

Healing & Development

2010 Edition

Yearbook of the Medical
Missionaries of Mary

INSIDE
THIS ISSUE . . .

NIGERIA



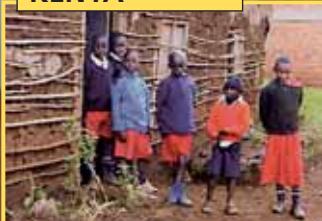
USA



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KENYA



ASSOCIATES



ENGLAND



Medical Missionaries of Mary:

Founded in Nigeria in 1937 by Dublin-born Mother Mary Martin, to-day MMMs number 400 Sisters, who come from eighteen different countries, and a growing number of men and women from ten countries who are Associate Members. 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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Paths that are new

Dear Readers,

Our Constitutions present us with a daily challenge where it is written: 'Today is a new day, be ready to walk in paths that are new'.

This invitation was before us all through our recent Congregational Chapter, as we committed ourselves once again to our mission of bringing healthcare to the poor and suffering of the world.

You will see from the following pages how we meet people affected by HIV and AIDS. In fact, one-third of our Yearbook is devoted to the wide range of services and skills that are required to face up to this challenge. There is still a lot of stigma around the disease. Because of the infection many are shunned by their families. Because of the stigma, many women refuse to be tested, while many men refuse to believe anything they are told about the disease or how it could be prevented. Many children of such parents are born with HIV and without treatment these children will die.



Some say the struggle against the disease is hopeless but it is not. Many of our Sisters and staff are educators and health care workers fighting to halt the disease through truth telling campaigns that are unafraid to shock. These efforts make a big difference.

Another major issue we face is water. This precious commodity is becoming scarcer at a global level.

The poor are the ones who suffer most. Water shortages can mean long walks to fetch it, high prices to buy it, food insecurity and disease from drinking dirty water. Our story from Rwanda, included here, gives an idea of what can be done with a little help.

Extreme poverty is a prison in which too many people are sentenced for life. Helping them to escape is not simple but we have learned that progress can be made through a combination of teaching more, expecting more, giving more, empowering more women and men and developing more equitable guidelines for employment, investment and trade globally.

Mission Statement

*As Medical Missionaries of Mary
in a world deeply and violently divided
we are women on fire with the
healing love of God.*

*Engaging our own pain and vulnerability
we go to peoples of different cultures
where human needs are greatest.*

*Our belief in the inter-relatedness
of God's creation
urges us to embrace holistic healing
and to work for
reconciliation, justice and peace.*

I send my special thanks and prayers to you – our friends and donors – for making it possible for our Sisters and Associate members, our staff and volunteers to provide a quality healing service to those most in need. With your help we pledge ourselves to continue this service with compassion and commitment.

Sister Siobhán
Congregational Leader



The Ambassador of

IN ADDIS ABABA, the smallest administrative area of the city is called a Kebele. Many of these areas are characterised by a high level of violence, drug abuse, and commercial sex. Because this can be a dangerous area for our field workers to enter on their own, we have trained several of the mothers of children with disabilities to assist them, since these mothers know the area well. Sintayeho, pictured here with her handicapped son Dagmawi, wants other children with disabilities to have the same advantages as her child. She has been so effective in promoting the benefits of Community Based Rehabilitation that she is called 'the Ambassador of Kebele 17'

Fantu's Story

THE LITTLE ORPHAN GIRL we know as Fantu was four years of age when we met her, just a year ago. She was very thin and unhappy and could not move well. She was always crying and would not make friends.

Our field workers in the Department for Children with Disabilities began working with her, playing and showing affection for her. After some days she began to respond. Gradually she would initiate the play herself, and began relating with them.

We discovered that Fantu was HIV positive. Soon after we got her started on treatment for this, she began to walk, and stand, and sit by herself. Before long she was communicating

well with all the other children and adults caring for her.

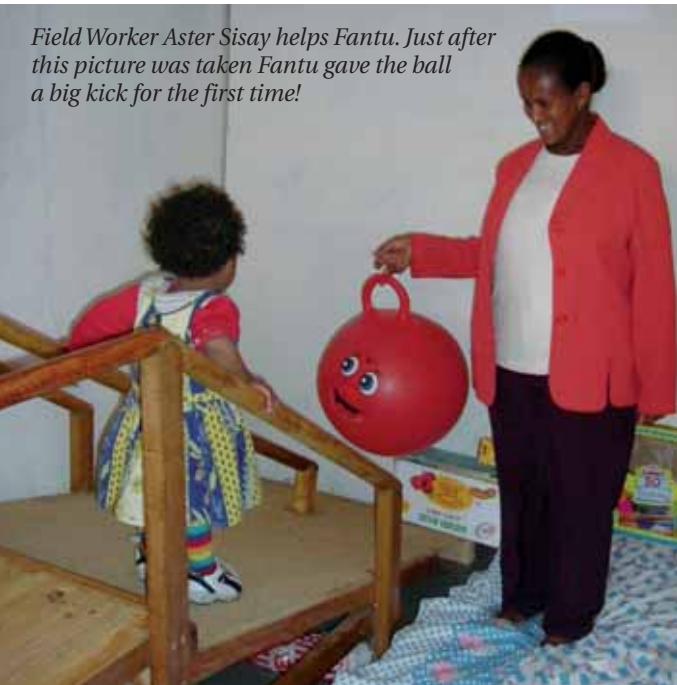
The parents of many children with disabilities have to travel long distances within Addis Ababa to access physiotherapy services. Since most of them have to use public transport and the children need treatment several days a week, it is expensive and time-consuming. The Franciscan Sisters of the Heart of Jesus run an orphanage near our Counseling Center. Some of the children they care for are also living with disabilities. We asked the Sisters if we could have a small room on their compound where children from our Community Based Rehabilitation Department (CBR) could have physiotherapy on a regular basis. We would also give treatment to children from the orphanage.

We collected equipment for the room, including a floor mat, a cerebral palsy chair, and toys. A visitor from Canada donated an exercise ball. We put in wooden stairs with parallel bars.

The physiotherapy room was opened in February 2008 and much wonderful work is being done in a very small space with simple equipment.

In addition to rehabilitation services for children, a major contribution of the CBR Department has been in meeting the needs of disabled people in relation to HIV. Our staff provide information about HIV to parents, children, teachers and the wider community. They give awareness through sign language to hearing-impaired children and have produced four books in Braille about different HIV-related topics.

Field Worker Aster Sisay helps Fantu. Just after this picture was taken Fantu gave the ball a big kick for the first time!



Fikerte Bekele, Coordinator of the CBR Department, and Alemu Haile, Assistant Coordinator.



Addis Malede, Field Worker.

Kebele 17

By Sister Carol Breslin

Nahom's Story



Nahom with his mother and a physiotherapist at Cheshire Services Ethiopia. He is having an adjustment made to his appliance. Parents are directly involved in the treatment of their children.

NAHOM IS SEVEN YEARS OLD. His father was a driver and his mother a housekeeper. He is their only child. When he was a year old, his mother realized that her child was not standing or walking. She took him to a hospital in Addis Ababa and the doctors told her that Nahom could not be treated in Ethiopia. They said that if the parents had money he could be referred to South Africa and they gave her a referral letter. His basic problem is a progressive deformity of his left ankle joint and his left foot is

smaller than his right foot. This has been a problem since he was born.

At this point, through Honey Kindergarten, Nahom's mother was introduced to the MMM Counseling and Social Services Center, where we have a special department dedicated to community-based rehabilitation.

Our staff visited the family at home to obtain background information and told them about our activities. They assigned a field worker to do exercises with Nahom at home three days a week. They also referred the little boy to ALERT (All Africa Leprosy and Rehabilitation Training Center). Dr. Solomon at ALERT then referred him to Cheshire Services Ethiopia where

he had an adjustable plastic brace made. He is now able to walk, run, and play with other children.

Sadly, when Nahom was 5 years old, his father died. His mother needed to do training to support herself. We arranged for her to do a course at the Catholic Archdiocesan Women's Promotion Center. She obtained a certificate in housekeeping and food preparation and she is now working at a bakery. Nahom is in second grade at Kidane Meheret Catholic School. He is doing well in his studies.

As this story shows, many organizations working together helped Nahom and his mother to have a happy and normal life.

The Burden of HIV/AIDS is for all of us to carry

by Connie O'Halloran, Irish Volunteer
and Administrator of the Faraja Centre.



Lake Singida, Tanzania

ALL THE VOLUNTEERS working with us here in Singida are driven by the mission of helping others. As one put it simply 'The burden of HIV/AIDS is for all of us to carry'.

Many volunteers are drawn to the work because they themselves are HIV positive. Those who are, can boost the morale of clients by being robust and active exemplars of life with HIV and by sharing their own experiences with HIV testing, disclosure of their status, and adherence to anti-retroviral drugs. Others became volunteers because of their experience with HIV-positive family members and friends and their awareness of their need for

Home Based Care. (HBC) Others have received prior training in nursing and HBC and want to apply their skills. When we asked what keeps them doing the work, volunteers responded: 'I feel proud and good about what I do.' 'I am accepted by the community.' 'I am happy about the skills the programme has given me.' 'It has allowed me to go to the community and sensitize them.' 'My clients are like my family, it becomes a joy to meet them.'

It is almost a year now since the Faraja Centre in Singida first introduced the HBC Programme to Singida. We did this in co-operation with a local agency known as Tunajali. Working in partnership with local Government, we first identified and selected twenty-five volunteers from the community and one Focal Person from the Faraja team.

THE FARAJA CENTRE GETS ITS NAME FROM THE SWAHILI WORD FOR 'CONSOLATION'.

As we rolled out the Programme, HBC training enabled the volunteers to acquire new skills which they use to care for their patients and communities. Currently we are reaching 400 people living with HIV on a weekly basis. Faraja is giving HBC services and palliative care, to cover interventions from diagnosis to the end of life care stage. We also assist with Voluntary Counselling and Testing and refer clients to the Care and Treatment Centre or to the Prevention of Transmission from Mother-to-Child.

Another important aspect of our work is providing opportunistic infection prevention therapies. We also provide nutrition education. An important component of our work is in the area of psychological coping – providing support mechanisms for positive living and education on stigma and discrimination.



Women doing HIV/AIDS education through drama.



Presentation of bicycles to Volunteers in Home Based Care Programme

COLLABORATION

Planning support for surviving children and dependants is very important. Clients need help with writing their will, understanding inheritance rights etc. During the past year more than 200 people were assisted in this way. The Tanzanian Women Lawyers' Association (TAWLA) offered to provide legal witness to the wills of people living with HIV free of charge.

Medical services are provided at symptomatic stages, when pain management is needed it is also included. We refer clients to the Care and Treatment Centre for symptom deterioration from opportunistic infections, assessment for anti-retroviral treatment eligibility, drug side effects and other adherence issues. We have identified family caregivers who have become treatment assistants.



Sister Marin Scena from Denver, Colorado, is the MMM doctor responsible for the Medical Services at Faraja.

At the end of life, nursing care is provided through the trained and highly motivated volunteers with family members. The trained supervisor and volunteers provide bereavement counselling and support to the extended family members during the loss of their loved ones.

SUPPORT GROUPS

The Faraja Centre provides support groups for people living with HIV/AIDS. These groups are very popular as they offer members the chance to have:

- Peer support – an opportunity to meet other people living with HIV/AIDS, share experiences and meet in a supportive environment;
- Culturally and linguistically appropriate emotional support in a safe space;
- Information about treatment, health services, pregnancy and parenting, legal issues, gender related issues, advocacy and volunteering opportunities;
- Opportunity to learn new skills through volunteering and giving awareness raising seminars.

The Faraja ethos is expressed in our general attitude to all who seek our assistance. We see and support people regardless of their age, gender, ethnicity or religious beliefs. This ethos extends to clients, service users,



With the sponsorship of the Faraja Centre, Fatuma Jumanne has completed a degree in Sociology and now works in the centre as a Social Worker, working closely with our Counsellors and Medical Staff at Faraja.



Sister Mary Friel from Croy, Scotland with Paul Kasiani, who is responsible for our Security.



Sister Mbuotidem from Nigeria is the latest MMM to join the Faraja Team.

volunteers, staff and the community. A lady receiving Home Based Care from one of our volunteers told us: 'This programme has to continue. My husband and I need such love and care so much.'



Caring for 1,401 Children

By Sister Emelda Ukaumunna

IN KENYA over the past three or four years, HIV/AIDS prevalence rates have shown a marginal decrease, from 6.1% in 2004, 5.9% in 2005 to 5.1% in 2006. However, in our geographical coverage – Kapsoya and Chepkoilel to the east of Eldoret and Rift Valley Province – hundreds of children are still being infected with the virus at birth. We are fighting this through our Prevention of Mother to Child Transmission (PMTCT) Programme.



Orphan group in family at homestead provided for them from galvanized sheets.

The majority of young people are sexually active. This is compounded by financial stress that forces them to engage in high risk sexual behaviour, which leads to the spread of HIV/AIDS and sexually transmitted infection. And, of course, it leaves a community faced with the care of hundreds of Orphans and Vulnerable Children.

Many children whose parents have died of AIDS lack the basic necessities for survival. They are kept out of school to care for the sick and help

support the family businesses or farm work. The little income earned through petty trading – roasting of maize, selling of charcoal, vegetables and fruits – and casual jobs is spent on treatment and funerals, leaving little or nothing to support the family. Teenagers, especially girls, need a lot of support. They are more vulnerable to early pregnancy and sexually transmitted infections.

The families that we care for tend to live in a one roomed rented mud house. Children of all ages share



Munyaka primary school.

the same sleeping space, mat and blanket. This causes both boys and girls to leave the family early.

At the time of writing, St. Mary's Medical Centre has 1,401 orphans and vulnerable children needing support. The majority of these children are attending Nursery and Primary Schools. While Primary Education is free, a child cannot gain entry to a Primary School without having attended a Nursery School, and that education is not free.

Despite the free Primary Education, the cost of items such as uniforms is considerable. We provide uniforms for all the surrounding schools. The cost of learning materials, shoes, school bags and food means that the majority of poor children are not able to attend school. For those who have lost their parents or have one or both parents infected and ailing from HIV, benefiting from such school facilities as are available becomes even more difficult.

Depending on the circumstances surrounding their families and their capacity, some orphans and vulnerable children are enrolled by our programme in private primary schools to enable them concentrate and develop some sense of discipline.



After sixteen years administering the orphan support programme in Kitale, Sister Teresa Hogan has now joined the MMM team in Eldoret, as advisor to the Social Care Department.

DEDICATED STAFF

We four MMM Sisters could achieve very little were it not for our twenty-three fulltime staff, who are exceptionally dedicated. As well as those staffing the Medical Centre, there is a team of

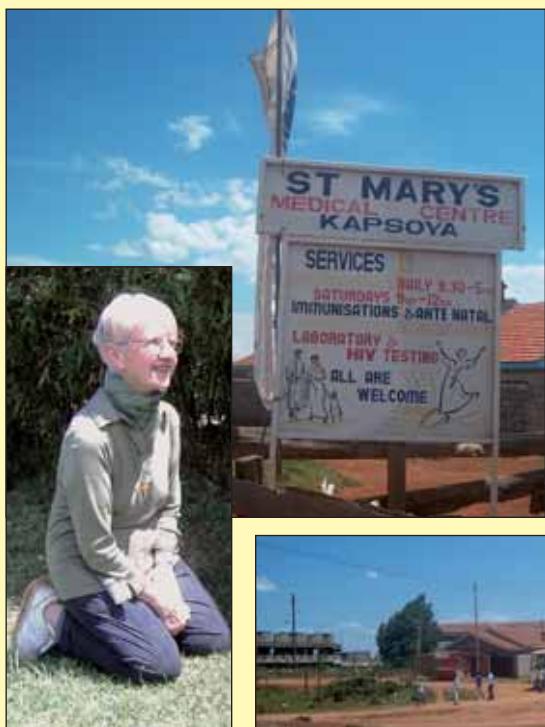
people responsible for Voluntary Testing and Counselling (VCT) so that people can know their HIV status.

Critical in the care of orphans and vulnerable children, are our Social Workers and Field Workers. Having

done the home assessments, members of this team identify suitable Nursery Schools in the community and make arrangements for the child's admission. To follow up the enrolment process and progress of the children, the assigned Social Worker or Field Officer will visit the children under their care in school and at their home once a week during term, and at

Continued overleaf

St Mary's Medical Centre was established as a Dispensary and registered with the Ministry of Health in November 2002. The services we offer are affordable preventive, diagnostic and curative health care and to identify and support families infected and affected by HIV/AIDS.



Sister Patricia Hoey established St. Mary's Medical Centre in 2002.

OBJECTIVES

- To provide quality basic medical and holistic care to the sick.
- To provide holistic healing to infected/affected families through provision of medical, social, spiritual, emotional and psychological support.
- To sensitize the community through creation of awareness on the cause, mode of transmission, signs/symptoms and disease progression of HIV infection.
- To reduce stigma and discrimination through AIDS education and education for life process workshops/seminars, thereby encouraging positive living.
- To provide care, assistance and educational support to orphans and vulnerable children.
- To empower the community through active participation and ongoing education in the care of children.
- To empower the communities in Kapsoya and Chepkoilel locations to enable the households to become independent and self reliant.
- To promote self-sustainability of families to care for their children.





Sister Emelda speaking at Youth Education Day



Orphan support provides uniforms for all

weekends during the holidays. In this way each child has an opportunity to share with the staff whatever they wish. Our team members also meet with the Head Teacher in each school and communicate to him or her issues that the children may have raised.

With so many vulnerable children in the area, we have to have some limits on who can be taken into our programme. Our service reaches to 10 villages within two main locations – Kapsoya and Chepkoiel. The only children we enrol are those of our deceased patients who have no relatives to support them, or those

OUR VISION

That Kapsoya and its environs will be equipped with quality basic medical services and holistic care provided for families infected and affected by HIV/AIDS Pandemic.

who have one or both parents still alive but very sickly.

Where children have no parents, or where parents are ill, weekend and holiday activities are very important. This too falls to the responsibility of our Social Care Team.

ENJOYMENT WITH EDUCATION

Weekend and holiday activities are designed to be enjoyable. They also aim to be educational, and provide emotional and psychological support, especially for the teenage group. On these days young people are given health talks and also provided with knowledge on prevention of HIV & AIDS. Counselling is also given to those who need it. The teenagers have been divided into three groups

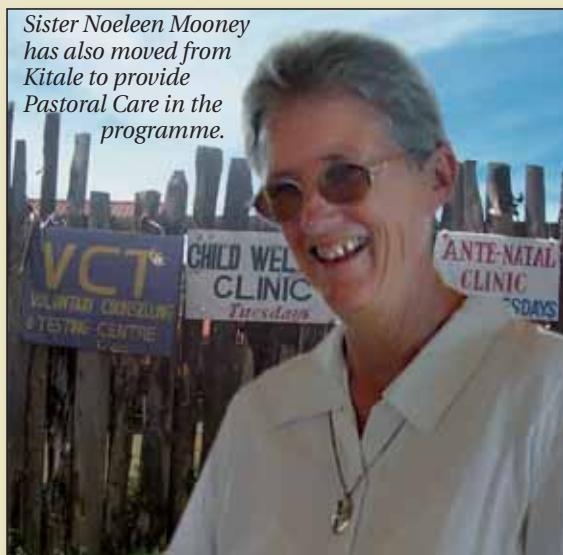
of thirty. Each group meets once a month for the Weekend Programme.

We are hoping that in the coming year we will have enough funds to give each group one educational visit to another Institution where they would learn and share ideas. This will include talent development and creativity by organizing ball games, songs, poems and drama.

We propose to take ninety teenagers to the National Trade Fair to be held at the Eldoret Show Ground. The final day of the Trade Fair is geared towards youth empowerment, horticulture and agro-farming. This is a good exposure for our young people as well as an opportunity to interact with others.

Then there is the Christmas celebration at St. Mary's Medical Centre. The children just love this. They learn to do face painting, play games, sing and interact with one another so as to create a sense of joy, togetherness and increased self-esteem. For that

Sister Noeleen Mooney has also moved from Kitale to provide Pastoral Care in the programme.





WHAT DOES IT COST?

<i>Here are just a few items from the 2010 Budget</i>	US\$
Nursery school fees, per orphan for academic year	60
Nursery school uniform, per orphan	19
Primary school uniform, school bag, shoes, per orphan	55
Secondary school fees, per student for academic year	479
Vocational training courses, per student	600
Essential school supplies and toiletries, per student per year	1,620
Trip to National Trade Fair for 90 teenagers	634
Weekend Educational Trips for 90 teenagers, per trip	543
Christmas Party, prizes and gifts for each child	5,436
Birth Certificate Fees for 300 orphans	682
Affidavits for 300 orphans	2,040

the local schools

day the children themselves organise various activities. Small motivational gifts are given to encourage talent development. But no child will leave empty-handed. Each will be given a Christmas basket of assorted items – biscuits, sweets, balloons, sugar, cooking fat, rice, Vaseline, biros and soap.

LEGAL SUPPORT AND DISENGAGEMENT

Another important aspect of our child protection is ensuring they have essential legal documents. Some are without Birth Certificates and some are without the Death Certificate of a Parent. The Social Workers and Field Officers facilitate their application of late birth registration through the Chief's Office and also advise single parents and child-headed households regarding affidavits. They are assisted with payment of registration fees. Ailing parents are encouraged and supported to write wills for their children.

The final step in the cycle of care of orphans and vulnerable children is what we call disengagement. This includes ensuring that the young person, who by now has hopefully acquired some income-generating

skills, has the basic equipment necessary to set up a successful trade. After that, our Field Officers and Social Workers provide continuous

monitoring visits to ensure that the graduates are doing well in their business and that assistance is offered to their families where needed.



Group of Social Workers and Field Workers



Group of VCT Counsellors

HIV is an ongoing learning process

Sister Felicia Muoneke, the MMM doctor responsible for co-ordinating our response to AIDS in West Africa reports from Lagos.

SINCE THE RETURN OF DEMOCRACY to Nigeria in 1999, there has been a serious national effort to tackle HIV and AIDS. The latest available UNAIDS report places the prevalence of HIV nationwide at 3.1%, which appears low in comparison with other African countries. Yet, Nigeria ranks third in the world in terms of the number of people infected with HIV (after India and South Africa). The Federal Ministry of Health highlights a wide variance in HIV infection levels across its thirty-six States. Thirteen States have a prevalence of over 5%, and in Cross River State it is as high as 12%.



Felicia and Anastasia at table with laboratory tubes

ACCESS TO TREATMENT

It remains a major challenge to provide access to treatment. It is reported by the Nigeria National Response Information Management System for HIV/AIDS, that only 16.67% of adults and children with advanced HIV infection are receiving anti-retroviral treatment. Of HIV-positive pregnant women, only 5.5% are able to access

treatment to reduce risk of Mother-to-Child transmission (PMTCT).

This is very worrying when compared with Nigeria's smaller neighbour, the Republic of Benin, where 57.75% of adults and children with advanced HIV infection receive ART, and 54.32% of HIV-positive pregnant women have access to drugs under the PMTCT programme.

While Government agencies are working hard to improve this situation, MMMs in Nigeria have also been engaged in an internal analysis with a view to increasing our response to addressing these problems.

The intensity of activity varies from project to project, but all our units are implementing a range of prevention, care and support initiatives.

WORKSHOPS

A series of Workshops has taken place for MMM Sisters and staff. Time for discussion and reflection on the problems included a listing of the strengths, limitations, opportunities and constraints around these services. Developing an extended strategic plan has proved to be an ongoing learning process for us, resulting in a more cohesive approach to the MMM response to HIV and AIDS in Nigeria.

One of the great strengths identified in a fairly long list of indicators, it was affirmed that MMM teams have a positive attitude to clients. However, among an equally long list of limitations it was acknowledged that we have a difficulty in maintaining skilled staff due to high competition from other NGOs and Government, who may be able to pay more attractive salaries.

Among the opportunities, it was seen that MMM's experience in other countries is a great resource. Among the strategies in the current five-year plan it is hoped to exploit the expertise of MMM personnel in other parts of the world to strengthen our capacity in Nigeria.

NON-DISCRIMINATORY ENVIRONMENT

Among the priorities in the MMM holistic package of prevention, care, treatment and support, it was resolved to maintain an educated, empathetic team of Sisters, staff and volunteers who have up to date knowledge and understanding of HIV and AIDS.

People Living with HIV/AIDS (PLWAs) are seen as key actors in education for prevention programmes. Where pos-

sible, they will also be included as staff members and volunteer teams. Supporting PLWAs includes training peer group support counsellors, establishing support units, empowering them to become self reliant and educating communities to reduce stigma.

At the same time, keeping up-to-date on universal precautions procedures is seen as essential. Clarifying our policies and procedures in relation to post exposure prophylaxis is included in our priorities, and monitoring compliance in this area.

GENDER

Our yearly analysis of our response to HIV, highlights the issue of gender inequality. Other cultural constraints including witchcraft, harmful traditional practices, and stigma and denial are also concerns.

A priority goal in our strategic approach is to mainstream gender throughout all our responses to HIV and AIDS. This means we have to develop closer links with gender promoter groups, learn from their expertise and provide training for Sisters and staff members on gender related issues. It means exploring with community groups, both male and female, gender related local traditions and practices which are impacting negatively in the HIV/AIDS crisis.



Sister Eunice Okobia with poster about AIDS

It also means bringing the awareness of the gender dimension of HIV and AIDS to the wider Church through the 'Education for Life' teams in each parish.

Ensuring a gender balance among staff and volunteer teams is also a priority.

CAPACITY BUILDING

To maximise the potential of MMM team members involves the ongoing review of strengths and limitations and identifying learning needs. It is necessary to develop annual capacity building timetables to minimise disruption to ongoing work schedules.

At the same time, it is important to enable more experienced team

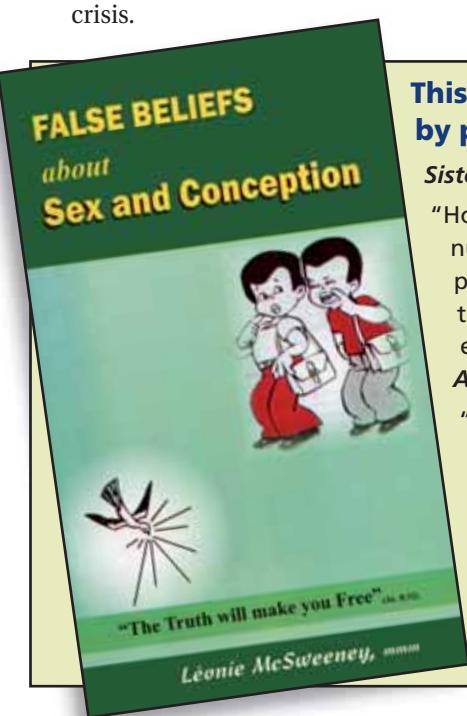
members to share their expertise with others. The challenging nature of this work is recognised, and it is seen as important to provide supportive supervision and counselling where necessary.

The dimension of providing pastoral care is also important. This involves training of pastoral carers for those who are terminally ill, and counsellors for families. It also means providing basic needs for medical and spiritual support to the dying. This involves the training of volunteers and the formation of Home Based Care teams.

COORDINATION CENTRE

With the assistance of the Irish Government through its embassy in Abuja, funding was secured to develop an MMM Co-ordination Centre for HIV/AIDS in the district of Agege in Lagos. As well as providing a service for people with HIV and AIDS, it will enable us to better monitor our interventions, keep us in focus and up to date with the rest of the world, and provide capacity building experiences for our Sisters and staff in matters concerning HIV and AIDS.

When blessing this new foundation in June 2009, the Archbishop of Lagos, Cardinal Okogie, encouraged us to make personal and community prayer a priority so that we may persevere in this ministry 'where many people are afraid to go'.



This booklet has been published by popular request in Nigeria.

Sister Leonie says:

"Hopefully, discovering the truth about a number of false beliefs will relieve many people of unnecessary fears and anxiety that often lead to unhappiness and even dangerous trouble."

Ambassador Magazine has said:

"This latest contribution of Dr. McSweeney to promote happy family life will be warmly welcomed by pre-marriage counsellors, youth leaders, catechists and others involved in guiding people at different levels. Their efforts to clarify misunderstandings and false beliefs will be greatly facilitated."

HIV is a very complicated business

By Sister Brigid Corrigan

MANY OF US who have been involved in anti-retroviral treatment programmes (ART) feel a need to balance our work with a renewed emphasis on prevention of this disease. The hard fact is that even the best treatment programme in the world cannot cope with all the new infections occurring annually.

There have been enormous strides in ART programmes throughout the world. But treatment regimens demand high pill burdens and continuous supplies of medicines. This makes countries dependent on outside resources.

Then there is the fact that strict adherence to the treatment plan is essential. Where the population is widely scattered the logistics of this can be difficult. In the Kitovu Mobile AIDS programme in Uganda where I am working, over 4000 HIV-positive people are being cared for, many living in distant villages.

ASSESSMENT

All these people have to be assessed for eligibility for ART. This assessment has two aspects. Clinically we have to stage the severity of the illness according to the WHO classification 1–4. Those who are classified as belonging to stages 3 and 4 are declared eligible for ART.

The second aspect is assessment by the client's immune status. CD4 is the name given to a particular white cell which is responsible for maintaining a person's ability to fight disease. In a healthy person this count would be about 1,000. In the natural history of HIV, this count is expected to fall. When it reaches 250, the person is eligible for ART. In fact, WHO has recently raised the level of CD4 eligibility to 350, but most people will not have access to ART at this CD4 level due to limitations on the services available.

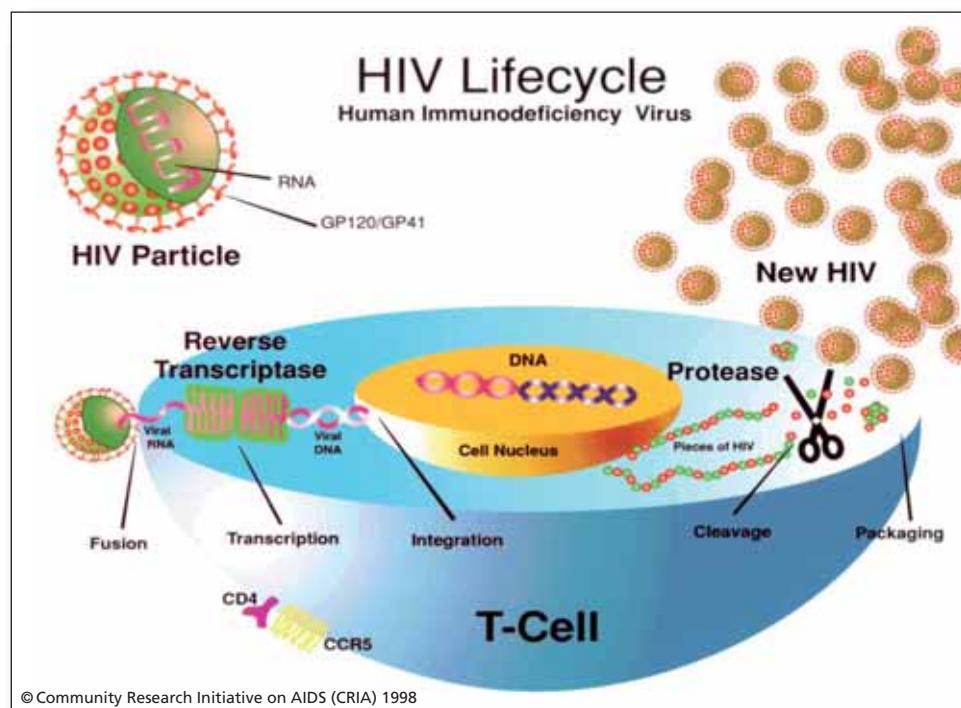
INHIBITORS

In essence, ART regimens involve the use of a combination of drugs acting at different points in the life cycle of the virus. What you are doing is slowing down the rate of replication of the virus. Instead of millions of viruses coming out of a cell, only a few will escape and this reduces the level of the virus in the body. By doing this it restores the CD4 count, and the person's immunity level goes up.

So that clients can fight diseases and do not progress to develop AIDS, the first line regimen utilizes two nucleoside reverse transcriptase inhibitors (which we call NRTI and NNRTI) and one non-nucleoside reverse transcriptase inhibitor. These drugs interfere with the enzyme which is responsible for enabling the RNA of the HIV to become DNA, which would then enter the nucleus of CD4 cells and become integrated there.

Once that happens, replication of the virus ensues within the CD4 cell. The new virus particles are extruded from the CD4 cell with the assistance of the enzyme protease.

It is at this point that the second line drugs – protease inhibitors – work, disabling this final step in the replication process of the virus. In this way fewer copies are available to enter and destroy other CD4 cells.



SIDE EFFECTS

All the drugs have their own particular side effects and these can be early or late, mild or severe.

Nausea, abdominal discomfort and mild body rashes are often experienced in the beginning of treatment. Peripheral neuropathies are also common. More worrying effects are the severe reactions to nevirapine presenting with extensive skin lesions with involvement of the mouth and mucous membranes. Liver toxicity is also a serious complication of nevirapine and other ARVs and so needs careful monitoring. Anaemia from AZT is one of the common and serious side effects we are seeing and also lipodystrophy.

So management of the ARVs demands close and careful clinical monitoring, also knowledge about when to change drugs and institute new regimens, as our treatment options are limited.

Once you are told that you are eligible for ART, first of all you have to learn a lot about it, to understand why you have to take these drugs regularly every day for the rest of your life. You have to know the complications you need to look out for, the interactions that could occur between these drugs and others you might be taking.



Sister Brigid Corrigan with the Team.

You really have to live a disciplined life when you are taking ARVs.

The best results follow when people understand how the drugs work. We talk of CD4 cells with people in the villages, and they understand that this is a level of their immune status. We have discovered that if you tell a patient their CD4 count is low it is even more upsetting to them than knowing they are HIV positive, because it is a sign they are going down. This can be very distressing, and their reaction usually is 'I am not going to live long'.

But a low CD4 count is their entrance to getting ARV drugs. Usually clients are happy to start on the drugs. They have to go through about three serious education sessions. Logistically this is very difficult for us, as they may live as far away as 70 kms.

KEY TO SUCCESS

The key to successful ART is in careful preparation of the patient, good adherence education, after which the patient knows the danger of missing even one dose.

To help us in this important task, we have developed a group of people whom we call 'expert clients'. These are men and women who are HIV-positive, already on ARVs, and to whom we have given some training. We rely on them to help us with new clients. I can say they are a doctor's absolute right hand. When we have a group of about ten people medically ready for ARVs, we leave them for about two weeks with these 'expert clients', and when we come back they are truly ready and understand the new discipline they will have to follow for the rest of their lives.

But it is not easy! What we experience is if we start a group of 10, all with the same education and willingness, one of them will probably feel sick after the first tablet and won't take any more and might be afraid to take it at home. When we go back, we have to check the number of pills they have left. You will be handed a full box and told 'I was afraid to take it.' But on the whole their adherence is very good. The Government expects us to have greater than a 95% adherence rate. We are blessed by having the help of community workers to strengthen the adherence and I can proudly say that the adherence rate of clients of Kitovu Mobile programme is about 96%.

Continued overleaf



Out of the 4,000 HIV-positive people under the care of Kitovu Mobile, about 950 are now on ARVs. Some of our clients are quite young. Our youngest is about 5. We only have about forty children on ARVs although we are meant to have 10%, but that is not easy in such a rural area as the one we are covering. The ARVs are available in syrup form for children, but our problem is encouraging the grandmothers, who are the usual carers, to bring the children to the centres. Of course, these children surviving with HIV have very likely lost their parents to AIDS.

Our Government provides ARVs free, but we have to provide the infrastructure of staff, transport and many other 'hidden costs' such as material support. We are closely monitored by Ministry of Health Quality Care Advisors. Very strict record keeping on every aspect of ART is demanded of us – patient attendances, procurement, storage and dispensing of the drugs, and close monitoring of the clinical state as well as CD4 counts. Every month we have to report the regimen people are on.

ART has certainly transformed the care and treatment of the person living with HIV. Most of our clients do well. Over 80% of those on ART have a good quality of life and are looking for ways of returning to work. This has prompted us to incorporate an agricultural dimension to our work, for people stabilised on ART. This project has just begun and it is very exciting and hopeful.

TWO SIDES OF ONE COIN

We should indeed see treatment and prevention as two sides of the one coin and renew efforts to reach all the vulnerable people at risk of infection.

In Uganda, the prevalence of HIV has dropped from around 30% in the 1990s to about 6.5%, but it has stuck there. Why does it not drop further? Certainly there is a lot of knowledge in the community about the ways to prevent the spread of HIV, but it is not translated into action.

- It seems that a lot of the 'fire' has gone out of the prevention campaigns.



*Sister Brigid and Sam Waliggo,
leader of the ART Team,
at rural clinic*

- Maybe ART has brought some complacency. Prevention messages often differ depending on who is giving them and they are also received with differing degrees of understanding.
- Many factors are involved in this complexity of human behaviour especially as it
 - touches our sexuality,
 - disrupts family life and is
 - so much bound to the issues of life or death.
- Maybe the ongoing search for a vaccine raises hopes that are unrealistic in resource-poor countries.

These are serious issues, especially with the return to good health of thousands of people on ART. We cannot overlook the fact that all these people have the potential to spread the virus.

STATUS OF WOMEN

Gender is at the heart of HIV prevention. Any improvement in the status of women will improve the prevention campaigns. The place of women in society and their possibility of negotiation in sexual matters is a complex issue. But certainly I think we are called on to advocate for the empowerment of women and to help them get their true place in society, treated with respect and dignity. Subordination of women in the society seems to undermine the best HIV prevention programmes.

Another important step is prevention of the transmission of the virus from Mother to Child. This can be achieved through careful counselling at antenatal clinics, having all pregnant mothers tested for HIV and providing ARVs for the mother and baby. Unfortunately the uptake of these prevention programmes is not as good as we would like.

Most of the spread of HIV is through heterosexual transmission. Therefore prevention of infection will be achieved by remaining faithful in a relationship with an uninfected equally faithful partner who has no other risk behaviour. This is what we advise and what we try to encourage in our prevention education.

But for those who are not yet ready to embrace a way of life that demands serious self-discipline, it is important for them to be given accurate information. They should be advised to reduce the number of sexual partners and know about the correct use of condoms. Male circumcision is also known to reduce the infection rate.

Obviously these messages must be tailored to the persons involved and their situation, bearing in mind that people have a right to full information regarding their life choices, which, sadly, can have bad outcomes.

Young people are seriously advised to delay the age they begin to have sexual relationships. There is good evidence that delaying the first sexual encounter does bring about a significant reduction of HIV infections. It also challenges adults to improve the recreational environment for young people by helping to provide facilities such as sports, clubs, limiting of alcohol, assisting with job opportunities and possibilities for further education.

Safe Blood transfusion and safety in handling infected body fluids in health centres will reduce the spread of HIV through contaminated blood. One important last word is that until most of the population of a country knows their HIV status, we are all somewhat in the dark as to the enormity of the problems and challenges before us.

Palliative Care...

by Sister Carla Simmons

THE WORLD HEALTH ORGANIZATION DEFINES PALLIATIVE CARE as 'an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.' Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Dame Cicely Saunders, the founder of the modern Hospice movement summed up our work.

'Palliative care does not add days to peoples lives, rather, it adds life to their days.'

This is a challenging order for those of us who work in resource limited situations, but as someone recently mentioned at a conference I was attending, 'being resource limited just means that we have to be more resourceful!'

Being resource limited just means that we have to be more resourceful!

Palliative care was introduced to the Kitovu Mobile Programme in August of 2000. Previous to that time, our home care nurses offered excellent supportive care for the thousands of patients that they had seen. But without strong analgesics for pain they often had to see their patients suffer terribly and die in agony. This was terrible for the patients and the nurses and also for the family caring for the patient. In those first years of the AIDS pandemic many of our patients were young adults and their care givers were their children. Imagine a child of eight or nine caring for a mother or father with persistent diarrhoea or the extreme pain of meningitis. It is heartbreaking.

When I started working in the programme, the majority of the patients were our own HIV/AIDS patients – those with diarrhoea, meningitis or shingles, to name only a few conditions. Our nurses were so happy to see how these conditions could be treated and patients became free from pain and mobile again. We couldn't cure patients, nor could we extend their lives, but at least we could ensure that they were comfortable and they died with dignity.

Continued overleaf



Clinic under a tree.

As time passed our patient picture changed. Anti-retroviral drugs became available for our patients and people presented earlier to the programme and many painful conditions were avoided. But at this same time, doctors in the nearby hospitals heard of our services and started sending patients with cancer to us. At first they were HIV-positive patients with associated cancers, i.e. cancer of the cervix and Kaposi sarcoma. But very soon patients with other types of cancer began to be referred. Once we realized that there were many people with cancer, we became concerned about those living deep in the villages who may be suffering silently, not knowing that there was relief for their pain. At this time we started giving workshops to our community volunteers -we have over 700 of them! We told them what palliative care was and what kind of people we could help. They then became one of our primary referral sources sending us friends, neighbors and relatives whom they saw in pain.

In my experience, the majority of patients with cancer fall into four groups. A very small group, who have the education and the finances to seek help early on; those who have seen someone else with the same condition and know that nothing can be done so they just stay at home; those who go to a local clinic or herbalist, get futile treatments and stay at home; and those who actually see a doctor who diagnoses their condition and then tells them to go to the Cancer Institute in Kampala, which they can't afford, so they stay at home too. These are the people that we were trying to find, and our Community Volunteers do a wonderful job sending them to us.

The majority of these patients come to us with advanced cancer. The few that come early, we try to send for chemotherapy and/or radiotherapy and some make a remarkable recovery. These are few and far between though. Most have extensive disease and we do our best to assure that they spend their last days pain free and die with dignity.



Sister Carla Simmons is pictured here prescribing drugs to a patient while taking shade under a tree on one of her home visits. Below: Home Care staff nurses Rose and Resty visit patient with Kaposi sarcoma.



MMM and AMMM in Partnership

Nancy Hinds is an Associate MMM and runs Hinds Hospice in California. Nancy has been a friend of MMM for many years, first coming to know us in Nigeria when she volunteered as a young nurse during the Biafran War. She later came to Uganda with her husband Dr. Godfrey Hinds who was working in our hospital in Kitovu. When Dr. Godfrey died of Cancer, leaving Nancy with a young family, she began caring for cancer patients in her own home in California. This grew into Hinds Hospice in Fresno California. (see: www.hindshospice.org). In 2004 Nancy attended an MMM AIDS conference held in Nairobi and came to visit us in Uganda. This began her friendship with our Palliative Care Programme. Since that time, Nancy has been supplying us with medication that is not available here in Uganda. In 2008, I was invited to Fresno to address a Palliative Care Conference that Nancy had arranged. At this time, I was able to visit Hinds Hospice and meet many of the staff. Following on this, in 2009, under the auspices of the Foundation for Hospices in Sub-Saharan Africa, Kitovu Mobile Palliative Care and Hinds Hospice became official Partners. We look forward to expanding this partnership in the future.

Hello to tomorrow

In 2010 Angola is host to the African Cup of Nations. There are great preparations at the stadium in the University City in Luanda and those at Benguela, Cabinda and Lubango. Hotels are gearing up for the influx of visitors. The memories of war are giving way to a new Angola.

There is new life for MMM in Angola too. Five new Associate Members made their Covenant in Chiulo during the past year, adding to the four AMMMs already in Lubango.

At Viana, on the outskirts of Luanda, the Sisters are still awaiting a permanent supply of electricity. The points for the electrical appliances and plumbing are all fixed, but the builders are short of materials, which demands great patience. Meanwhile they use diesel to run a small generator after dark. Angolan-born MMM, Sister Josefina, attends the University in Luanda, leaving the house at Viana each morning at 6 a.m., she has to take five different local taxis to get to College, returning home late each evening.

Nigerian-born Sister Rosemary Akpa who is MMM Business Administrator at Viana says it also takes patience to get documents for everything! The process of registration for the new vehicle for the Health Centre is taking forever. 'I prefer to call these things challenges', she says.

They would like to see the Sisters' house completed because 'the Annex where we are living now is not too wonderful'.



Sister Brigid Archbold

Meanwhile, in the city of Huambo, a day's journey away, the Sisters provide a health service in the parish of São Luis. In addition to nursing, Sister Brigid Archbold, veteran missionary from Ireland, helps young girls to develop skills in needlework as a help to income generation in the future.

Sister Jacinta Akonaay from Tanzania has been in Angola for several years. She says: 'We have a sense of joy and fulfilment as we serve the needs of the patients that we see in our clinic every day and our mobile clinics once every Thursday. As well as health care we do food distribution to the elderly. In the schools we do education for prevention of HIV/AIDS and sexually transmitted diseases. Our wonderful staff work hand in hand with us to see to the needs of the marginalised in our society. The ministry of Health in Huambo collaborates with us, providing drugs and diesel for our mobile clinics.'



Sister Jacinta Akonaay in the clinic

The MMM Central Leadership Team understands the challenges and the potential of our healing mission in Angola. Two more Sisters have been assigned and are awaiting visas. Sister Therese McDonough from USA has already spent many years on mission in Brazil so speaks Portuguese



Sister Therese McDonough

fluently, the official and widely spoken language of Angola. She says: 'This new assignment is rekindling my missionary vocation. I almost feel like I did when I was assigned to Brazil back in 1979. I am more realistic about my strengths and limitations but I do feel a great excitement welling up within and for this I offer gratitude. I have a sense of who my community will be a small, vibrant, young and hope-filled group of women who stand on the shoulders of other MMM who, in the footsteps of Jesus, went about curing the sick, comforting the downhearted, teaching, and empowering others to live to their fullest potential'.

Also awaiting a Visa is Nigerian-born Sister Alice Ashitebe. She is pictured below during an earlier missionary assignment, crossing the Kaduna River to reach an outstation in northern Nigeria. Sister Alice will bring invaluable experience to the MMM community in Angola who hail from six different nations.



Years of war disrupted life for the people of Angola from 1975 until 2002. Through it all the Sisters remained, giving the best service possible as one victorious side after another took over the area. Today the guns are silent. Together with the people of Angola, MMMs look forward now to a period of steady growth.



Sister JoAnne Kelly with her niece, Adele Doherty and baby Matthew.



The celebration of Golden Jubilees was a great occasion for a family reunion. Ten Sisters who served in Angola, Ethiopia, Italy, Kenya, Nigeria, Tanzania, Uganda, the Czech Republic and USA, gathered for a Mass and Reception to mark the fifty years each of them has spent on Mission.



Sister JoAnne with her brother, Fr. Terence.



Ita McCormack, niece of Sister JoAnne, with husband Martin, and twins Finbarr and Fergal.



Frank Shephard did the first reading at the Jubilee Mass.



Sister Davnet O'Kane, with her brother Fr. Seamus.



Sandra and Saoirse O'Kane.



Sister Davnet with former colleagues Gerry McDonnell, Dick O'Reilly and Georgina Clarke.



Aylish Quin, Teresa Carroll, Ann Lucas, Pauline Beggan, Joe McElvanna



Patsy and Al Dillon, Sean McElvanna, Sister Mairead Gorman, Teresa, Ita & Frankie McElvanna



Susan Clegg, niece of Sister Davnet, with her husband Paul and twins Emily and Katie.



Sister Patricia O'Kane with her nephew, Stephen.



Sister Patricia O'Kane with friends Patsy Gilmore and Florrie Williams



Sister Marguerite Killion with her niece Marguerite Geoghean and her daughter Emily.



Sister Teresa Hogan with her niece
Jacinta Daly.



Sister Jacinta Roche with nieces Jacinta,
Helen, Edel and Lucy.



Nieces of Sister Jacinta, Anne Sinnott and
Elizabeth Whelan.



Sister Teresa Hogan and family including grand-nephews James and Keith Murphy.



Sister Maura Lynch and family, including Fr. Finbarr
SJ, who was the chief celebrant at the Jubilee Mass.



Sister Maura Lynch with her brother,
Brendan.



Celebrating in Tanzania were the first two Tanzanian MMMs, Sister Vincent Palotti Sarwat, pictured here with her friend Celine, and Sister Aloysia Lagwen, pictured here with staff nurse Paskalina.



Dr. Leslie Baker, one of our Uganda
volunteers, came from Nottingham, UK.



Sister Marion Reynolds pictured with Sister
Veronica Hanratty.



Sister Radegunda Shayo pictured with Canon
Jim Carroll, Parish Priest of Drogheda.



Sister Ursula Sharpe with Mary & Pat O'Carroll,
old friends from Uganda.



Aoife and Fiachra Guihen, with their mother,
Maria, niece of Sister Marguerite Killion.



Sister Mary Shephard with her brother,
Frank



Sister Mary with her sister, Kathleen, and our
Congregational Leader, Sister Siobhan Corkery.



Sister Siobhan Corkery with Sister Breda Ryan, our Central Business Administrator

Sister Siobhán Corkery, our new Congregational Leader, comes from the townland of Aghinagh in Co. Cork. She has served in our missions in Nigeria, Rwanda and Brazil, and was a member of the previous Congregational Leadership Team when she had responsibility for our work in north and south America. In her first address to us after taking up her new job as Congregational Leader, Sister Siobhan said:

'As we look at the profile of the Congregation and the needs of our world we are very aware that meeting the challenges facing us will take time and will not be easy. Along the way there will be setbacks and false starts and days that test our resolve – both as a leadership team and a Congregation. But despite all of this I believe that the dream of our foundress, Mother Mary Martin and her founding companions, will live on in our time and we will indeed walk together in paths that are new.' She added: 'The true character of any Congregation is revealed not during times of comfort and ease, but by the right we do when the moment is hard. These are hard times so let us be ever more committed to doing what is right.'

Sister Joanne Bierl comes from Buffalo in the United States. Before being called to serve as Assistant Congregational Leader and First Councillor with our new Congregational Team she had spent many years as a missionary, in Kenya, Ethiopia and most recently in Honduras. It was not easy to leave Honduras, where she was deeply involved in the running of the newly founded *Casa Visitación* in the town of Choloma. When asked how she copes with such a transition, she replied:

Lifegiving

Members of our new Congregational Leadership Team began their six-year term of office in April 2009



Sisters Joanne Bierl and Radegunda Shayo with our Financial Controller, Martin Bracken

'As a missionary, we expect change and new assignments that challenge us, that is true. But each time is different and calls out deeper faith and a sense of humor. Just as I was beginning to be comfortable with Spanish, I leave. I leave just after a huge earthquake and right before a political coup which still is crippling Honduras. Our only vehicle for the project was stolen, and here I am adjusting to a new country, a new community and a new ministry. My mind and heart is with Honduras still, of course, but now Honduras is added to the other thirteen countries where MMMs are serving and each one becomes real for me, with all their joys and struggles at this time. I am stretched again to think globally and to make every effort to listen very carefully to events, to one another, to reflect deeply, and pray. It is a privilege to be a part of the forward journey of MMM and I feel proud to be part of such a great group of women.'

Second Councillor with the new Team is **Sister Angella Anigbogu**, who comes from Adazi-Nnukwu in Eastern Nigeria. She completed her initial formation in MMM at our Novitiate in Kenya, and then served as a missionary nurse and midwife in Angola. In recent years she had been working as Administrative Head of St. Mary's Hospital, in the city of Ibadan in Nigeria. While there she was selected for the graduate programme entitled Master of Science in Community Leadership at the Rome campus of Duquesne University.

Leadership



Sister Angela Anigbogu had been studying in Rome when called to serve on the Congregational Leadership Team.

The twelve courses in this programme combine modules taken on campus with practical work and online tuition at the participant's mission. The courses are designed to help integrate religious formation and professional development along with management and leadership skills. The programme places emphasis on the spiritual and professional foundations of leadership, culture, change, management of relationships, conflict resolution, transformation, problem solving, decision making and strategic thinking. All these skills will be needed in Sister Angela's new role in our Congregational Team.

Sister Radegunda Shayo comes from Moshi in Tanzania. After some time on mission in Nigeria she became one of the first all-African group of MMM pioneers who founded our work at Zaffé in the Republic of Benin in the year 2000. Two years ago she was selected for a future role in Formation and had embarked on a Master's in Leadership and Pastoral Care at All Hallows College in Dublin. While taking these studies she was called to serve as Third Councillor. Months beforehand, and with no idea of what lay before her, she had embarked upon a Dissertation that would explore the way women religious view leadership and specifically why many are reluctant to take on leadership in their Congregations.

In her Dissertation she wrote: 'Religious life has experienced many changes from within the Church and from the society for which it exists. Most of these are not simple changes but rather paradigm shifts, that have challenged the life style of Religious as well as the forms of ministries in which they are involved. As Religious struggle to remain relevant in the midst of globalization, they also need to portray through their life, a model of leadership that reflects the Gospel values they witness.'



Above: Congregational Secretary Sister Mary Teresa Reilly is assisted by Karen Stacy.

Left: Sister Veronica Hanratty assists with the management of the Congregational Centre.



In the grounds of our Congregational Centre a mulberry tree still bears fruit although more than 200 years old. The tree is pictured here with Brian Murtagh (on mower) and Eric Staines who help keep all aspects of our Congregational Centre's house and grounds in order.

In the ebb and flow of life at our Congregational Centre at Rosemount in Booterstown, Co. Dublin, there are many meetings, many trips to the airport as the members of the Leadership Team travel to visit our overseas missions from time to time, many visitors from our own Congregation and others. The running of our Central house is under the care of Sister Veronica Hanratty, who is helped by Brian Murtagh and Eric Staines. Sister Breeda Ryan, our Central Business Administrator, and Martin Bracken our Financial Controller, help to ensure that the funds we are given for our work are well managed and accounted for with transparency. Sister Mary Teresa Reilly is assisted by Karen Stacy at the Central Secretariate. It is no small task to keep everyone in touch with what is happening and what needs to be done in more than sixty communities spread widely around the world.

Protecting Water Sources

LITTLE PASCHAL MBARUBYKEYE collected water for his family from the river every morning before setting off to primary school. Today, that task is much easier, as the well at Gihimbi has been protected as part of a programme developed in association with Kirambi Health Centre.

According to the World Health Organization, diarrhoeal disease is responsible for the deaths of 1.8 million people every year. It is estimated that 88% of that burden is attributable to unsafe water supply, sanitation and hygiene. The most likely victims are children in developing countries. We are now half way through the Decade (2005 – 2015) dedicated by the UN to focussing on the question of water and its fair distribution.

In collaboration with the local authorities, members of the Kirambi Community Health and Development Programme identified communities who had no clean water supply. Seven springs were selected and they all set to work.

Our staff Social Worker, Xavier Bizimana, became responsible for managing the programme to protect the springs. The community in each

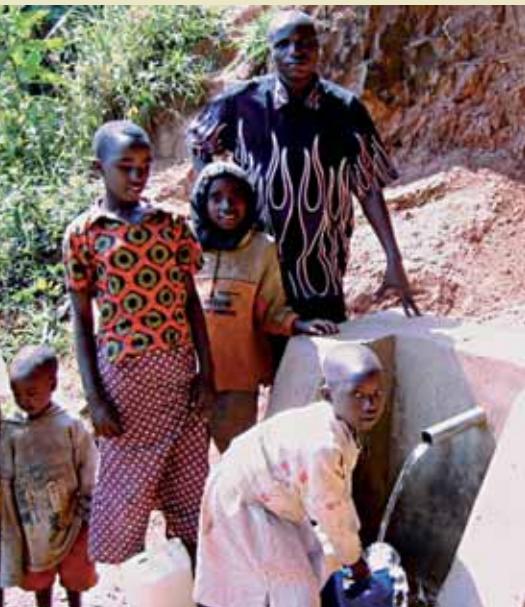


area was asked to tuck in and prepare the land around the new well, planting vegetation and grass if possible, so that the place could be kept in a hygienic condition. Then the plumber had to be engaged, the pipes measured and purchased, and plastic waterproofing installed to prevent mud and contaminated products entering the water.

Near the village of Nyagisozi there is a spring called Kabaliro. The community had been suffering from a lot of intestinal infestations. Now that the spring has been protected, a great improvement has taken place. Xavier is pictured right at Kabaliro, with Immaculeé Itangishaka, who was collecting water when we visited the spring.

In the village of Kaneke, there was an unprotected source where children came at all hours to fill their plastic containers from an old pipe protruding from the hillside. The water became very dirty in the rainy season. Pictured left is Marie Rosie, one of the children who used to go there daily.

Her mother Martha Uzamukuanda is one of the Community Health Workers. Pictured below is the newly protected spring at Kaneke, where children collect water today.



They are watched in this picture by John, the man who was employed to supervise the plumbing at the protected springs.

For villagers at Nyamabuye, the old well made it difficult to collect water, as well as providing contamination from the unprotected source. Today that is all changed. Sister Helen Spragg is pictured here with Liberata Mukashema, who is very happy that her community can now



be assured of clean water when they come to the newly-protected spring.

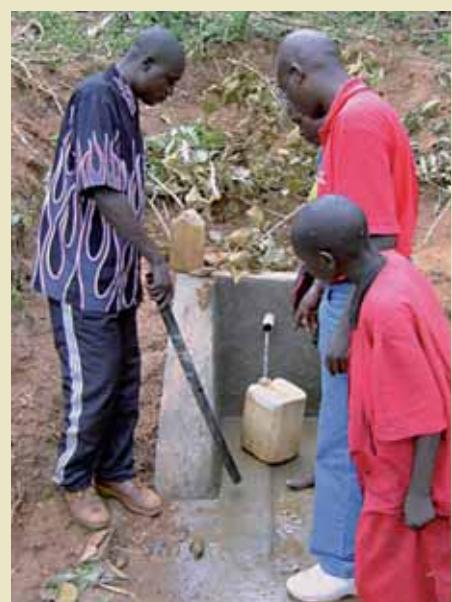
Sister Helen says:

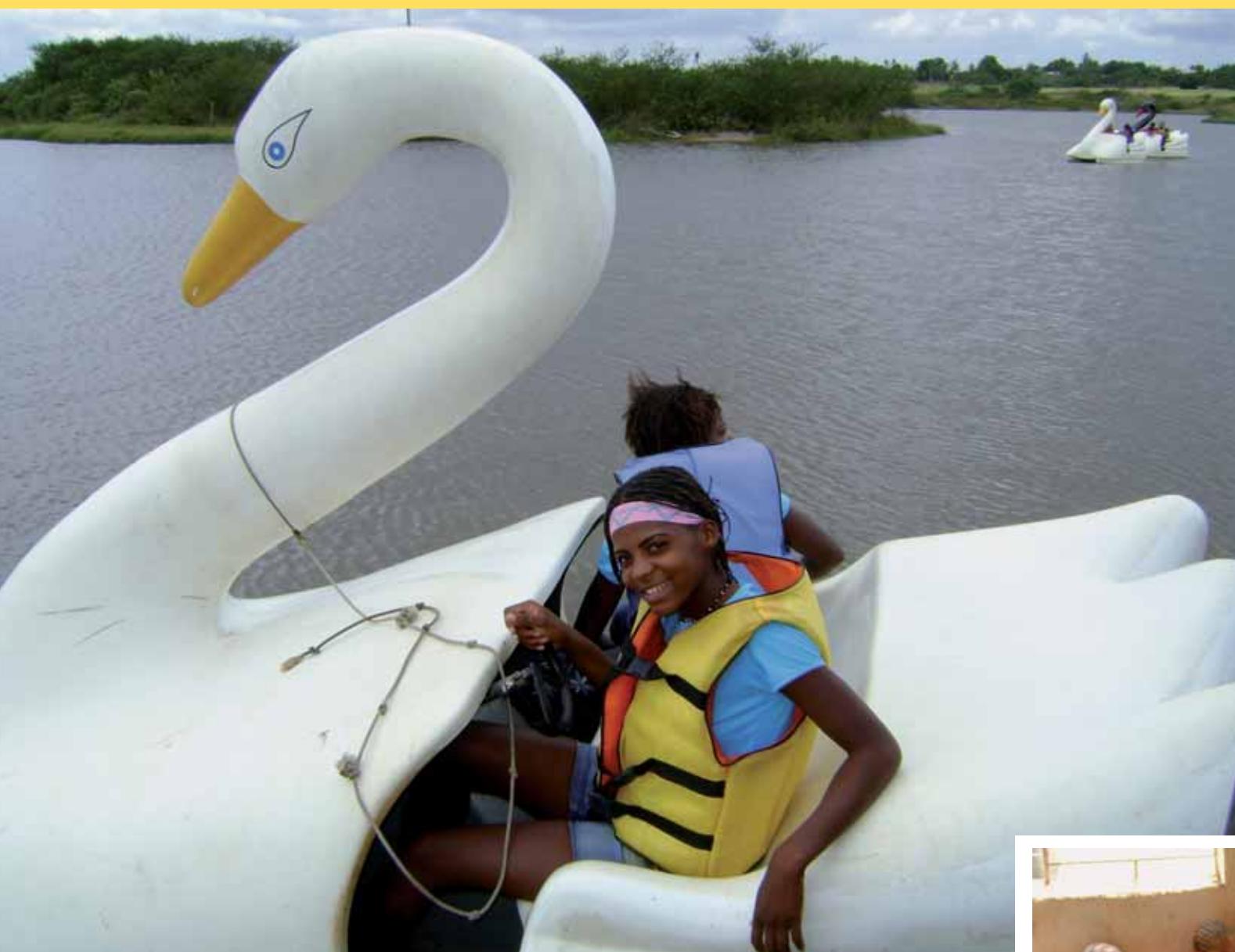
'Our problem is not lack of water, but lack of clean water. The temptation for people is to use the dirty water because it is near, rather than walk an hour to a clean source. That has been a real health problem for us. Now that seven of our communities have a protected spring, we can begin to identify more areas of need. It involves a lot of work at community level, because the first step is to form a Committee of volunteers who will ensure that the protected springs will be cared for, that the surrounding areas will be kept clean, and that there will be no wastage. When it is possible, a community Health Worker is appointed to be responsible to ensure that each community's committee is living up to the

promises made when the initial discussions about protecting their spring were begun.'

Glorieuse Mukashema is a young married woman with three children. She is a participant in the agricultural training course run by the Kirambi Community Health & Development Programme, which is aimed at reducing malnutrition. She is very happy to be able to collect the water for her family needs at Gisuma.

Children attending Gashyenzi Primary School used to walk a long distance to collect clean water, or else make do with water from the river, which was risky. But today the protected well at Gashyenzi serves 1,000 children attending the school. Xavier Bizimana is delighted to see what a difference the protected water sources make to the communities.





Going Places with the AMMMs

Brazil

Associate Members of the Medical Missionaries of Mary (AMMMs) are taking our charism to varied and far-reaching places, and finding new ways of bringing a healing touch to people whose lives are at risk.

In the city of Feira da Sant'Ana in the State of Bahia in north-east Brazil, Cristiane Andrade Baião is an AMMM who works closely with Sister Ursula

Cott. They saw a huge need to attend to underprivileged children and teenagers who are often left to themselves, with nobody to guide them. Cristiane had the idea of devising a Summer Programme that would help to build up their sense of self-esteem, make them aware of their rights as citizens and encourage healthy relationships among themselves.

Group work was central to the task. This was designed to develop their abilities and discover their potential. Learning how to observe guidelines and keep the rules of the group would lead to a good community life. 'My proposal was to offer age-relevant activities and leisure games with a pedagogical dimension', said Cristiane. 'Our goal was to reach areas of low or non-existent financial resources. In the



Malaysia

Living in Penang, Malaysia, Anne Choon is separated by thousands of miles from other AMMMs, but shares closely the spirit and aim of MMMs everywhere. Anne is a nurse-midwife, wife of a doctor and mother of four children, the youngest nearly eleven. She devotes her time as a freelance volunteer nurse for palliative care – mainly cancer patients.



Anne Choon

She writes: 'most of my patients are young parents and children. Palliative care goes far beyond nursing duties! You do whatever the patient needs. Sometimes it's fixing handrails, so I arrive with my power drill and do the necessary. There's also a lot of counselling involved for all the family members as well as the patient.'

At present I am caring for a forty-six year old Muslim man Clement who has motor neuron disease ALS (Amyotrophic Lateral Sclerosis) for the past three years. That's a very rare condition, I think the frequency is approximately 1:100,000. It's a horrific disease as world-wide they have not found a cure, in fact they don't know what causes it either. The person's

mind remains 100% alert, while his whole body becomes a useless shell as all the nerves everywhere in the body stop sending signals to the muscles and so the muscles atrophy. This man has seven children, six by his first wife whom he divorced after seventeen years of a rocky marriage, and one by his present wife of four years who has chosen not to care

for him. She now lives hundreds of miles away with her parents and their 3-year old son. So Clement lives alone with an abusive Indonesian maid. I go in every day to do physio, speech therapy and whatever care or help he needs. A few years ago he was a perfectly healthy man with his own company which did Team Training & Consultancy where he was basically a motivational speaker and trainer. Now he is totally dependent. His speech is very badly affected and his tongue can't move properly, he's in a wheelchair as he cannot walk, he cannot even lift up his hands, he has to be fed,

bathed and even in the bed he cannot turn himself. He's very frightened of dying as he's afraid that they'll bury him alive as Muslims have to be buried before the sunset of the following day after they die. He has breathing and swallowing difficulties and cannot cough, his peristalsis is also affected and he frequently needs enemas to relieve the distress.

My other patients include Gabriel, aged 18, an only child who was diagnosed with Acute Lymphatic Leukaemia last year and is fighting for his life. The only hope for him is to have a bone marrow transplant but so far they have not found a suitable donor for him. His mum is

Continued overleaf



Cristiane Andrade Baião



context of drugs and aimlessness, of real hardship and often survival-driven existence, young people need to be helped to find new spaces where they can feel safe.'

A Summer Camp provided the break-in activities and learning. Knowing the young people, Cristiane could then continue the work over a longer timeframe, providing further workshops and guidance for the young folk.

Malaysia – *continued*

also a cancer sufferer, she has breast cancer. Thank God she is doing well four years after diagnosis.

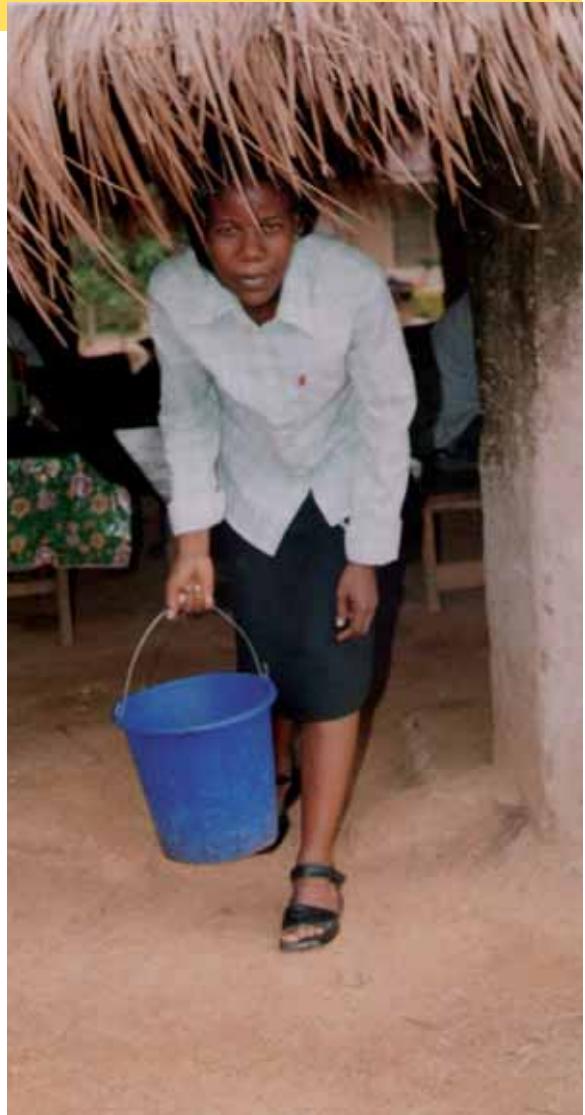
Another young boy is Mahadi aged 19, a Muslim also and an only child. His father died two years ago and his mother has a heart condition and osteoarthritis which limits her mobility. He has osteosarcoma and has had a large part of his pelvis and right leg amputated. He is having pains now in his left leg and some numbness, perhaps due to the spread of the tumour to the left leg or possibly spinal cord compression due to the growth of the original pelvic tumour putting pressure on the spinal cord. He always wanted to be a professional footballer and had no other hobbies, interests or ambitions, so you can understand how depressed he is feeling. It's heartbreaking to see such young kids fighting to survive and all their hope disappearing like this. We set some immediate goals: To get outside his room door by wheelchair or crutches by himself, and to get home to celebrate Hari Raya at the end of the fasting month of Ramadan. He has to keep visualising himself going through that door and believing that he can do it and I'm sure he will make it... that's what we're working on at the moment.

I find it an incredible privilege to be allowed to share in people's lives in such a deep and meaningful way during their worst times, and to be able to bring some light into that darkness. I have learnt so much through the many sharings with my patients about life, God and myself and I treasure every moment that I spend with them. God has enriched my life so much through them. Of course I cry buckets when they have to go, but that's important too and if I ever get to a stage where I don't at least feel the pain of losing them, then it's time for me to stop and reassess what I am doing, as you cannot do this work half-heartedly. It's a beautiful gift to serve in this ministry and that is how I choose to fulfil my AMMM vocation, *Rooted and Founded in Love.*'

Nigeria

Georgenia Ndulaka is nurse-midwife from Imo State in Nigeria. As an AMMM working with MMMs at Amukoko Health Centre, she also works with a group called 'STOPAIDS', an organisation involved in home-based care, prevention education, syndromic management of sexually transmitted infections, HIV counselling and testing. Amukoko is a very deprived and densely populated area of Lagos. People like Georgenia are priceless gifts in such a community.

Emmanuel Ikenwe is another AMMM involved with the Sisters at Amukoko where he is a member of the Clinic interview panel. He hails from Delta State, and majored in economics, with an MA in Banking and Finance and works with the media. He made his Covenant as an AMMM in September 2008.



Georgenia fetches water for a client in the Home Based Care Programme



Georgenia and Emmanuel help Sister Felicitas Egeolu at Amukoko

Supermarket of the Swamps



by Robert Power

Robert Power has studied Archaeology and Folklore in UCC and developed a strong interest in traditional cultures and their adaptation to the modern world.

As a volunteer with MMM in Malawi, he had an opportunity to investigate cultural attitudes to wild plant foods.

OVER 500 WILD PLANTS OF NUTRITIONAL VALUE GROW IN MALAWI, particularly in the country's native Miombo woodlands where most useful flora can be found. A plethora of fruits, leaf vegetables, roots and legumes thrive naturally in Malawi's virtually year-round growing season. In addition, fungi offer a seasonal delicacy in rural areas.

Of all wild foods, perhaps roots have the greatest potential as a dietary staple. Many plants store high amounts of nutritious starch in their root systems allowing them to serve as food reserves throughout the year.

Reedmace, or bulrush, a familiar wetland plant, grows in wet areas of Malawi. Virtually all parts of this remarkable plant are edible – roots, flowering heads and shoots. Thus it has earned the nickname 'the Supermarket of the Swamps'. The roots of reedmace comprise of 30% starch and 7.8% protein, with vitamins A, B, and C, as well as potassium and phosphorus. Per hectare, reedmace can yield harvests of flour comparable

to wheat. Although popular as a thatching material in lake shore regions, little nutritional use is made of it. There are numerous other examples of neglected foodstuffs.

PLANTLORE

One major factor restricting use of these traditional resources, is the nation's rampant deforestation. Unwavering demand for firewood and charcoal creates an annual deforestation rate of 2.8% – one of the highest in sub-Saharan Africa. Regenerating woodland is frequently stunted or even stopped by indiscriminate clearance fires. Forests that once offered a bounty of essential raw

materials and seasonal foods are now reduced to barren charred scrub.

Within a generation of deforestation, the relationship with the forest and intimate knowledge of its resources is forgotten.

A tragically inflated mortality rate due to the high rate of HIV/AIDS has also contributed to the break-down of traditional social structures, diminishing the handing-down of local knowledge. The loss of this primeval oral inheritance is leaving Malawians undeniably poorer in cultural, if not economic, terms.

Traditional knowledge seems to be rapidly disappearing as a new generation grows up unversed in traditional plantlore. The depth of food expertise varies considerably. In part, it seems to be gender specific.

Continued overleaf

Women typically have a broader knowledge of wild foods than men. However, female knowledge is often medically orientated, with the inclusion of many medicinal herbs. This reflects the traditional role of women as the family healer.

Regardless of gender, traditional knowledge survives better in remote rural areas with less access to food aid programs. Here knowledge survives out of sheer necessity.

The restricted use of plants is compounded by the limited growing range of certain species, such as the Mbunguzi or Waterberry. This tasty berry is limited to stream edges and other riverine habitats. As availability of many species is so tied to local habitats and environmental conditions, once it has been lost, detailed local knowledge is extremely difficult to relearn.

FOOD SECURITY

Malawi is a country with immense food security problems. Its rapidly growing population is essentially dependant on subsistence farming.

Food gathered from the bush has always been a feature of subsistence in agricultural economies. Since the very beginning of agriculture, there has been an ever present risk of harvest failure, whether by drought, disease or war. This has necessitated the use of wild foods, in particular wild plants, as a reliable alternative staple.

Generally speaking, indigenous wild plants are much more resistant to extremes of weather than domestic agricultural crops, making them a reliable resource even when severe drought has wiped out planted crops.

Not all wild foods are used solely as an emergency backup. Some, especially wild fruits, are regularly harvested at certain times of the year, providing important vitamins and minerals otherwise lacking in the bland starchy diet typical of many developing countries. Well-known fruits such as the Tamarind and Baobab are popular treats where they

Flavour memories learnt between the age of six and twelve seem to be particularly tenacious.

occur, but are made into porridges as the main meal of the day in emergency famine conditions. The Msuku, also known as the wild Loquat, is particularly relished for its rich sweet flesh. Naturally high in carbohydrates and potassium, it makes for vital sustenance.

However, the role of wild foods has been under estimated. During my own time in the country as a volunteer with MMM at Chipini Health Centre I noticed the dearth of formal research in the area. I could see that the current extent and reliance on wild foods is poorly understood. By looking at the records of the colonial nutritional survey carried out in 1938-39 by Jessie Williamson, it became apparent to me that the range of plants used today is greatly restricted compared to past decades.

I found the uptake of wild foods is usually determined by taste and the preparation required. Less desirable foods, inherently less palatable, are typically eaten only as a last resort. They may require laborious prepara-



tion to make them edible and therefore are 'resource expensive'. Some of the more popular fruits normally used to supplement the diet as treats are also traditionally relied upon as staples in times of hardship. But only a fraction of the hundred or more wild fruit species are valued enough to be gathered for household use. This seems to be governed by social attitudes which restrict their usage. These are only causally gathered and eaten by children as snacks while passing through forested areas.

The fruit of the Kakope or Toad Tree is one such example. The sweet pulp of this fruit with distinctive toad-like skin is only eaten by children in isolated communities such as on Chisi Island in Lake Chilwa in southern Malawi.



Little boy shows us Kakope fruit he has collected on Chisi Island in Lake Chilwa.

For many, wild food is solely a childhood memory. Interestingly, anthropologists have observed that in many cultures familiarity with different edible species learnt in childhood may provide an important background in later life for selecting foods during famine. Flavour memories learnt between the age of six and twelve seem to be particularly tenacious. Regrettably, in Malawi there seems to be an increasing reluctance to utilize this childhood knowledge in adulthood.

THE PROBLEM OF MAIZE

Maize is overwhelmingly dominant across the country. Other more drought resistant crops indigenous to Africa, such as millet and sorghum, have largely been abandoned, especially since the mid-twentieth century. Mono-cultivation of maize leads to soil degradation, gradually reducing yields. Recent improvements in national yields have depended on the heavy use of subsidised chemical fertilisers, with increased governmental expenditure on agriculture.

Most problematic however, is maize's perilous vulnerability to the increasingly unpredictable dry spells during Malawi's traditional wet season. Diversification of food sources is certainly needed. While great efforts are under way to broaden the range of crops – such as the Farmer Clubs programme at Chipini Health Centre, there remains much untapped potential among the country's indigenous wild resources. Much of this neglect relates to the special status given to maize by many Malawians. Curiously, despite its relatively recent introduction to East Africa, it is viewed as the traditional staple of the nation. It is favoured to the detriment of other staples. Traditional attitudes held by many, hold that unless maize porridge known as Nsimba, is eaten in a meal, one has not really eaten at all.

Nutritionists working in Malawi have reported people who complained of hunger turning down offers of fruit and staples such as yams and millet. In these cases only maize was wanted. Anything else was not considered real



food. Local attitudes such as these continue to hold a profound influence over rural communities and their livelihoods.

INCOME POTENTIAL

The persistent problem of hunger makes wild food resources an obvious coping strategy. In addition, they could offer a rare opportunity as a supplementary income for rural people. There is a steady, increasing demand for Msuku, mentioned above, from Malawi's expanding urban centres. For some, the sale of fruit serves as an important secondary source of income. But sale of wild forest produce is usually only a supplementary activity to make ends meet. However, with more organisation at a local level, larger scale production is achievable through the harvesting of these wild species.

With local processing, considerable value could be invested into local

resources. The production of jams, juices and wines have been identified as sustainable small scale industries, all possible with outside investment.

More perplexing is the present disdain for wild foods. It seems that certain stigmas are attached to food and determine what is regarded as an acceptable food item. Much greater use was once widespread. Now local wild foods seem to be stigmatized as symbolizing poverty and backwardness. The use of wild foods has become negatively seen as tantamount to desperation.

The notion of food is undoubtedly culturally constructed and in many ways is a 'new tradition'. The replacement of the old traditions of wild foods with a new tradition seems to run contrary to common sense. The strength of the community spirit prevents divergence from this accepted norm. A village ethos will enforce conformity in rural areas, rarely accommodating individualism.

The persistence of these stigmas in a nation that experiences food insecurity bears testament to their strength. Beliefs about food shape what the farmers plant and harvest and therefore ultimately will determine food security.

Understanding the cultural beliefs that determine food choice is necessary to achieve sustainable rural development. This remains an issue in need of further study.



Rachel's Cry of Hope

NÊGO'S DEATH was only one of many sorrows that I accompanied during my last five years in the city of Salvador, in Bahia, north-east Brazil. He was one of several hundred Afro-Brazilian boys who were assassinated in 2007. The following year, the number of victims rose alarmingly, to a total of 2,237 homicides. In the first 36 hours of 2009, no fewer than 19 victims were registered in the metropolitan area of Salvador.

I shall never forget that morning when Nêgo was killed on June 11, 2007. At 11 o'clock I had stopped briefly on the street when I met his mother, Margarida. It was a warm greeting, a simple chat, a smiling wave as we parted. She had three adult sons. The youngest, Nêgo, had a small depot where he bought tins and plastic and cardboard salvaged from dumps by other children, even poorer than himself, which he then sold on for recycling by which he gleaned a very meagre income.

I was just home for lunch at 12.30 when the phone rang. The parish secretary said 'Nêgo, the youngest son of Margarida, has received seventeen bullets and died on the spot.' Yes, I had heard correctly. It was indeed Nêgo, my rastifarian friend, always appearing here and there on his bicycle. Whenever he saw me he would stop. We would talk and laugh. I called him the 'Bob Marley of Bahia', because he would always sing that Reggae number 'No Woman No Cry', pronouncing the English words with his Bahian accent. He would be so happy when he could make me laugh.

The phone rang again immediately. This time it was Margarida. 'Please come and lead the prayers at the funeral, there is no priest in this place'.

According to the law, the funeral had to take place within twenty-four hours. In the chapel at the cemetery we gathered. Many were crying. Men took off their caps and made the Sign of the

Cross as they came in, and quickly kissed the dead boy's hand. The street children came in, those who collected the refuse. One cried out: 'Dear Nêgo, you taught me to be good and generous. You always paid me 50 cent when the normal price was only 30.'

It was the drug traffickers who killed him. Nêgo didn't take drugs and they believed he was informing the police of their activities.

QUESTIONS

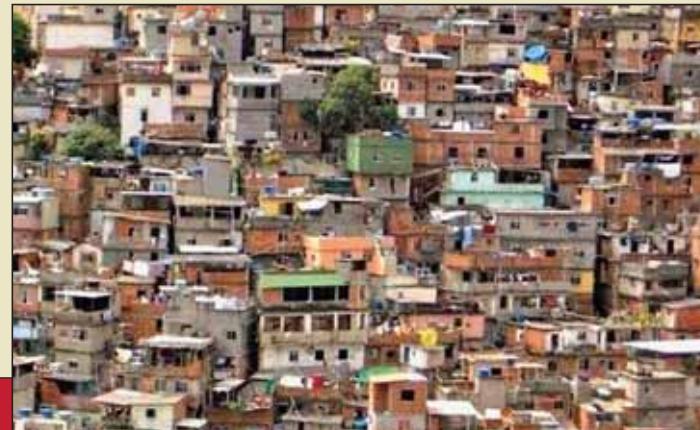
All through these years, this terrible list of deaths among the young has given rise to many questions in my mind. They are questions about the mothers – what sustains them? How do they see life, how do they live following the brutal death of their sons? What is their concept or experience of hope in their day-to-day lives?

On the other hand, their questions haunt me: 'Why Nêgo, my son?' sobs Margarida. 'What did he do to merit such a death?' 'What did I not do?' 'What was wanting in my rearing of this son of mine?'

These mothers, like Margarida, gave life to these sons. Each of them would have gladly given her own life, had it been possible, to save the life of her son.

The situation of the metropolitan area of Salvador is not unique. In Buenos Aires, we can observe the mothers of the Praça de Mayo. For more than thirty years now, they have assembled each week, white scarves on their heads, photographs in their hands, walking in memory of their sons lost to injustice. Three decades have passed, yet they continue their act of remembrance as a symbol of hope on the margins of society.

This manifestation began with just fourteen women. Instead of retiring to their private interior world of pain, remaining separated from one another, and allowing their sorrow to terrorize their lives, they decided to put the truth before the public gaze. They are motivated by their hope for justice. They express this in a unique feminine and peaceful way,



Neighbourhood where Nêgo lived and had his depot.

confronting the male dominated world before the Municipal Chambers, the economic, political and cultural world of the capital city of Argentina.

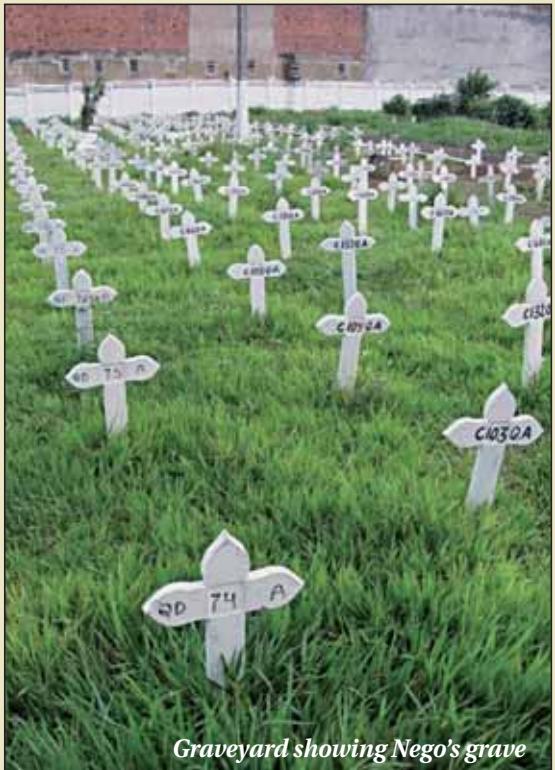
We hear the same cry of pain, also a cry of hope, coming from China, where the Tienanmen Mothers continue their long struggle for justice for their children, massacred in 1989. Ding Zilin was a professor of philosophy at the People's University in Beijing, her husband, Jiang Peikum was head of the Aesthetics Institute at the same University. Their seventeen-year-old son, Jiang Jielian was one of the first to be killed in the crushing of the Tienanmen Square protests.

Ding was told by eyewitnesses that her son was shot and left to bleed to death on June 3, 1989. He had defied the

curfew and was shot through the heart by riot police on his way to Tienanmen Square. Ding's first reaction was to end her own life. But in August that year, she met another bereaved mother. They formed a self-help group which continued growing to include a network of 150 other families who had lost sons and daughters during the Tienanmen massacre. They are asking the government to apologize for the deaths, to let the truth be known. Ding has faced imprisonment, house arrest and constant surveillance. During the 2008 Olympics, she was forced by the authorities to take a vacation abroad lest her protests be noticed internationally.

RACHEL

The voices of these women, mothers, grandmothers, aunts, sisters, wives and partners, represent a voice of hope. In them the search for peace which will be the fruit of justice (cf. Is. 32, 17) becomes visible. They record history from the starting point of loss. Their voices, their locations, their era and their situations are innumerable. Their voices stretch across the years and the miles. Their voices echo the voice of Rachel – that Biblical woman who is mother, matriarch, shepherd and protagonist of hope.



Graveyard showing Nego's grave



Margarida, Nego's mother

This Biblical woman evokes for us the key role of woman in the history of her people as both victim and conqueror. Rachel was victim of the patriarchal society into which she was born. She became mother of Joseph, who was later sold into slavery in Egypt, and ultimately saved his people from death by starvation. Rachel had long since died following the birth of her second son. She was not even granted her desire to name the infant for whom she gave her life. She would have called him Ben-oni, meaning 'child of my struggle' or 'child of my strength'. Her husband, Jacob, named the child Benjamin. In this refusal to honour her wish, even the memory of her death was to have been obliterated.

Yet, the story of Rachel refuses to go away. As his own death grew close, despite his advanced aged, Jacob spoke, of the sorrow the death of Rachel had brought to him. We know from several Biblical texts* that she remained in folk memory as a matriarch in the deepest sense of the word – one who built up her people. Most importantly, the prophet Jeremiah links her with the events – still a long time in the future – where Herod massacres innocent children in an attempt to kill the newborn Christ-child.

'A voice was heard in Ramah, sobbing and loudly lamenting: it was Rachel weeping for her children, refusing to be comforted because they were no more.'

Thus Rachel becomes an important figure in the early proclamation of the Saviour who is to come.

Today, we can see in the Rachels of this world, women who will not be comforted as long as injustice prevails. They have the courage to confront contemporary reality with authenticity. From suffering, they nourish hope, supporting one another amid tears and laments. They carry the vision of a future born of justice – the hope and the dream of a society built on the values of the Gospel.

This is well expressed in the song by Colleen Fulmer:

*A voice is heard in Ramah,
Hiroshima, Salvador,
Women refusing comfort,
for their children are no more.*

*No garland of lovely flowers can
dispel the ancient grief,
Or silence the anguished voices
that abhor the war machine.*

*If the Herod in us could be faced and
then tamed with compassion
all the dark clouds we've cast,
we'd bind in a murmur of peace.*

*If our leaders could look in the eyes
of the children we carry,
they would forget the bombs they
drop and their budgets for war.*

*If the nations so distant and
separate could break bread
together, coming to know that
they are family with warm
hearts to share.*

*If the beauty of God's creation
could draw us to wonder,
humbly we'd drop our fears and
pride and give birth to new life.*

* Gn 29-49; Rt 4,11; 1 Sm 10,2; Jr 31, 15ff, Mt. 2: 17-19.

Motherhouse News



Stained glass windows which were salvaged from a disused nurses' home repaired and reinstalled in the kitchen and dining room of the new extension

Sister Bernadette Freyne accepting the keys of the new building from Eugene Laverty the Building Foreman

*May God bless this home, and this community,
may its windows catch the sun
and its doors open wide to friend and stranger
may it be a safe place
full of understanding and acceptance;
may each room resound with laughter
may the walls shut out trouble
and hold in peace and happiness
may this home be filled with joy in the morning
and sweet dreams at night
may it be a home where Love can come to live
and may Jesus Christ be Lord, Amen.*



THE PRAYER opposite was said by our Congregational Leader, Sister Siobhán Corkery, when the keys of the new extension to our Motherhouse in Drogheda were handed over last July. Sister Jean Clare Eason had represented the outgoing Central Leadership Team during the years when the project was at the planning stage and under construction. She thanked everybody who had helped to bring the project this far.

'What are we celebrating today', she told the gathering, 'is that we are this far... not at the beginning and certainly not at the end, but this far. The building that has been growing and taking shape in our garden is now more than just a building, it now starts to become a home.'

Sister Jean said there were many people to thank for this achievement. Clearly, she felt, God has been with us at every step of this endeavour. We thank God. Next come the many MMM benefactors who have supported us over the years and helped us to be in a position to undertake a project like this.

The outgoing Central Leadership Team, she said, recognised all along the need for improved accommodation at our Motherhouse. They were supported by our Financial Controller, Martin Bracken, who led those overseeing the legal and financial aspects of the work.



Architect James McEvitt, Sisters Eileen Morrison & Edna O'Gorman

The Motherhouse Community, she said, were exceptional in the way they helped to decide what needed to be done and co-operated at every step, living on a building site for twenty months and accepting great inconvenience without complaining. The Sisters who formed the long-term planning committee who had worked solidly on this project for five years, were outstanding in their dedication and teamwork.

'Then in 2006 the firm of McEvitt Architects entered our life,' said Sister Jean, 'and it has never been the same since!'

Architects Turlough McEvitt and his son James listened to our needs. They tried so hard to design something to accommodate us. They listened to our fears and helped us to deal with them. As obstacles developed, no question was ever considered to be foolish, we were taken seriously, each one given a patient hearing. It came to the point where it seemed they knew our needs as a community better than we knew them ourselves. Sister Jean said special thanks are due to the entire McEvitt Design Team including Quantity Surveyor, John Murphy and Electrical Engineer, Jim Brunswick.

Sister Jean expressed sincere gratitude to Frank Toner and all the team from Building Contractors, JP Castle, especially Eugene Laverty, the site foreman 'for the gentle way you dealt with each of us'. In conclusion she quoted poet David Whyte who says of work:

Once the job is done, we circle it, admire it, clean up and move on. Leaving the work to find its own place in the world is the mark of a good workman.

'This building which you have built will have a mark in the life of our MMM Community and indeed in the larger community in Drogheda. Other people will circle it, and admire it, for many years to come they will be saying well done.'

Once the building was ours to occupy, the Motherhouse became a hive of activity as everyone had to de-clutter and move. In phase two of the project, another wing has to be renovated, which will take a year to complete, while an extensive part will have to be demolished.

Sister Eileen Morrison says the past two years have been a nightmare for her, ever since she heard the Fire Chief speak of the difficulties with the old building.

'Despite regular fire-drill, we were worried that the upper floors could have been very difficult to evacuate in case of a serious fire. This thought haunted me until we were able to finally move', she said with obvious relief.

Many of the elderly Sisters now living at our Motherhouse remember the devastating fire in our Novitiate block back in 1952. While nobody was hurt in that fire, those flames and the stench of smoke are permanently burnt into their memories.

Sister Edna O'Gorman was responsible for all the logistics of the move, and much, much more. Everybody

has highest praise for the way she succeeded in this.

'You would get a tip on the shoulder in the morning', said Sister Teresa Connolly, one of the most senior members of the Community. 'Will you be ready to move the day after tomorrow?' It all happened quite tranquilly in the end. Ten rooms at a time were occupied till all 70 of the new or refurbished bedrooms were filled. Then those who have to wait for Phase Two had to move out to other communities, and that was not easy. However, the spirit of hospitality was quickly enshrined in the new home. Its doors were soon wide open to friend and stranger as before.



Rockery in the garden at the Motherhouse

Many Nations... ...One Church

A Programme for Global Awareness

EACH YEAR OUR SISTERS CRISS-CROSS ENGLAND, SCOTLAND AND WALES as part of a great team effort involving more than two dozen missionary Congregations and Societies. In a programme called 'Many Nations... One Church', they keep before the faithful an awareness of the global dimension of the Church's mission.

'Go ye afar...' is the refrain of the traditional missionary hymn that was sung at Departure Ceremonies when these missionaries were young and setting out on their first long-haul assignment. We all remember the verse: 'How beautiful upon the mountains are the feet of those who bring good news...'

Sounds ideal, but Sister Maura Magner knows that the reality can feel less wonderful! She will admit that when you have left home early on Saturday to catch your train for a three or four hour journey, have spoken at Evening Mass on Saturday, two morning Masses on Sunday, and then after Sunday evening Mass you head for the local station to catch a train for home, the feel of the winter wind cutting through your shins as you wait on the platform can make you wish you were back in Africa!



At our house in Solihull, West Midlands, from where this work is co-ordinated, you'll find a map on the community room door. Little coloured stickers mark the parishes already visited. They stretch as far north as the diocese of Hexham and Newcastle, as far south as Jersey which is in the diocese of Portsmouth, east to Frinton-on-Sea, and west to Cardigan Bay.

Based in London, the Catholic Missionary Union organises the programme for parishes in England and Wales. Visiting missionaries bring news from the front line to a faith-filled home-based community. Their generous response totals more than a million pounds each year to support missions run by the participating Congregations and Societies. In Scotland, the agency known as Missio organises the parish visits and appeals. An equally generous response can be assured, and a very warm welcome in the host parishes.

The recession has not shown any cut back on donations. But, Sister Maura says: 'the London Midland train have



Sister Maura Magner

cut back on Sunday overtime pay. You can be waiting on the platform only to hear a last-minute announcement that the train you were expecting has just been cancelled. It could be a couple of hours before the following one is due.'

Apart from raising much needed money for our missionary work, there are other rewards for these hard working missionaries. Sister Pauline Dean says: 'You learn a lot from the people who come up and talk to you after Mass. It is also amazing to see their commitment to so many good causes on the home front.'

Whether it is the activity of the local St. Vincent de Paul Society, programmes for welcoming the stranger in our midst, or something like the Father Hudson's Society – the social care



Mrs. Tina Wilmot, Principal at St. Augustine's Primary School, Solihull, is fascinated by a hand-drawn colouring book sent from their partner-school in Tanzania. The school children have exchanged the scenes they meet on their way to school.

agency of the Archdiocese of Birmingham – it is most encouraging to see the real difference Catholic parishes make in their local area, as well as to people thousands of miles away whom they will never meet. Solihull is making a bid to become a Fair Trade Borough, whose purpose is to give a chance to producers and workers who have been disadvantaged by conventional trading.

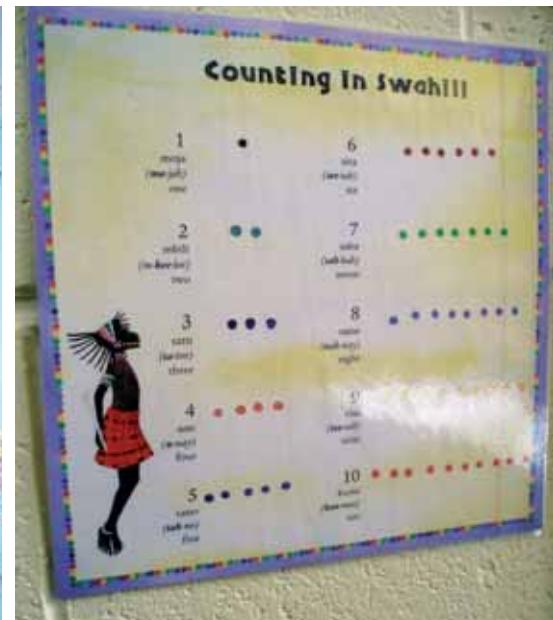
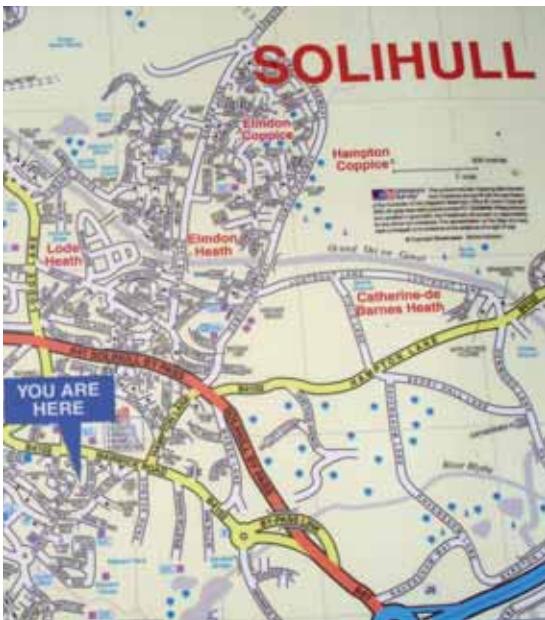
SCHOOL PARTNERSHIP

Sometimes a group we have spoken to sets up a long-term partnership with an overseas mission they discover through these missionary visits. In Solihull, the local Catholic Primary

School, St. Augustine's, has developed a partnership with a primary school in Tanzania which is mutually very enriching.

The picture below was sent to the children in Solihull from the children in Tanzania showing how they learn to count in Swahili.

The Principal of St. Augustine's, Mrs. Tina Wilmot says the exchange of materials between the children of the two schools is a wonderful way to help the 300 pupils in her school to learn about another culture and to become aware of the wider world. 'We have all learned so much through this partnership, and it is a big focus for our school', she says.





Marie Martin: the Searching Years

by Sister Isabelle Smyth

In a recent blog, Abbot Joseph of Mount Tabor Monastery in California, comments on the writings of a famous spiritual director of the last century, Fr. Edward Leen. He tells web surfers about Fr. Leen's distinction between seeking God's Will and accepting God's Providence.

BORN IN 1885, the outstanding potential of the young Edward Leen was well recognised by his teachers at Rockwell College. Later when he joined the Spiritan community and studied at Chevilly in France, in Rome at the Gregorian University and at University College Dublin, terms like *summa cum laude* were used by his examiners. In 1919 he was one of a small team who launched the first issue of the *Missionary Annals*. Contributions from his pen made the publication an instant success. He became well-known in educational circles. His later writings revealed a man whose thinking was ahead of the Second Vatican Council. Writing in the *Irish Ecclesiastical Record* he reflected on the priesthood of the laity. Some sensed that a new wind was being blown by the Spirit in his teaching. He was not unacquainted with controversy over some of his ideas.

It was overwork that forced him to take a break from academic life. The great missionary, Bishop Joseph Shanahan, persuaded his superiors that an assignment to Nigeria would be just the cure! In November 1920 they sailed for Calabar. Fr. Leen was then aged thirty-five. The time spent with Bishop Shanahan marked a new outlook as he discovered the latter's vision of evangelisation.

At the same time, he encountered a young Irish woman, Marie Martin, who arrived at the mission in Calabar in June 1921. She had just turned twenty-nine. She had a hunch that she should establish a congregation of religious sisters devoted to medical work. It was her pursuit of this dream that had brought her to Nigeria. She was a lay woman, but for expedience they all referred to her as 'Sister Mary'. Fr. Leen was soon caught up in exploring God's Providence in her life.

Early in 1922 he agreed to direct a retreat for her. The evening conference on the fourth day covered the mystery of suffering, a theme to which he would return in his future writing. He told Marie that those who look on at others in some agony of mind or body are awed. If they love the sufferer, they would willingly enter into the person's being and help them to resist it. Suffering puts a kind of consecration on a person. We are bewildered and do not understand it.

Marie, who had nursed the wounded through the worst battles of the Great War just a few years earlier, could well put context on such thoughts. These reflections can only have fuelled her determination to get on with her medical

missionary dream. At the close of the retreat, she consecrated her life to God, taking private vows.

She returned again and again to think about the themes covered by Fr. Leen during this retreat. Later that year she wrote to him: "I often use your conferences, they will always be of untold value to me, they lift me right up, not to emotional feelings but to truth and love, courage to face the Cross and darkness if it is God's Will for the rest of my life."

Years later she would tell us: "Always be at the disposal of God's Will through the circumstances He sends, this is real holiness". For her, like Fr. Leen, circumstances were always part of God's Providence.

After Easter in 1922, at a gathering lasting two weeks in Calabar, ideas about the need for a missionary congregation of women became more clear. Constitutions were drawn up. Present at these meetings with Bishop Shanahan were Fr. Leen, Fr. Tom Ronayne (then a volunteer priest from Dublin Archdiocese who later joined the Spiritans), and Marie Martin. She was seen as the future foundress. Fr. Leen remarked on the four personalities:

"The members of the group differed one from the other in many respects – in temperament, experience, education, mentality – in almost all that contributes to impart psychological stamp to a human being. They were drawn together and unified in one particular; they all shared in an absorbing passion for the welfare of souls, for the thronging multitudes that peopled the land of southern Nigeria."

Marie also commented on the foursome. In a letter to Fr. Leen on 28 April 1922, she said:

"The Bishop, you and Father Ronayne and myself have a very close tie in Our Lord, we should be united in all our prayers and works as I believe we are."

Later on, Fr. Leen earned the reputation of being austere, demanding, living on some plane apart. Maybe that went with the territory in academic institutions in Ireland. But Marie experienced nothing of that aloofness. Their discourse was not confined to the spiritual realm. There were missions to be run. They discussed stocks of linen and soap, and how the grass around the school needed to be cut. He would arrange with the Supervisor of the prison to send up twenty prisoners to do that for her.

He was a frequent visitor to 'The Convent' where Marie and three companions from Ireland resided, all of them laywomen. There he would learn to darn socks and get tips on baking in return for his advice on the revised Catechism.

By August 1922, Fr. Leen had returned to Ireland. Marie found his departure hard. Three times she told him so. On 21 July 1922 she wrote:

"I must tell you in sincere truth, I feel your departure very much but it is a great source of joy and consolation to know we are all three united in the sanctification of our souls and the service of our Divine Master."

A month later, on 15 August, she wrote:

"I need not tell you how anxious I am to hear from you, it was harder for you than any of them to leave Nigeria, as I believe if it were God's Will you would like to give your life to these people. I felt your and the Bishop's departure very much but such is the Will of God. You had prepared me for everything so I made the offering while I was strong for the time of weakness."

They corresponded frequently throughout 1922 and 1923 about all the difficulties and threats to the success of their fragile scheme. Marie remained in Calabar until 1924. Historian John Manton speaks of this period of her life as an essential failure to achieve her goals. But for her these years were only a step on a long road of exploring God's Providence.

The next step was dictated by Bishop Shanahan. His plans to establish the new religious congregation in Nigeria had changed. Instead, that would happen in Ireland at Killeshandra. Dominican Sisters would be given responsibility for the initial formation of the new recruits. Marie was not at all convinced that this was the way she should go. But she bowed to Bishop Shanahan's request and left Nigeria early in 1924 to join the Novitiate of the Missionary Sisters of the Holy Rosary. Fr. Leen was appointed Spiritual Director to the group.

Fr. Tom Ronayne had become ill in Nigeria and travelled to Ireland with Marie. He spent long periods at Killeshandra off and on. He had been Marie's director before either of them had gone to Nigeria. When they first met back in 1917, it was his zeal for overseas missions that had moulded her vision into the concept of a medical missionary endeavour. Now in 1924 the web of circumstances that were part of God's Providence became quite dense.

In Killeshandra Marie felt she was in the wrong place. Fr. Leen and Bishop Shanahan, were dismayed at the possibility that she might leave. They saw her as a key person in the new foundation. Fr. Ronayne was more open to the idea that she might be right to go. But they advised her to complete her canonical Novitiate year before deciding. She agreed.



Fr. Edward Leen

Marie looked at every possibility. She was very drawn to prayer. Life in Killeshandra didn't give enough time. She thought a contemplative life, praying for the missions like Saint Thérèse of Lisieux, might be the best way to go. Fr. Leen was not long about disabusing her of this notion. In an eight-point letter, he went to great lengths to spell out what a delusion she was under:

"This drawing to the interior life is such as every soul that is sincere feels... It is a constant and ordinary temptation to mistake it for a call to the purely contemplative life. I felt it myself and thought that my vocation was to become a Trappist... You have neither the mental or physical qualities

that would make a good contemplative... this is not written to persuade you to stay on in Killeshandra or in any other place, as what I have said holds good whatever you decide to do... my own view, which I submit with all reserve, is that you are allowing your mind to be diverted from the present... by the wanderings of your imagination and that you are wasting a good deal of energy and valuable time on what I might term 'supernatural building of castles in the air'... This may seem to you a very hard letter – it is really sympathetic."

His opinion didn't deflect her from exploring that route. She left Killeshandra in March 1926 and later asked the Carmelite community at Hampton in Dublin to accept her. Although the community voted in her favour, the Prioress, Mother Dympna – like Fr. Leen – felt her calling was elsewhere.

She remained friends with Fr. Leen. In 1927 he still addressed her 'Dear Sister Mary', commenting, 'pardon my mode of address... I am afraid that it is as such that you will always be for me to the end as I have known you from the beginning.' In 1931 he reassured her that she need have no anxiety. He shared with her his own journey, and some of his papers.

The last letter he wrote to her was on 8 December 1941, just three years before his untimely death in 1944. In 1937 she had eventually succeeded in founding the Medical Missionaries of Mary and was becoming widely known as Mother Mary Martin. Writing from Kimmage Manor, he told her that the forthcoming issue of *Studies* would deal with the medical aspect of missionary work. He expressed some frustration that "This part of the article was longer but had to be cut through exigencies of space."

Exigencies of space prevent us now from exploring further the remarkable friendship between Mother Mary Martin and Fr. Edward Leen. Their spirituality was expressed in a language that is rather different to that used by spiritual writers today. But in their separate ways each of them has left us a spiritual legacy of enormous wealth.

The author is indebted to Spiritan Archivist, Brother Ignatius Curry CSSp, for access to biographical data on Edward Leen and correspondence to him from Marie Martin, and also to MMM Archivist, Sister Catherine Duyer, for access to correspondence from Edward Leen to Marie Martin and to his retreat notes of 1922.

We stand on their shoulders



Sister Breda Hogan

Died 4th November 2008

When Sister Breda entered MMM in 1958, she brought twelve years' experience as an administrative assistant with Tipperary County

Council, so it was not surprising that as a professed Sister she went on to study Hospital Administration. She is remembered too as an emergency driver for the maternity Flying Squad in Drogheda, when she would have just three minutes to rise from her sleep and get the Ambulance on the road! As well as service with MMM in Ireland, she was asked to fill jobs in UK, USA, Kenya and Uganda. She knew sorrow and sacrifice, as well as prayer and commitment. She let all these deepen the special qualities of warmth and interest she brought to everyone who crossed her path, leaving a lasting mark wherever she went.



Sister Lucy Staines

Died 15th January 2009

A former civil servant, Sister Lucy came from Clontarf, Dublin. Her talent in administration and public relations was quickly recognised by our Foundress, to

whom Sister Lucy acted as personal secretary for many years. It was an exhilarating and challenging time as the young Congregation expanded. After that, it was not easy to adapt to other assignments, but Sister Lucy went on to graduate with an MBA when few women were taking those studies. She spent time in Rome, Lagos and Arusha. But she was best known for her work in Hospital Management in Drogheda, and teaching hospital administration in Dublin. She later became Editor at MMM Communications. In this post her great love of photography and video-making found an outlet. Among her great legacy is the example of courage and patience with which she bore her final long illness.



Sister M. Michael Farrell

Died 2nd January 2009

MMM was less than two years established when Sister M. Michael joined in February 1941. She came from Castleblayney, Co. Monaghan, and trained as a nurse and midwife. Her first missionary assignment took her to Nigeria where she was part of the establishment of the mission at Ogoja. She later worked with MMM at Kitovu Hospital, Uganda after which she was asked to go to USA. Back in Ireland she was among the Sisters who provided nursing care for our Foundress, Mother Mary Martin, during the last seven years of her life. Sister M. Michael always treasured the fact that she was the person on duty in the small hours of the morning on 27th January 1975 when Mother Mary finally slipped away to heaven. For nearly thirty years after that Sister M. Michael helped with fund-raising for MMM, in close relationship with the Drogheda Ladies' Committee. They, like everyone who knew her, were inspired by all she did.



Sister Winnifred Newell

Died 5th February 2009

Sister Winnifred left her native Cloonkeely, near Tuam, Co. Galway, to study nursing and midwifery in Liverpool a decade before she joined MMM in 1949. Her experience and dedication were an enormous help to the young Congregation, where she served as Labour Ward Sister in Ireland and Director of Nursing at Clinica Mediterranea in Naples, before taking up her assignment to Nigeria in 1978. She served in Nigeria for almost twenty years, first at Ndubia and later at Abakaliki, only returning to Ireland when her eyesight began to decline. Even then she remained active, for she never knew what it was to be idle. The word 'retirement' was not in her vocabulary, even as she turned ninety-three years of age. Her large circle of family and friends can witness to that!



Shortly after our last Yearbook went to press, on 11th November 2008, news quickly spread around the world of the death of **Sister M. Magdalen O'Rourke**. This was indeed a milestone in the history of MMM as she was the last surviving member of the pioneer group who, along with Mother Mary Martin (1892-1975)

laid the foundations of our Congregation in Nigeria in 1937. A special tribute was printed in time to circulate with our last Yearbook. Since then, more MMMs have been called to God. More complete tributes to these Sisters are published on our website, where you also can add your own memories or tributes. May they rest in peace.



Sister M. Enda Gallagher

20th February 2009

Sister M. Enda hailed from Kinlough in Co. Leitrim. Her talents in office work and household management were put to good use in our communities in Ireland, during which she dedicated herself cheerfully to the MMM charism of hospitality. She also worked in the Hospital Records Department. In 1986 she had an opportunity to work on our overseas mission at Ganta Leprosy Centre in Liberia. Her years there were a time of great upheaval in that country. But she put her skills at the service of the people, helping patients to develop income-generating activities and become self-reliant. She never liked to talk about the trauma she suffered during that war, hiding in a wardrobe while soldiers pumped bullets into the house, and later being kidnapped. She was a cheerful though quiet member of our retirement community for some years before God called her home.



Sister Catharina Nakintu

Died 25th August 2009

Sister Catharina was the first Ugandan member of MMM.

She introduced the pioneering Sisters who arrived in Uganda in 1953 to the local culture and remained by their side for many years, eventually deciding that her own vocation was to join MMM. She completed her novitiate in Ireland, and was professed in 1965. She was always an advocate of intercultural living. She completed nurse training in Drogheda, and brought all her genius to her missionary assignment in Tanzania. She studied Swahili and was part of the first team of MMM Sisters to work with the Government of Tanzania at Babati in a far-seeing programme of healthcare against the backdrop of community development. She later served among the famous Maasai people. Her great desire was to see other Ugandan women follow her into MMM. Her prayer was heard. Young MMMs from Uganda followed her to serve in Malawi, Rwanda, Nigeria, Brazil and Angola as well as in Uganda



Sister Brigid Kavanagh

Died 21st July 2009

A native of Newtownmountkennedy, Co. Wicklow, before joining MMM Sister Brigid had qualified in orthopaedic nursing, and later studied general nursing and midwifery, and subsequently studied anaesthetics. Back in 1946 she joined the community establishing a Leprosy Unit at Ogoja, then known as 'The Lost Province'. In those days an estimated 50,000 people were suffering from the dreaded Hansen's Disease in that area.

Later she was asked to move to Mater Hospital at Afikpo, and remained there for forty years!

She was a key member of staff, and a born teacher, loved by patients and pupils alike. Into her old age she would often entertain the community with stories of the early days of MMM and of our foundress, whom she knew so well.

The death of those can never leave us free from grief whose friendship during life was a solace and delight. There are some who say we should not grieve. Then, let them try, if they can, to ban all loving interchange of thoughts, cut off and outlaw all friendly feelings, callously break the bonds of all human fellowship or claim that such human relationship must be emptied of all tenderness.

And if this is utterly impossible
it is no less impossible for us not to taste as bitter
the death of those whose life for us
was such a source of sweetness.
It is, in fact, because such grief
in a broken heart is like a wound or open sore
that people feel it a duty to offer us
the balm of their condolences.
And if the heart is more easily and quickly healed
the more virtuous a person is,
that does not mean that
there was no wound to heal.

– St. Augustine, City of God.

The Legacy of Ruby Rogers

The Boston Globe reported the death of Ruby Rogers in these words:

'In Turners Falls, nearly 100 miles west of where she spent decades confined in Boston psychiatric facilities, Ruby Rogers died quietly in a nursing home, a relatively anonymous end for a woman whose name is routinely invoked during Massachusetts court hearings involving the mentally ill.'

The paper pointed out that Ms. Rogers left a sweeping legacy that established key rights for the mentally ill in the Commonwealth. She had voluntarily sought help for her mental condition, but was deeply traumatised by the treatment she was forced to accept. A landmark case bore her name – Rogers v. Okin, following a lawsuit filed in 1975. Ms. Rogers was the lead plaintiff for a group of seven people fighting for their rights regarding medication administered to them. The outcome also helped determine the course other States took to help certain psychiatric patients participate in decisions about their treatment.

As a result of her legal battle, the mentally ill in Massachusetts must give informed consent before doctors and

nurses administer medication. A doctor who believes a patient isn't competent to grant permission must schedule what is known as a 'Rogers hearing.' If the patient is found to be legally incompetent, a judge – through what is called 'substituted judgment' – decides whether the patient would want to accept the prescribed treatment. Then and now, many psychiatrists disagreed with the ruling.

NOTHING ABOUT US WITHOUT US

This campaign for justice for those living with mental illness inspired the slogan 'Nothing About Us Without Us'. Following her death in January 2009, the state Department of Mental Health honoured Ms. Rogers during a legislative breakfast at the State House. The picture above is from that brochure.

Ruby Rogers was born in Clinchco, Virginia in 1937. Life in the coal-mining town among the Appalachian hills offered little prospects to the high school graduate. Those like her who were 'people of color' had less chance

CELEBRATING THE CONSUMER VOICE



Honoring Ruby Rogers

than anyone else. Ruby migrated to Boston and settled in the inner city. From there she encouraged her younger siblings to follow her. They did, her sisters Claudette, Kay, Nancy and Brenda and her brothers Robert and Jessie.

Ruby worked as a Nurse's aide at Boston City Hospital. She had six children. When she voluntarily decided to seek help for her mental condition, her children were taken into foster care. Though she loved them dearly, she was never able to locate them. Up to her death, she spoke longingly of them. Ruby was brought back to Clinchco in the springtime, for burial beside her mother.



The MMM house in Clinchco.



A Sister clears the snow from the steps of the MMM House in Somerville, Massachusetts

RUBY'S MOTHER

Ruby's mother, Margaret Anderson, lived on in Clinchco after her sons and daughters left. When the first community of MMM Sisters opened a mission in the town in 1978, she quickly made friends. A special bond formed with us because we had come to Clinchco from Boston.

Sister Bernie Kenny, who is still living in Clinchco, tells us:

Back in the 1980s, I would sometimes drive the long journey, over 750 miles to New York, and after an overnight break with our community in City Island, I would go on to Boston. I would invite Margaret Anderson to travel with me so that she could meet her children. One time another lady called Miss Mabel asked if she could join us, as she had a sister in the Bronx who was dying. The 'girls' as I called them, would nap for much of the journey, but at other times engage in animated discussions.

When I heard them talking about folk who had died, divorced and got cancer, I was amazed that I did not recognize any of the names, because I knew most of the people in our area who were sick or dying. When I asked, they burst into gales of laughter – they had been talking about their favourite soap!

I remember taking Margaret to visit Ruby, and it was touching to see the reunion. Both were very appreciative. I remember one time Margaret came with me to visit my Mom for afternoon tea. My Mom found her accent difficult to understand, and Margaret had the same difficulty, but both elderly ladies enjoyed that afternoon very much.

RUBY ROGERS CENTER

They have all left us for heaven now! But the legacy of Ruby Rogers is important for the people of Massachusetts. As well as the legal outcome, she inspired the founding of

the Ruby Rogers Center located at Union Square in Somerville, not far from where the present MMM community is located.

This innovative Center offers free membership to people at risk of psychiatric hospitalization, ex-patients or current patients. It provides information about self-help methodologies developed by people who have been diagnosed with serious mental illness. It promotes the legal and civil rights of people labeled mentally ill. And it seeks dialogue with mental health and rehabilitation communities, professionals, family members and care workers.

The Ruby Rogers Center is run by the members. All decisions, upcoming events and activities are discussed and voted on democratically at weekly business meetings. At the self-help, social and advocacy sessions, the emphasis is on freedom with responsibility. It is open every day and a snack service is available.

The Sister Bernie Kenny Scholarship

In Dickenson, the Appalachian coal-mining area where Sister Bernie Kenny has worked for many years, a three-day Health Fair was held at the Wise County Fairgrounds. The Remote Area medical Volunteer Corps (RAM) flies in a large team of experts to provide free medical, dental, vision and veterinary services for the poor, the unemployed and the noninsured. This year 5,598 patients were seen and more than 1.6 million dollars of health care was provided free of charge, involving 1,746 volunteers.

At the close of the event, it was announced that a Nursing Scholarship has been established for a resident of Dickenson County, Virginia, and has been named the Sister Bernie Kenny Scholarship.

Sister Bernie is a passionate advocate of healthcare for all. She has been involved with RAM for several years. This year she was once again part of the huge, free, volunteer health event in Wise County. Two of Sister Bernie's nephews were part of this volunteer force and had driven up from Florida (over five hundred miles) to lend a hand and 'keep family traditions alive'.

The recipient of the Sister Bernie Kenny Scholarship will have to keep a 3.0 average. The goal of the scholarship is to continue the legacy of providing health care for the under-served and to promote outreach amongst the needy.



At the Health Fair in Wise County Fairgrounds, Sister Bernie is congratulated by her colleague Teresa Gardner, watched by Karen O'Quinn.



At the Health Fair in Wise County Fairgrounds



Don Francisco

DON FRANCISCO is 92 years old. He has suffered from asthma for years. He has also lost his sight and his hearing. Last year he lost his dearly-loved wife. They had already lost ten of their twelve children. 'It was poverty that took them', Don Francisco told us.

The two surviving sons live far away and he doesn't expect to see them again in this world. He lives alone now, with his dog, Nokia, who sleeps beside him in the tiny room where he lives and with whom he shares whatever food comes his way.

Francisco is a man of faith and hope. His courage has helped him to face life's problems. He depends on our team for food and medication. We often remark how much we have learned from him and we marvel at his generous heart. He says 'God is with me. You are the Angels in my life.'

Isn't there the light of seven heavens in your heart alone, the way you'll be an angel's lamp to me...

JM Syngé, *Playboy of the Western World*

Angels in my

By Sister Cleide da Silva



Out on home visitation from 8 a.m. to 5 p.m., the team stops for a roadside lunch break. Sister Cleide (left) with Concepcion, Eucaris, Don Felix, and their faithful driver, Roberto.

Next stop on the round is to the home of Iris. She is 22 now and lives with her parents who have cared for her from infancy, watching her grow up and wondering about her learning disability. They have a small farm but her father has a problem with alcohol and doesn't work very much. They live in a small house with a kitchen

and one bedroom where seven people sleep. They depend on us for clothes and food.

Iris suffered from malnutrition for most of her young life. Someone took advantage of her, and now she is six months pregnant. She has little possibility of being able to care adequately



Women's workshop including Dilsia Hernandez Romero, Dona Maria Benigna Marquez, Gloria Hernandez Romero and Aida Aguilar, co-worker with Sister Rita Higgins.

life . . .

for her child, but her mother says she will welcome it and care for the baby as well as for Iris for as long as she lives.

There are thirty people in our parish like Don Francisco and Iris. In our Pastoral Care Team we visit them twice each week. The most common diseases among them are Parkinson's, diabetes, asthma, arthritis, Alzheimer's, hypertension, strokes, blindness, deafness and cancer. Sometimes we feel so helpless facing problems like these, because we don't have answers. At the same time we know that our presence makes a difference in their lives. They are always looking out for us when we come. They love to receive Holy Communion, knowing it brings them closer to God.

As I set out, I often think of the challenge of our MMM Constitutions: '*Be with those who suffer, the oppressed, and those on the margins of life. Heal the sick, excluding no one. Constantly strive to promote the wholeness of all people and their milieu.*' Here in Marcala, among the poorest people of Honduras, that is a big challenge.



Sister Bernadette says hand massage helps children who have problems with balance. It helps them relax, be more aware of their bodies and helps coordination.

Choloma Report

Sister Rosalinda



Martha prepares to give a talk on five local plants which have healing properties – eucalyptus, camomile, guava, juanilama and lanten.

IN THE TOWN OF CHOLOMA in the north of the country, a health survey of 200 families in the newly developing surrounding communities was undertaken. Sister Rosalinda Gonzales who is the doctor in charge of Medical and Complementary Health Services at our center – known as Casa Visitacion – says when all the data is gathered it will help in our annual evaluation and planning.

The hinterland around Choloma has a growing population. The survey revealed that the majority of residents are people coming from different regions of Honduras seeking work in the factories of Choloma. They rent a small patch from a land-owner and build a house, which they may eventually own after an agreed amount has been paid. When the land-owner has a sufficient number of tenants, he registers a new village with the local authorities. But while the 'village' may have electricity, providing water and sewerage is a bigger problem. The houses have only outside latrines at best. There is no potable water supply. Those who can afford it purchase water from the tankers, or buy bottled water from the town. Everyone tries to harvest any rain that falls.

Through frequent meetings of different health committees and visits to the sick at home and supervising home pharmacies, we continue to discern what are the most immediate needs of the people and see how we can best respond.



Training Workshop
at Choloma



Extension of Primary Health Care Outreach

by Sister Jacinta Lumenze

THE VILLAGE OF ZAFFÉ is home to about 11,543 people, more than half of whom are children. There are different ethnic groups, people have varied educational and economic standards and political outlook.

A survey of Zaffé observed that the village is economically underdeveloped. Farm products and animals are difficult to sell. Only very few people can pursue their dreams of completing their education. While the official language is French, this poses a big difficulty for many where local languages are spoken at home.

The fact that illiteracy affects up to 60% of the population makes it more difficult to engage in health education. While many people are Christians or Muslims, there are also many with traditional religious practices, and there is no great consistency. This can affect people's acceptance of certain

treatments and aspects of health education. Much work has been done through our Health Centre and other Centres in the area to reduce the incidence of disease and promote health, but there is still much to be done.

People present in large numbers at the clinic with cases of malaria, anaemia, arthritis and bone disorders, cough, skin infections, sexually transmitted infections, abdominal infections, hypertension and emotional turbulence.

The villagers have also told us of the need for toilets and continuous outreach to them and their children in school.

The majority of people are full-time farmers, so it is difficult to get them to participate in health gatherings, particularly during the rainy season.

Deep rooted cultural beliefs inhibit the comprehension of advice like not engaging in premarital sex, the consequences of abortion, unprepared parenthood and faithfulness in marriage.

Nevertheless, meetings and health education with the villagers have been very productive. We are hopeful that the new outreach program for primary health care, given quality time will – as it is already signaling – yield its objective of promoting health, preventing disease, curing the sick and rehabilitating the physically challenged, in collaboration with the Lilian Fonds Foundation.

Food demonstration in the village of Oke-owo. Villagers are encouraged to use their farm products to prepare nutritious meals, so as to be healthy and less prone to diseases and infections.

On this day, they contributed the beans we used and also the pot. They made the fire on which we cooked the food. The beans were specially prepared to include all the nutrients needed for healthy growth and development. We used palm oil, onions, crayfish and Moringa to prepare this meal which can be served for lunch or supper.

In the Clinic and in the villages, moringa which is rich in iron is constantly being introduced to the people. They are also encouraged to eat enough beans, soya, groundnuts, and maize which they cultivate. Some of these can also be sold to buy fish, meat and eggs for the family.

This part of the programme seems to interest the people very much. Apart from the focus on food preparation, it is a time for learning, sharing and eating from one pot and also a forum for social gathering and fun. They look forward to this moment very much.



Small Miracles

During the past year we felt we needed to take a new initiative because of the health challenges we were meeting, including severe anaemia, poor hygiene and malnutrition. The effects of these problems often presented at the Clinic. We decided to extend our Primary Health Outreach Programme. This involved home visits, inspection of sanitation, health education, treatment of sick people and food demonstrations.

This step forward has broadened our horizon regarding the state of health of the people here. So far, the people have responded impressively in the areas of health education that we give in the villages and in the churches and likewise regarding the food demonstrations.

Following the home visits, we have realized that we have still a lot more to do to enhance people's health and life. It is amazing to find that some people still lie on the floor and have no beds. In a single room, most families cook, store farm products and sleep with the house pets. In the same room, some have idols and shrines where they worship.

During one home visit we met a young breast feeding mother who was very sick with anaemia. She had a high fever and severe malnutrition. She was so weak and helpless, that her aged mother had to help her with the house chores. Both lived, slept and cooked in the same room with the baby. By the corner of the room was

their shrine with idols. The house was so congested. We began our work, shared some information on health with them, treated the young mother and followed her up in the Clinic until she got better.

Today, she is back to better health and is able to fend for her family and breast feed her baby well. Seeing her in subsequent visits gives me hope that ignorance can be alleviated.

In another village, we found a woman lying on a neatly made floor bed. She had high fever and a gangrenous foot. We observed her and treated her with a good dose of antibiotics. With subsequent visits, we found her greatly improved. A pathetic condition is what I will say hers is. One day, like the healing stories we are acquainted with in the Bible, she addressed me:

'Ma Soeur, please make me walk again' at that moment, I wished a miracle would just happen for her. I wished Christ would make her walk again. I was deeply moved. However, I believe that finding her was already a miracle. Whenever she hears our 'jingle' which alerts the villagers of our arrival, she calls out in a faint voice, *'Ma Soeur peux pas m'oublier'* – she asks that we do not forget her. She is very thankful of our care.

Another very moving situation was a woman whom we found with a severe cough, fever and pains. She was very ill until we treated her and she began to improve. The next time she saw us, she began to dance, praising God, thanking us and telling the villagers that we healed her. To show how well she was, she jumped, ran and flexed her knees. Pondering on this, I just said 'thank you' to God for bringing us to these people in whose lives we can make a difference. I could go on and on with more stories of the small miracles I have witnessed in the few months since we began this extended Outreach Programme.



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