1898.

It was the sincere wish of the Presentation Sisters that the convent should continue to meet the needs of the community of Kilmacow. There were several ideas about how this could best be done. Before long, a committee representing parishioners approached Bishop Laurence Forristal of Ossory, with a request to make the property available as a centre for the care of the elderly of the area. The committee would see to the financial management on a non-profit basis. The Bishop readily agreed.

Sister Fidelma

Sister Louis Marie

Sister Bernice

Sister Marguerite has been at Rosedale since 1987

MMM was asked to provide a community to oversee the day-to-day running of Rosedale. On January 9th 1987 – barely six months after the Presentation community had gone, the convent was empty no longer!

Sisters Fidelma O'Shea, Louis Marie Brett and Bernice O'Neill arrived in Kilmacow in the thick of a blizzard. Water pipes had frozen. The committee were embarrassed because there was no running water. But Sister Fidelma was coming from Malawi, and Sister Louis Marie from Nigeria and Sister Bernice from Angola. A village without water was nothing new!

The name *Kilmacow* is said to be an anglicized form of the Irish *Cill Mhac Bhuada*, meaning the *Church of the Son of Buadach*. Others suggest the origin as Cill Mochua, of the *Church of St. Mochua*. The village is beautifully situated in the southernmost part of Co. Kilkenny, on the banks of the river *Blackwater*, a tributary of the *Suir*.

You could say Kilmacow is not on the road to anywhere really – that is, geographically speaking. It never needed a 'bypass' because the main roads to Waterford and the towns of south Tipperary bypassed it anyhow!

Bungalows at Rosedale, with Penny who minds everyone.

A view of the lower part of Kilmacow village.

But the people of Kilmacow always knew where they were going! Even though the original village population has now grown to a parish comprising 650 families, Kilmacow has a dynamic community spirit that could be envied anywhere in the world.

The parish weekly bulletin lists contacts for Irish set dancing with *Comhaltas Ceoltoiri*, St. Senan's Athletic Club, Kilmacow Hurling & Football Club, Soccer Club, the Shanti Tug o' War Team, the Kilmacow Youth Club, the Pioneer Total Abstinence Association, the St. Vincent

The fountain and summerhouse are features of the garden.

Sister Agnes Manifold with Mrs. Josie Corcoran

de Paul Society, *Macra na Feirme*, the Health Clinic, and of course, the local correspondent for the paper everyone reads – the *Kilkenny People.*

Among such a vibrant community, it was not difficult for MMM to put down roots. Sisters involved in Rosedale over the years have been a happy bunch. The parish built a new bungalow for the MMM Community, just behind the main residence.

Rosedale is *not* a Nursing Home but a Residence for Senior Citizens. In the central house, each has his or her own bright, cheerful room. Just across the lawn there is a crescent of 16 bungalows, some with one bedroom, some with two, for single people or couples who can manage on their own – once they have the security of knowing there is someone to call in a moment of need. Day or night, there is always someone close at hand to answer the intercom. And even if you don't call, the Sisters visit the bungalows regularly and know who may be in need of a little extra care. Residents who are well enough might stroll down to the village hairdressers just beyond the gate, or pass an evening hour in the village pub and stay in touch with social life of Kilmacow in this traditional Irish fashion!

Sister Noreen with Mrs. May Dowling

Even those who are unable to go out to the village can experience the 'buzz' of life around Rosedale. The parish primary school is located right at the entrance. You can hear the children at play. And you can join parishioners for the many activities in the Parish Hall adjoining the grounds. One of the parish Sunday Masses is celebrated in the Day Care Centre at Rosedale which brings the village community right into the midst of the Rosedale community.

Residents are drawn only from the surrounding area, so they have family and friends who drop in to see them. There is an independent Admissions Committee comprising parochial and medical officers. Each admission is considered on its own merits, with medical assessment. Catering and caring staff are also drawn from the local community which adds its own special warmth. The Management Committee and the MMMs leave no stone unturned to ensure that Rosedale is truly a 'Home from Home'.

View from the kitchen windows of the Sisters' bungalow.

Left: Liam Dalton, Chairman of the Rosedale Management Committee with Sister Noreen Smyth

Below: Happy residents relax in the lounge – while down in the Parish Hall helpers prepare for a coffee morning and bric-a-brac sale to raise funds to maintain the Rosedale flower beds.

Kilmacow Share 2000

Beautiful Rwanda: its people cannot enjoy the natural attractions until a Reconciliation Process has helped them overcome the horrific memories of 1994.

From this… …to this

Like most towns and villages in Ireland, the Kilmacow Millennium Committee had many ideas about projects they would take on to improve local amenities, with matching funds from the National Millennium Committee. But Kilmacow was different – in addition to local needs, it looked beyond its own boundaries and decided to do something to help people more needy than themselves. Several proposals were put forward.

After lenghty consideration the majority favoured a housing project in Kirambi, a small village in Southwest Rwanda. The thread that linked Kilmacow with Kirambi is that MMMs served in both village communities. The project's goal was to provide housing to 21 families identified as being those most in need.

The energetic Millennium Committee that launched the *Kilmacow Share 2000* project was Chaired by Tomás Breathnach. The first big fund-raising event was the sale of 'Light for Rwanda' candles. Local shops and schools in Kilmacow, Kilkenny and Waterford each took a quota. Local radio stations and newspapers were asked for support. On January 30 a Variety Concert was held in the parish hall, involving Macra na Feirme, the boys' school, Kilmacow Foróige, and the set dancers. It received sponsorship from many clubs, local organisations, businesses and individuals. After that there were monthly quiz nights. 'Share 2000 Certificates' were printed for all who contributed. When representatives of the twinned town of Saint-Thurien in France came on a visit to Kilmacow, they too were roped in to help Kirambi!

To date, more than £5,000 has been transferred to the MMMs in Rwanda, where local people were helped by Sister Helen Spragg to organize a group to get the houses built according to local government specifications. The new houses are no mansions! But, a good roof, secure walls and door and a clean floor are a big improvement on having no home at all.

In Rwanda, Sr. Helen Spragg works with the local housing committee. Below: Tomás Breathnach and Mary Walsh of the Kilmacow Share 2000 Committee.

When shall we three meet again…?

Before going their separate ways, three very European MMMs posed for a picture at our Motherhouse in Ireland. Half a lifetime may pass before their paths cross again, if even then. Sister Irene Balzan (left) from Malta, has been missioned to Nigeria, where she is busily working as nurse and midwife in St. Mary's Hospital, at Urua Akpan. Sister Geneviève van Waesberghe, (centre), was born to Dutch parents but brought up in France. She has previously served as a doctor in Tanzania for many years, but went to Rwanda in 1994 in response to the crisis there. Sister Regina Reinart from Germany first came to know MMM in Tanzania where she worked as a lay volunteer laboratory technologist. Now she has been missioned to Brazil. The last we heard, she was on placement with a family in one of Brasilia's satellite cities, to learn the Portuguese language. Very soon, she should be ready to join the other MMMs in São Paulo. But, meet or not, these Sisters will pray for one another every day and stay in touch by e-mail, bonded by their common calling as MMMs.

Rwandans of Tomorrow

By Sister Geneviève van Waesberghe

MMMs were invited into the Diocese of Butare with a specific request to do something for women caught up in the sex trade. The genocide of 1994 contributed to the spread of HIV infection by increasing the number of vulnerable groups, in particular orphans, street children, widows, women whose partners are in prison. This has increased the number of women driven to prostitution in order to survive. It is believed that as many as 83% of women may be in this situation.

RWANDA FILE

- Population: 7.5 million
- 90% of population live in rural hillside area
- 50.9% of population is under 14 years
- 34% of families are headed by women. Many other families by children
- Literacy rate: Men 51.7% Women 44.8%
- Children made orphans by AIDS: 170,000
- Rate of HIV infection between 15 and 25 years: 11% of young women, 5.6% of young men.

Since June 1 this year, when we opened a house for MMM in Butare we have been reflecting and planning, praying, and getting to know our environment. We have been meeting people already engaged or interested in *la lutte contre le SIDA*. We have contacted persons who know women engaged in the sex trade. They have mapped for us the areas where they live. They have told us there are some who have expressed the wish to meet with us in their own time and in private. We must be patient. But we hope that eventually some of these women will become members of our team. Soon we will make ourselves known to the police and explain to them our objectives.

This delay has, in fact, helped us to look at the prevention of prostitution among young women at high risk. Some of these young women have been referred to us by the staff of Street Children Shelters. We are currently accompanying nine of them, helping them to find ways to a better and more stable way of life.

Most orphans and young single parents have known the fear of dying. They have been separated from their families and lost family members and friends. Others have been victims of various forms of abuse. Some have lost their homes. Others have no land to cultivate.

We have been able to help some of these to rent a small parcel of land to cultivate, as the rainy season is near. We are also helping others who have been evicted from their shelter to build a small mud brick house – groups of mud houses are mushrooming everywhere to accommodate the homeless.

Each day, walking the streets of Butare has enabled us to befriend some of the Street Children. They are mainly boys. But we have met a few girls, like Pelagia and Francine – who carries a baby on her back. They are often found outside the main hotels. We have listened to their sad stories and often stop to chat with them. We have promised that one day we will help them to re-visit the 'colline' from which they were forced to flee to the city. The Street Children – numbering more than 6000 – are often referred to as *Rwanda rw'ejo* or 'Rwandans of Tomorrow'. Our challenge is to help them to be able to reintegrate into society, through a little help and loving support.

As part of our preparation, we have gone to Kigali, to participate in workshops on Street Children and Children Heads of Families. We visited three social centres there that welcome women in the sex trade and we spent time at the Polyclinique of Hope, a center for women who are victims of violence.

By September, we felt ready to offer two workshops on HIV/AIDS. For this we were happy to welcome two experienced counsellors from Kitovu Hospital in Uganda, Jean Bosco Mulinzi and Immaculate Mbalusha. We had 20 participants in each of these workshops.

Our plans for the future are to find a suitable center to welcome our clients for counselling, medical advice, alternative therapies. We also envisage an outreach programme with three main activities: the promotion of behaviour change, the formation of volunteer carers for HIV/AIDS patients at home, and a mobile team to supervise home care and give support to the carers.

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