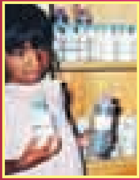
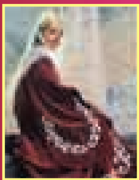
Healing & Development

2005 EDITION


Little Glamour in Los Puentes

Makiungu Hospital Celebrating 50 Years


The Town I Love So Well

AIDS – No longer an epidemic

Joseph's Dream

The Miracle on our doorstep

Yearbook of the MEDICAL MISSIONARIES OF MARY

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Medical Missionaries of Mary:
Founded in Nigeria in 1937 by Dublin-born Marie Martin, to-day MMMs number almost 400 Sisters, who come from 18 different countries. The three words in the Congregation's title carry the inspiration that gives us energy to become engaged in healing some of the world's pain.

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

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

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

Our Motto:
Rooted and Founded in Love *(Eph.3,17)*

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Healthcare in a Changing World

Dear Friends,

Our cover story from Honduras highlights how much our lives are dominated by the industrial and economic forces that surround us. For those who are poor, these conditions can put great demands on individuals and families. These social aspects of our changing world cause us to continually adjust the ways in which we respond to the needs of the people through the services we provide.

We rejoice with our community at Makiungu Hospital in Tanzania, who have marked the 50th anniversary of our foundation there. Further west, at Kabanga, we have been engaged with local Sisters known as Bene Maria in passing on to them the administration of Kabanga Hospital. At the same time, we have given approval for the opening of four new missions – in Tanzania, Malawi, Nigeria and Honduras.

The impact of HIV and AIDS continues to challenge us and puts a strain on our human and financial resources. Keeping pace with the availability of new treatment and the expectations of governments means that we have to constantly renew and re-educate ourselves in order to be able to take on board the wide range of services that are needed. We were very fortunate to have been sponsored recently for an important MMM Conference on AIDS held in Nairobi, involving our Sisters from thirteen countries. Our Yearbook gives you a little taste of what was covered during this important event.

We also feel very blessed by the final commitment of ten young women from six different nationalities, who made their Final Vows during the past year. Just as we rejoice with our Golden Jubilarians on their life-long achievement, we are gladdened by the assurance that there are young people following who will carry the work of MMM into the future.

The world has many needs and we cannot hope to address them all, but with your help we are eager to continue the work to which we feel called – that is to bring the healing ministry of Christ to those who are in need, and in this way to help them understand that they are children of God in whose name we are sent to be with them.

Without your support we could not have begun this work, nor could we continue it. I want to extend our thanks to all the individuals and groups and donor agencies who make it possible for us to make our contribution. You are part of our extended family, and we think of you and pray for you with gratitude. May God bless you and yours throughout the year ahead.

Sr Margaret Quinn
Congregational Leader

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.

Little Glamour in Los Puentes

OUR COVER-GIRL, Brenda Hernandez, lives with her family in a village called *Los Puentes*, which means 'The Bridges'. In this area of Honduras, coffee is the main export crop.

The story of this six-year old girl is the story of many of the families with whom we work in Health Committees in these small, scattered mountain villages. Their lives revolve around the growing and harvesting of coffee.

Most of the people who belong to our Health Committees have little or no land. For most of them, their annual source of income comes from picking coffee between the months of November and February. They work for the land owners of large coffee plantations known as *fincas*. After picking one hundredweight of coffee, they earn less than two euro – about the same price you pay for a cup of coffee in the airports, restaurants or coffee shops of the richer world!

Brenda's family consider themselves lucky! They have a small patch of land around their home where they plant corn. Their mud-brick house consists of two rooms with mud floors, and openings in the wall for ventilation. The house is dark and furniture is scanty. Yet, each month, this family opens its home for Health Committee meetings.

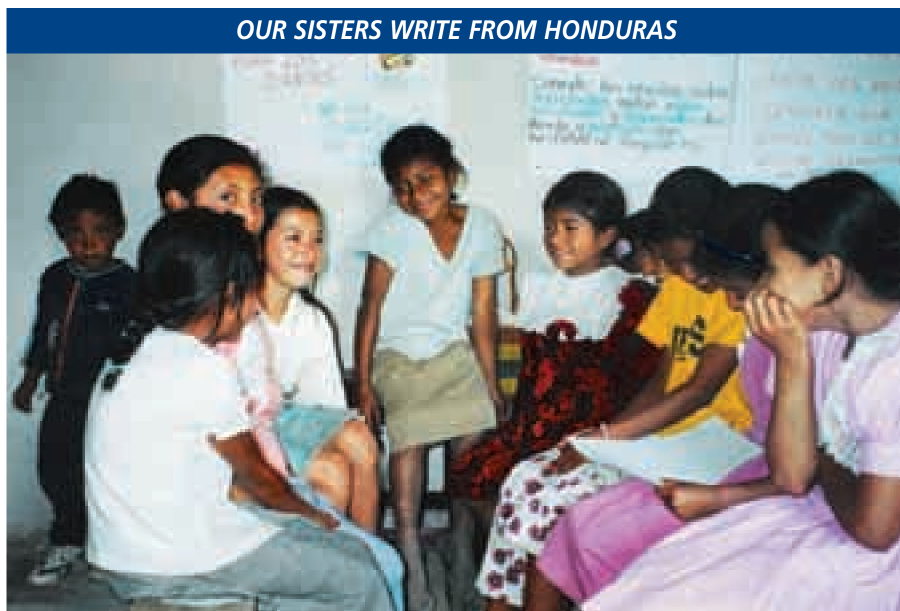
In the Hernandez home, the twelve men and women on the Health Committee produce natural medicines for all the families in the village. The little cupboard used to store medicines for the village has pride of place in this household!

Brenda wakes every morning at six o'clock and helps her mother care for the baby before heading off to school. Her mother has been up since 4:30, making tortillas which is the staple, and often the only food, of these families. After tortillas and coffee, Brenda walks for an hour with her sister and brother to reach their school. At midday the children in school eat a lunch prepared in turn by their mothers with food donated by CARE International.

For Brenda and her family the days and weeks follow a similar pattern with little change, except in the coffee-picking season which is also school holiday time here in Honduras. For these three months of school 'holiday', the entire family spends the day at the *finca*. Mom, Dad, her brother and sister all pick coffee. Brenda will join them when she is a bit older.

For now, her work is to mind the baby while her family picks the delicate beans. This is her life. This is the life of her family and that of thousands of other families here in Honduras and in all of Central America.

OUR SISTERS WRITE FROM HONDURAS



The health committee arranges classes for children too.

The medicine cupboard, with its natural remedies, holds pride of place.

Rigoberta Menchu, one of Guatemala's indigenous people, won the Nobel Peace Prize in 1992. In her story, she wrote: "…Picking coffee is like caring for a wounded person. I worked more and more as I set myself bigger quotas. For instance, I made myself collect up off the ground an extra pound over and above what I picked every day. So I kept working harder but they did not pay me more, they did not pay me for the extra work that I did. They paid me very little".

Rigoberta and Brenda have a shared history – that of a childhood spent helping their family to survive by picking coffee.

Children's First Aid class in Los Puentes.

As Rigoberta grew in her awareness of the life around her, so Brenda is growing in her awareness as she listens and is part of the work and conversation of the Health Committee that gathers in her home each month.

As you sit down to enjoy your next cup of coffee, we invite you to be aware of Brenda and her family who, along with so many others, receive very little of the money you have to pay for your purchase.

Our New Mission in Honduras

Sr. Joanne (above) and Sr. Renee (below) felt intuitively 'this is where we should be'

Towards the end of October in 1998, Hurricane Mitch struck Honduras. It was listed as the most deadly hurricane in the Western Hemisphere since the Great Hurricane of 1780. In some places, it produced 450 mm of rain in 24 hours and caused significant flooding along most of the country's rivers, including Rio Choloma. The municipality of Choloma, with its 180,000 inhabitants was among those badly affected.

Back in 1998, MMM responded to the disaster by establishing our first mission in Honduras at Marcala. Now the decision to establish a second mission has been made, near Honduras' northern border with Guatemala and El Salvador.

The headwaters of Rio Choloma are located in the heavily forested Cordillera de Merendón highlands. Since the devastation of 1998, major reconstruction of the highway bridge, railroad bridge and flood plain has been undertaken.

In March 2000, personnel from the University of Texas took a small fixed-wing aircraft on a mission to survey Rio Choloma using light-detection-and-ranging equipment and a precise global positioning system. This enabled comparisons with a ground survey of five cross sections in the floodplain – all with a view to preventing future flooding.

Meanwhile, the Spirit of God was quietly at work in MMM too, resulting in the opening of a new mission, staffed by Sisters Renee Duignan and Joanne Bierl who tell us:

"After a time of prayer and discernment, it was obvious to us that God is leading us to respond to the needs of the people in Choloma in the state of Cortes about 30 minutes north of San Pedro Sula which is in the north of Honduras. In the Diocese of San Pedro Sula, Bishop Angel Garachana Perez gave us an overview of the diocese and suggested two specific places to consider. One of them was Choloma. Athough this would not have been our first choice because of the intense heat, after spending time there and getting some sense of the needs, we felt intuitively that this is where we should be.

"Choloma has a growing population. Many of these people have migrated to here from all over the country to find work in the many factories in the area. It has all the problems of a growing urban setting including a high incidence of HIV infection.

"Our MMM contribution to its many problems will be small, but we hope it will be effective for those whom we can reach."

Celebrating 50 Years
MAKIUNGU HOSPITAL

FOR MANY MONTHS, plans were afoot to celebrate the 50th anniversary of the founding of Makiungu Hospital in Tanzania. In the final days of preparation, it all grew to a great crescendo.

Sister Maria Borda, the doctor in charge, breathed a grateful 'alleluia' when the day drew to a close.

'How can I put the 18 waking hours of last Saturday into one email for you?' she wrote:

We had been so busy all the week with meetings, preparing rooms for visitors, and then receiving them, on top of the usual hospital emergency demands.

But it was wonderful when people started arriving – it set the joyful flavour for the celebration. MMM Sisters came from Uganda, Malawi and Ethiopia as well as from other communities here in Tanzania.

Sr. Eileen Carmel Keogan – on of the three founding Sisters.

On Friday I was in the hospital until 5 pm, then of course I was greeting the visitors, so our 6 pm Evening Prayer had to be postponed to 7 pm We sang *Our Healing Call* – the words from our Constitutions set to music by Sister Marian Scena – and John Michael Talbot's *Magnificat*, which people keep requesting. Sister Catherine Fallon did a liturgical dance to this, which was beautiful.

At 9 am on Saturday, as I did my ward rounds, the whole hospital compound looked wonderful with plenty of bunting and flowers placed at strategic points. The hospital was busy with many very sick patients. Every time I tried to get away to the parish I was called back for someone else needing attention.

Bishop Desiderius of Singida has a reputation for punctuality, and he appeared at 9.40 am We all gathered in the middle of the main quadrangle for the blessing of the new chapel where ambulant patients can spend a quiet time. From there we processed to the level ground in the Village in front of the parish Church, where Mass was to be celebrated. Again, I was waylaid from the main body of the procession, and it was half an hour later when I was able to join in the Mass.

Original House

Founding Sisters: Kieran Saunders and Christina Hanly, both now deceased.

Sr. Maria Borda, Medical Officer.

In our culture here, the role of the *Mgeni Rasmi* or Guest of Honour is very important on occasions such as this. The account of the hospital's history and all the main speeches are addressed to this person, who is the focus of the celebration. This person provides a symbolic personification of the cause for celebration.

Despite all our planning, we were not certain as to exactly which person would arrive to fill this important role until a car marked 'Ministry of Health' drove up! Our Area Leader, Sister Catherine O'Grady and I went over to receive the Guest, and to our great joy out stepped someone we knew of old – the Personal Secretary of the Minister of Health, Mr. Mwakilufi, who has always been very helpful to us, knows our work and understands our spirit very well. We felt very honoured by his contribution to the event.

During Mass there was plenty of singing and liturgical dancing and jubilation, after which we made our way to the administration block for food which was a credit to Sisters Priscilla and Justina and all the staff and helpers involved in organising its preparation. There was food in the village for those who could not fit in to the hospital administration block.

After that, everyone returned to the space outside the Church, where we had local dances, dramas, speeches and songs. As a group of children were doing one of their dances, many of us could not resist the beat of the drums, so we joined them, to everyone's amusement.

By evening, when all was quiet again in the village and the hospital, we had our own time together and ended up having the inevitable sing-song. Throughout the whole celebration, our thoughts were with all those who have been part of Makiungu's foundation and history and with all our supporters who could not be with us for this great occasion.

Sr. Sheila Berthiaume, General Surgeon at Makiungu

Sr. Marcellina and staff use the herb garden for complementary therapies.

Sr. Justina Odunukwe, Hospital Administrator

Sr. Catherine Fallon came from Nagwa Mission for the Jubilee.

Sister Marian Scena, former Medical Officer came from Kaganga for the Jubilee.

Sr. Priscilla Anene, Director of Nursing.

Fr. Oliver O'Brien, Regional Superior of the Pallotine Missionaries in Tanzania, writes about

Makiungu

through the decades

THE EARLY' brick burning' days – when the bush was being cleared and the first buildings began to take shape – must have been very exciting and challenging. In those early pre-independence times, Singida Region was considered to be so remote that only single men were allocated posts in the colonial administration. The intrepid single women of the Medical Missionaries of Mary appear not to have been burdened with any such constraints. It was precisely because the area was remote that their free and generous spirit guided them to a place where there was a real and pressing need to assist with the provision of preventive and curative health services.

Blessing of original block by Bishop Winters

In 1970 President Julius Nyerere opened the new children's ward.

The life of a hospital – i.e. the range, type and quality of the services it provides – is closely linked to the environment and the demography of the area. Equally true but not so obvious to the casual observer is the impact of the wider socio-economic factors. Almost by definition, the delivery of an efficient voluntary health service in the context of a subsistence economy is always difficult. If we accept this point we will begin to appreciate the enormous contribution that Makiungu and similar health units make towards the well-being of people in Singida Region, especially the rural areas.

Factors entirely outside of the control of hospital administration such as unpredictable, soaring prices for fuel and other inputs can make balancing the books a daunting task. Negative factors can sometimes coincide (and have) bringing about near disastrous consequences for the effective running of the institution. A quick look at the records will show there was a very serious outbreak of meningitis in the late 1970s, cholera more than once and cyclical food shortages resulting in widespread malnutrition and associated health problems.

The hospital has been often on the verge of crisis in financial terms but has never lost the vision, the capacity and the commitment to deal with any situation no matter how dire.

If that were not enough, there is the near certainty that at some stage every year the numbers presenting at outpatients and inpatients suffering from malaria will peak at seriously high levels. Closing the front gate is not an option. Nor would it ever be considered an option by those responsible for and associated with the hospital.

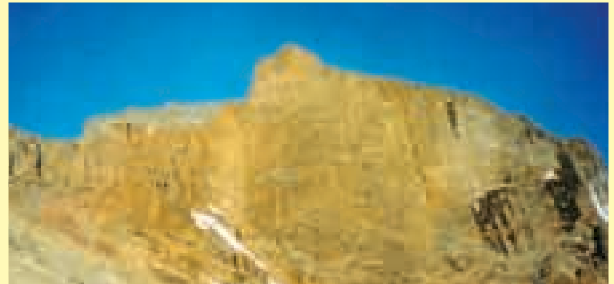
Staff is a critical component in the delivery of a holistic, preventive and curative health service such as we see in Makiungu. Not only recruitment but also retention is a major challenge. Professionals have every right to be adequately remunerated with an attractive package to sustain their morale in often very demanding work circumstances. This and the combined cost of drugs, equipment, transport and utilities amounts to a figure 'on the bottom line' of the expense sheet not to be contemplated by the faint-hearted. Yet, if most or all of this must be passed on to the patient in what is nowadays called cost sharing, we would seem to have lost sight of the fact that there are genuinely dis-advantaged people who are seriously ill, at risk and in need of treatment.

In the Church voluntary health units, the human dignity of people is respected and always has been. To the extent of their ability, people do contribute to the provision of what is their health service and always have done so. However, there is a quite obvious need and very good reason – even an imperative – to share our resources with our fellow human beings. Makiungu Hospital does this extremely well.

In conclusion I would like to say that it is my good fortune and privilege to have been associated with the Hospital. My hope and prayer is that along with the other excellent health units in the Diocese of Singida it will continue to deliver a professional and compassionate health service to the people of the Region.

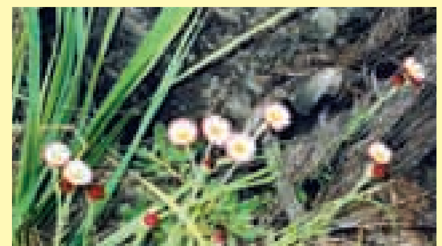
Kilimanjaro Fundraising Expedition

L-R: Peter, Mary, Michael, Christine, Kelly, Josephine, Ellen



Dr. Mary Coffey is an Associate MMM who keeps close links with Makiungu Hospital, where she worked for a number of years. She likes nothing better than to devote her annual holidays to returning to help out.

For the 50th anniversary of the Hospital, she decided to embark on a major fund-raising campaign, rounding up all her friends in the effort. Christine Foley and her husband Aidan were roped in to organise a Golf Classic at the Headfort Golf Club near Kells, after which they opened the grounds of their lovely home for a summer barbecue. Their son, Michael (top right), joined other friends, including Ellen Greaney and Josephine Mulryan, on a sponsored climb of Kilimanjaro. They arranged this expedition with other climbers who were raising funds for the charity Moving Mountains. They each paid their own expenses, leaving all of the money collected available for the hospital.



After their descent they took the long dusty road over 300 km south to visit Makiungu and deliver the proceeds of their mighty effort to mark the hospital's Jubilee – totalling more than €85,000.

Freedom to make Choices

by Sister Catherine Dwyer

IT IS OUR conviction that without education people will have neither the ability nor the freedom to make choices. They will be unable to critique policies and traditions which keep them oppressed, or to contribute to the development of their country in a way that enhances the dignity of every person.

For MMM, healthcare has always been our mission. Care of mother-and-child is predominant among all the aspects of health that concern us. But life is neither simple nor clear-cut any more.

Faced with a growing orphan generation, when the mother has been taken out – by death – from our mother-and-child mandate, we find ourselves sponsoring education in a way that we never had to do before HIV struck.

We have always supported our staff in the education of their children. Now we must stretch our resources much further.

Our first concern is for orphans. The girl child is usually the one who drops out of school to care for other children, to assist sick parents, to run errands or simply because there is not sufficient money to buy clothes for all the children to go to school. The boy gets first consideration. Too often, the girl remains illiterate.

In Malawi, back in 1994, free primary education for every child was central to the Education policy of the newly elected Government. However, the human and physical resources needed were not in place – it was almost an impossible task. The Teachers Union of Malawi has declared that HIV and AIDS are responsible for the deaths of up to 1,200 teachers every year, in both primary and secondary schools. In third level institutes, both lecturers and students are affected in the same way. School buildings are inadequate. Children and teachers are often gathered under trees in place of a classroom.

Without education, fear prevents people from questioning the causes of their poverty, let alone unravelling cultural traditions and customs, which can keep them in bondage. All too often, a widow becomes impoverished on the death of her husband. The relatives of her husband grab what property she has, even down to beds and chairs and other basic essentials.

Then there is the cultural silence and taboo around sexuality, which has contributed to the high incidence of HIV/AIDS and the difficulty of encouraging behaviour change.

Literacy Programme at Mtsiriza

Against this backdrop, we try to sponsor education at every level, insofar as our resources allow.

In Mtsiriza we support a literacy programme. You cannot imagine the joy on women's faces as they are finally able to sign their names!

- In Chipini, we are sponsoring 78 orphans through secondary school.
- In Mzuzu, we continue to sponsor 30 children in secondary school, to enable them to finish this cycle.
- In Mtsiriza, a township outside of Lilongwe, we are sponsoring 15 children – mostly girls.
- We are sponsoring some twenty students through third level education – technical skills, teacher training, accountancy, information technology and medicine.

Thanks to the wonderful support of our many donors, we have been able to help communities to build schools. The local people provide sand, stones and mould bricks. We help with cement, timber and roofing. It would be totally beyond their means to buy cement or even pay for the technical labour.

Health Education

As well as formal education we involved on a daily basis in health education, pastoral training and human development. People who lack the basic education are less likely to maintain a programme of medical treatment. This is a huge challenge as countries are enabled to avail of anti-retroviral treatment for HIV.

Encouraging farmers to diversify crops, and mothers to avail of a more nutritious food for their children demands a constant effort.

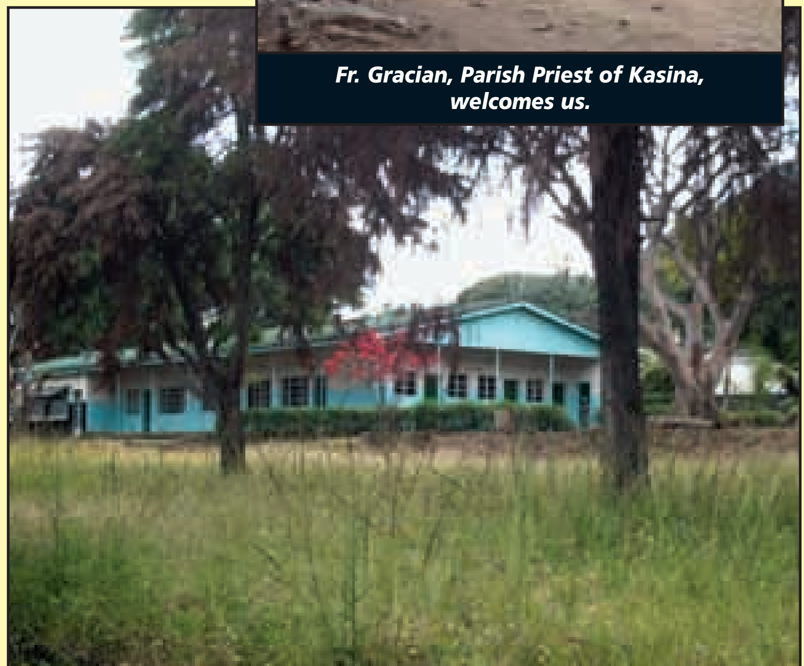
So, while we are not called to be teachers in the traditional sense of the word, we find that helping people to ensure their good health means we have to become involved in the world of education – just as our work in nutrition involves us more and more in the world of agriculture.

There is so much for all of us yet to learn!

New Mission in Malawi

Kasina Mission is set in the beautiful Dedza Mountains. As well as the Health Centre, the mission compound is home to Kasina parish church, a primary school, a convent of Teresian Sisters who run the Health Centre, and a Minor Seminary for students from four Dioceses.

Fr. Gracian, Parish Priest of Kasina, welcomes us.



Bishop Sainte-Marie has invited MMM to go into those mountains and develop with the local communities six Outreach Clinics. In this way we hope, in time, to overcome the malnutrition and many illnesses that can be prevented. Seeing the many malnourished children at the Nutrition Unit attached to the Health Centre, many of whom are returning for a second time, leads us to wonder what life is like for the people on the other side of the mountain.

The MMM Team in Kasina have been joined by two Canadian Volunteers, John and Johana Booy. John is assisting with construction and repairs. Johana is helping with administration and women's development.

Interdenominational Pastoral Care Centre at

Kamuzu Central Hospital

By Sister Anne Carr

KAMUZU CENTRAL HOSPITAL in Lilongwe has 1,100 beds. At times there is a 300% bed occupancy. The hospital chaplains and pastoral care team take an interdenominational approach to the spiritual and pastoral care of the sick and dying.

Like most hospitals, space is hard to find, and over-crowding is a huge problem. To achieve our goals, we needed a place where we could bring staff and family members together in groups.

With the help of a grant from the Beit Trust, our Interdenominational Pastoral Care Centre has now been completed. As ours is a government-run hospital we drew up a Memorandum of Understanding between the Ministry of Health, the Director of the Hospital, and the four major church authorities – the Catholic, Anglican, Presbyterian and Evangelical Lutheran church groups.

Our aim at the Centre is to provide holistic spiritual and pastoral care to the sick, their relatives, and the staff who care for them, as an expression of God's love for all. Our commitment is to manifest love, truth and justice for all, regardless of religious affiliation, status, ethnic or economic background. In this way we hope to uphold and respect the dignity of every person, especially at times of greatest vulnerability. It is a place where patients who are ambulant can come, also their relatives, staff and others who would like pastoral or spiritual care.

We opened the Centre with a series of one-day workshops for all the staff. To date over 500 personnel have availed of these in-service training workshops. The effects of this initiative have contributed to improved patient care and greater compassion for the sick and the dying.

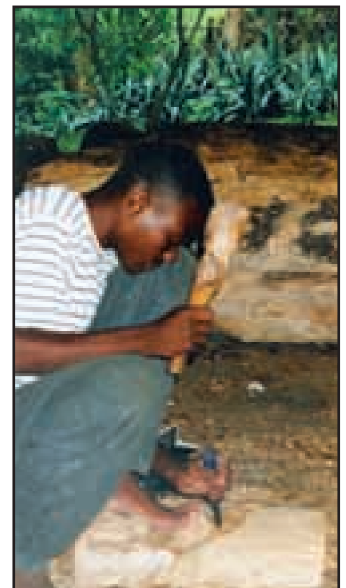
In the process, staff members are helped to get in touch with some of their personal pain and frustration. Many of them told us the workshops helped them cope with their task. At times they feel over-whelmed by so much sickness and so many people dying in the wards. We also offer one-day workshops on Care of the Carers and intensive workshops for church groups who visit patients in the hospital.

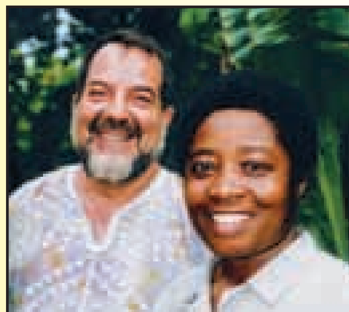
For our chapel, thanks to a grant from Missio, we were in a position to commission carvings from the famous KuNgoni Art Centre at Mua, which is not too far from Lilongwe. These will greatly enhance this sacred space. Perhaps one day you will be able to come and visit us.

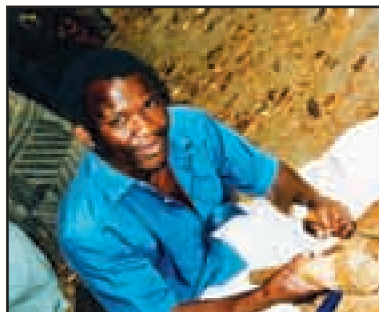
Some of the Pastoral Team, Srs. Ursula, Patti and Anne.

KuNgoni

KuNgoni means 'the place where the history of the Ngoni people is kept' – as in a museum. Its founder is Canadian-born missionary, Fr. Claude Boucher, M.Afr., pictured below left with Sister Teresa Ugwuliri. He is a collector of details of the Ngoni culture and is constantly deepening his knowledge of the Ngoni people, some of whom inhabit parts of Malawi near to the mission at Mua where this museum is housed and where beautiful artwork is created.







AIDS – No longer an epidemic

WE CAN NO LONGER SPEAK OF HIV/AIDS as an epidemic, nor even as pandemic, for it is now endemic in our society all over the world, Sister Maura O'Donohue told a recent Conference attended by 62 MMM Sisters and Associate Members in Nairobi. This means that it is firmly entrenched in all countries worldwide. It is a condition that is not going to disappear in the foreseeable future.

She emphasised the importance of ensuring a broad-based and multi-faceted approach to services related to HIV/AIDS. This is essential because of the broad spectrum of implications and the consequences for everyone affected.

Since the middle of the 1980s, when HIV was first identified, Medical Missionaries of Mary have been adapting our services to cope with this major health problem. Our response represents a very big investment in thirteen countries where we are involved. In some countries, our Sisters have pioneered unique services, and we have made a long-term commitment to this work.

In responding to the problem of HIV and AIDS, we aim to support and enhance people's own coping mechanisms, respecting their religious and cultural traditions, while we treat the symptoms, care for the person suffering and support the wider families involved.

Some of conference participants were very experienced in dealing with the problem. Others were seeking help in getting to grips with various aspects of the disease and its social impact. Those present represented many teams of dedicated professional workers and trained volunteers.

Eleven main papers were presented, sixteen participants were invited to talk about their personal experience and there were eight workshops – each of which was repeated so that everyone could attend all. The discussion which these evoked explored ways in which we can help one another to ensure best practice in the ongoing struggle to cope with this health problem.

'Energy' is the word that best describes our week together in Nairobi. When we parted and headed back to the thirteen different countries from where we had come, we knew that this energy must now carry the momentum of a memorable week to every city, town and village where we work.

Preparation by eForum

Starting last June, preparation for our September Conference was done by eForum. Over three months, a wide range of topics concerning the services provided by MMM in the field of HIV and AIDS were debated. In this way, everyone became familiar with what was being done in other parts of the world.

The topics included experiences, tips and pitfalls encountered in setting up an AIDS programme; anti-retroviral therapies; alternative therapies and herbal remedies; counselling; pastoral care; home based care; women in prostitution and trafficking; care of carers; spiritual and ethical issues; orphans; prevention of infection; AIDS in the hospital; hospice and palliative care; poverty and AIDS.

For some Sisters living in remote parts of Africa or Latin America, this meant travelling long journeys to the nearest Internet Café, even queueing for hours to get access to the Web. But when evaluated, our eForum was felt to have been an indispensable tool, helping Sisters in isolated missions to feel part of something much bigger than their own effort.

Sr. Maura O'Donohue

World Problem

An extract from the global overview presented by Sister Maura O'Donohue

We know from the WHO statistics reported at the Bangkok Conference in August 2004 that there are now 38 million adults and children estimated to be living with HIV/AIDS. Each day, there are 13,700 new infections, 60% of which are in women. Of all the people living with HIV or AIDS, 70% live in Sub-Saharan Africa. Without enormous and effective prevention strategies, an additional 45 million people are likely to become infected by the year 2010.

AIDS is unique among illnesses. Like all epidemics it was initially recognised as a health problem. But it quickly highlighted other issues. It showed up the inequality that is pervading the world. Poverty greatly increases vulnerability to HIV infection. It also jeopardises programmes aimed at social and human development.

Long term effectiveness requires initiatives which:

- mitigate the impact
- address the consequences
- reduce immediate risks of infection
- decrease vulnerability
- are peer-led, involving all concerned

When dealing with HIV, care of those already infected is inter-linked with education for prevention. Development work is also closely related, because programmes that reduce the social effects, the health risk and the economic impact of HIV will also reduce people's vulnerability to HIV infection.

This is most evident to everyone involved in home based care – for it becomes impossible to treat a person with anti-retroviral therapy if they are hungry, or to involve extended family members who volunteer to help in the care of the sick person if there is no roof over their head.

Likewise, the work of advocacy is closely linked to the problem of HIV. This leads to involvement at national level in education around issues like:

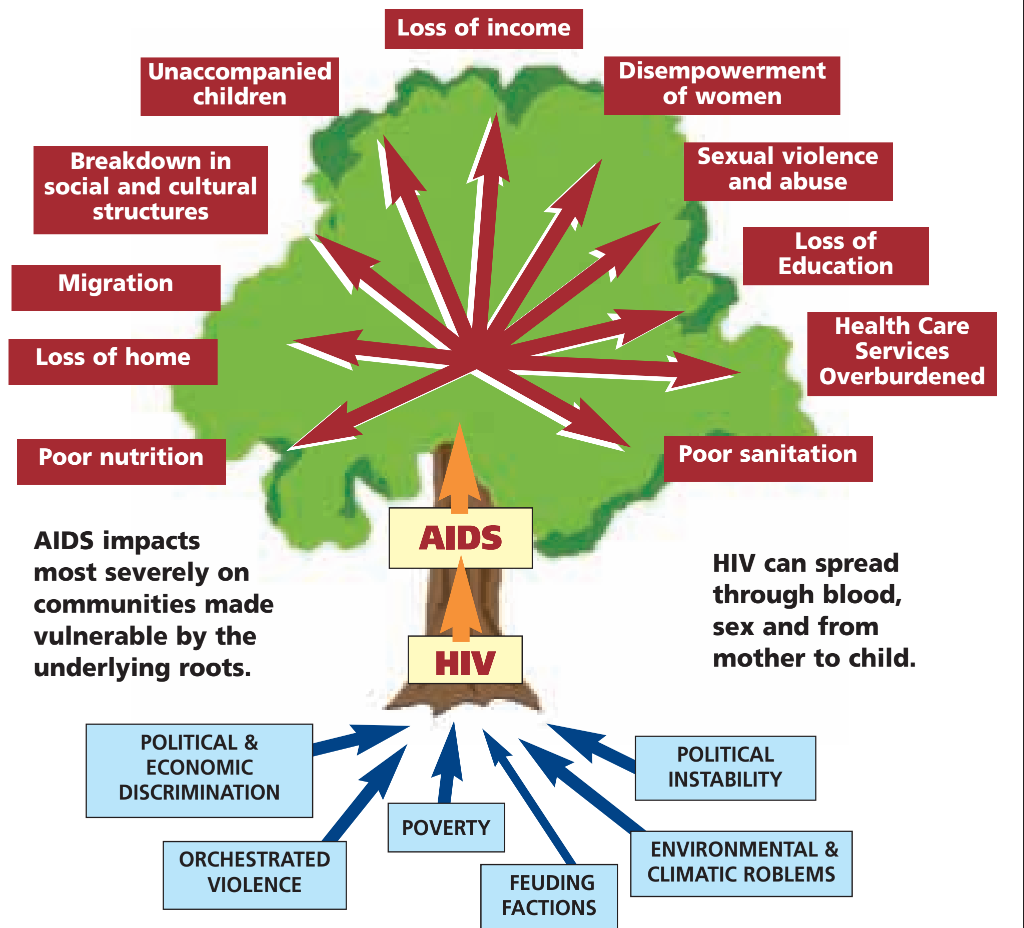
- inheritance and property rights of women and children
- reducing discrimination and the stigma associated with the disease
- working to ensure the importation of essential drug supplies and
- securing human rights legislation

THE PROBLEM TREE

Vulnerability to HIV and to Discrimination

Care and support of those already infected with HIV mitigates the impact of the disease. But in the healthcare continuum, the deeper root causes must be addressed in order to eliminate the effects. Alongside this, it is important to raise awareness among the healthy population to prevent the spread of the disease.

The Problem Tree illustrates the underlying roots highlighting vulnerability to HIV infection. The leaves and branches represent some of the consequences.



Courtesy of CAFOD

Anti-retroviral Treatment

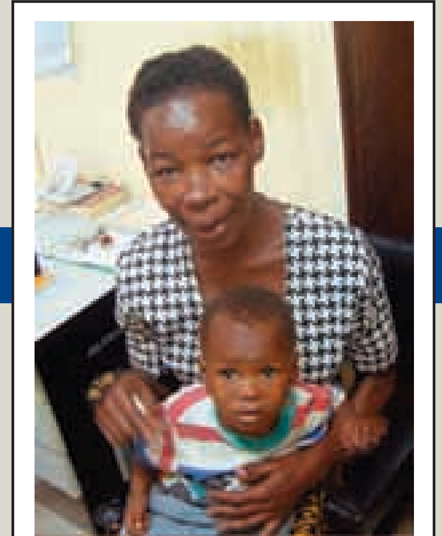
An extract from detailed presentations made by Sister Brigid Corrigan

Sister Brigid Corrigan is medical director of PASADA, the pastoral service to persons with AIDS in the Archdiocese of Dar es Salaam. In her presentations at our Conference she provided detailed guidance to participants on different issues related to the use of anti-retroviral treatment.

With the use of anti-retroviral drugs (ARVs), some of the damage to the immune system can be slowed down or prevented. The aim of anti-retroviral treatment is to stop the progression of the disease. It does not eliminate HIV from the body, because HIV hides inside the body and makes millions of copies of itself every day. This means that the drugs must be taken every day to keep the virus under control. Adherence is the key word. She emphasised that patients need support to help their adherence. In PASADA, there is a large support team dedicated to this work.

- Patients must not stop the drugs when they feel better
- People who are depressed or isolated may have problems
- Do they really believe in the treatment?
- The regimen must be user friendly, or they will not take it.
- If they do not know what they must do, and when or how the medicine will act, the drugs will not be taken.
- You must warn about side effects.

In a session on Funding, Planning and Management, the implications of prescribing ARVs which patients will need for the rest of their lives were highlighted by Associate MMM, Eamonn Brehony. While we would hope to lengthen a person's life through ARVs, we need to ask the question 'what if donor agencies change their priorities in coming years and cease to fund the provision of these drugs?'



Prevention of mother-to-child transmission (PMTCT) is a critical part of the strategy to limit the spread of HIV. Sophia, pictured here with baby Justin, was the first mother at PASADA to receive Nevirapine, ensuring that her baby was born HIV-negative.

Statistics do not cry…

'Statistics do not cry; numbers do not tremble; graphs do not need a hug; data does not touch our hearts – but children should.' These are the words of Sister Ursula Sharpe, who was overall Coordinator of our Conference on HIV and AIDS.

The figures for children orphaned by AIDS are staggering:

- **Uganda** — **2 million**
- **Nigeria** — **1 million**
- **Kenya** — **1 million**
- **Zimbabwe** — **1 million**
- **South Africa by 2010** *(estimate)* — **1.5 million**

These numbers are expected to increase over the coming years.

'What does that imply for us when we are faced with an Orphan Generation?' asked Sister Ursula. 'What of teenage mothers who are orphans themselves?'

She pointed out that the original charism of MMM placed particular emphasis on care of mother and child.

'If we do not cry, we should not be on mission. If we are not moved by what we are seeing, we should go home', she said, encouraging all participants with our teams in our various missions to take a serious look at the need to provide counselling for orphans.

Counselling and Testing

Mr. Bahati, laboratory technician at PASADA

Sister Brigid told the Conference that HIV Counselling and Testing are critical to meet the WHO Emergency Plan Goals. But, 95% of the almost 40 million HIV infected people worldwide do not know they are infected. Only 5-10% of the population in focus countries have ever had an HIV test and less than 10% of pregnant women have received an HIV test.

Despite the critical role played by counselling and testing in reaching the goals for treatment, care, and prevention, professionals are only now beginning to discuss the number of persons that will need to receive Counselling and Testing services and how we will go about providing this level of service.

Many of us are working in programmes that use the Voluntary Counselling and Testing (VCT) model to reach people. But the yield of HIV-positive people is low. An alternative is to look at Provider-initiated HIV Counselling and Testing. This refers to HIV testing done as an integral part of the health care services. It is important to ensure that clients have the right to refuse (i.e. opt out) and that testing is not mandatory.

Studies suggest that there is an increased uptake of HIV testing when it is offered as part of routine ante-natal care and the option to opt-out is used. In Kenya the uptake increased from 57% to over 80%; in Botswana from 70% to 90%.

Using the VCT model, everyone who comes forward voluntarily is tested, without reference to risk of infection. However, the Provider-initiated Model means testing clients who are attending for some health-related issue. The yield of HIV-positive results, as shown in the tables below, is much higher when using this second model.

The chances of reaching the Emergency Plan Goals would be considerably higher if Provider-initiated Counselling and Testing were introduced.

		Using the VCT Model		Using Provider Delivered Testing	
	To provide treatment to this many people...	*We'll need to identify this many who are HIV+...*	*Which means we'll need to test this many (% of population)...*	*We'll need to identify this many who are HIV+...*	*Which means we'll need to test this many (% of population)...*
In Botswana	**33,000**	**165,000 @37.3% prevalence**	**401,000 (27%)**	**82,500**	**100,000 (7%)**
In Kenya	**250,000**	**1,250,000 @6.7% prevalence**	**19,000,000 (60%)**	**625,000**	**4,800,000 (16%)**
In Tanzania	**150,000**	**750,000 @ 8.8% prevalence**	**8,500,000 (25% of 34.5 m)**	**370,500**	**2,000,000 (6%)**

Sister Davnet O'Kane runs the Blood Bank at Kitovu Hospital, Uganda, where they depend each year on 9,000 blood donors, and test over 5,000 patients as well as those who request voluntary testing. At the Conference she presented two papers – one on Virus Aetiology and the other on Testing for HIV.

She outlined the structure of the virus and how it attacks the CD4 lymphocytes in the body. These cells have 'receptor' sites, like a key getting into a keyhole. Once inside the cells, the outer part of the virus falls off and the inner RNA is transcribed to DNA through the action of reverse transcriptase. This DNA goes into the DNA of the CD4 cells and takes over.

During the first three weeks, the person suffers flu-like symptoms. This is a very infectious time with a high viral load in the blood. There is antibody production, small and weak during the first six weeks, but gradually increasing at three months. Opportunistic infections take over the body. HIV is present in the body from the time of infection until the time of death.

Saving a generation of young people

The task of saving a generation of young people from HIV involves a wide-scale campaign of Education for Prevention. This was emphasised by Jacinta van Luijk, a Dutch volunteer nurse working with the MMM Kitale AIDS Programme.

The Behaviour Process Method, designed by Sister Kay Lawlor, is a programme developed for use with groups who are living in an area where there is a high prevalence of HIV infection and a need for safe sexual behaviour. It aims at either reinforcing present safe behaviour or bringing about a change in behaviour. It is the individuals in the group who choose the appropriate behaviour and then commit themselves to it. The group simply facilitates this.

Jacinta, who has worked in Kenya for the past twenty years, reports that many participants have told her that the Workshops she runs using this process have marked a turning point in their lives. They say the workshops have helped them to freely discuss sensitive issues such as sex and death with their spouses and children leading to greater peace at home. The workshops have also helped to break down barriers between religions and to create networking.

- Knowledge about AIDS is not enough. To achieve change in risky behaviour all aspects of life need serious attention.
- For AIDS education to successfully address behaviour change, there is a need for full participation of everybody involved.
- It is important that psychological, social, cultural and educational approaches are used simultaneously.

Volunteers trained using the Behaviour Process Method have done a lot of AIDS education in communities and schools. Several support groups have been started and maintained. As well as young people, participants have included adults, widows and widowers, village elders and school teachers.

A great increase has been noted in the uptake of Voluntary Counselling and Testing after the Workshops. Another benefit has been the opening up of opportunities to involve theatre groups in education for prevention of the spread of HIV. It has also helped to increase awareness of the need for home-based care activities and support for child-headed households. Leadership of several organisations has become convinced of the value of this approach to Education for Prevention.

Jacinta van Luijk

Embarking on such a process involves many difficulties and challenges. It is not easy to maintain the spirit and keep up enthusiasm. Encouraging voluntary commitment in an age dominated by 'money madness' requires perseverance. The ever-present problem of poverty is a major obstacle. Likewise, issues such as alcoholism, drug abuse, and corruption complicate the situation. Behaviour Change is a life-long task. It requires much patience, perseverance and not-yet-perfect results.

AIDS AND WAR

Sadly, the context in which the struggle to overcome the problems related to HIV and AIDS is often set against a background of war. Where military spending is high, health care spending is proportionately low.

Since 1993, every year the world has seen between 40 and 59 wars. These have led to economic collapse, human rights abuses, refugees and internally displaced persons, increased numbers of disabled people and orphans.

The nature of war has changed. The casualties are no longer confined to members of the armed forces, but spill over into the civilian population.

In many places where there is a military presence or a peace keeping force living under abnormal levels of stress, there is a general acceptance of sexual activity between the military and the local community, leading to a greater likelihood of HIV transmission. For example, studies have shown a HIV prevalence of 11% among peacekeepers returning to Nigeria from Sierra Leone and Liberia compared to a 5% prevalence in the rest of the adult population in Nigeria. In South Africa, the prevalence among returning military personnel was found to be between 60% and 70% compared to 20% in the rest of the adult population.

Spiritual and Ethical Issues

Fr. Kevin Kelly, author of many titles including *New Directions in Sexual Ethics*, was with us for the entire Conference.

Fr. Kevin's presentation on Person-Centered Moral Theology covered important dimensions of the human person – free and responsible subjects; embodied subjects; part of the material world; interrelational and interdependent social beings; historical, equal, unique and open to the transcendent.

He drew the distinction between the ethical goodness of the person – which is morality in the truest sense of the word – and the ethical rightness of actions or behaviour. The evaluation of a person's goodness is indisputable, while that of right action or behaviour remains exposed to the possibility of error.

Our discussions on the spiritual and ethical issues related to our work with HIV and AIDS were set in this context.

The Catholic church's position on the use of condoms is something on which we are often questioned. While we do not distribute or promote condoms as part of our programmes, the proper use of condoms is always discussed in education about the prevention of HIV. The development of Catholic thinking through recent writings of various spiritual leaders was noted, including Cardinal Daneels of Belgium, Cardinal Jean-Marie Lustiger of Paris, Cardinal Murphy-O'Connor of Westminster, and African theologian Laurenti Magesta among others.

It was seen as important to place the issue of condom use in its broad context, as was done by the Sisters for Justice of Johannesburg, when responding to the South African bishops' document *A Message of Hope*:

'What is on the table now is about much more than condoms. It is about the kind of Church we would like to be as we reach out in compassion, as disciples of Jesus, to those who are in mortal danger and have no other means of protecting themselves. It is about the way we feel for people in complex socio-cultural-economic situations; people who do not live in regular, equal and loving relationships. It is about educating people so that their consciences are formed in making responsible moral choices. It is about our accompaniment of young people, and particularly of young women, at this crucial time in their lives, as they face choices that are about life and death. It is about how we search humbly and sincerely for truth, justice and compassion without seeing everything in "black and white" terms as though there are no grey areas in between. And finally it is about gender imbalance in society and Church; about the on-going injustice, violence and discrimination against women. The HIV/AIDS pandemic, with all its ramifications, calls us urgently to address the issues of social, economic, racial and gender injustice which make our country so vulnerable to the spread of the virus.'

We are deeply grateful for funding to cover our Conference on HIV/AIDS and other aspects of our work in this field from the following agencies:

CAFOD
(Catholic Agency for Overseas Development)

TROCAIRE

Catholic Relief Services

Catholic Medical Mission Board

MISSIO

Development Cooperation Ireland

LOGISTIC SUPPORT

It was no small feat to organise visas, flights and ground transport for 62 participants from 13 countries.

Most of this work behind the scenes was done by our Area Leader in Kenya, Sister Patricia Langian, pictured here with Sister Ursula Sharpe, overall co-ordinator of the Conference.

A key role was also played by Sister Kathie Shea who is involved in our financial administration in East and Central Africa.

Nobody is more experienced at collecting and depositing travellers at Nairobi Airport than our driver, Michael Thuo Muiriri, who has been working with our Sisters at Sports Road for many years.

AIDS IN PRISON

Sr. Helen Aherne

Training prison staff and prisoners is an important aspect of the care of persons living with HIV and AIDS. In Kenya, our Kitale AIDS Programme has provided training for Officers from four prisons. In Uganda, Sister Helen Aherne works with prisoners in Masaka, where she provides a clinic twice every week. The HIV incidence among those Sister Helen tested is between 40% and 60%.

Many of the women prisoners are pregnant on admission and are allowed to keep their babies until they reach two years of age. Sister Helen finds that providing nutritional supplements to keep these mothers and babies well is quite a challenge.

Nancy Hinds, who is an Associate Member of MMM, is the founder of the Hinds Hospital Home in Fresno, California. Many of those she cares for are homeless and alone. As part of the Home's extensive outreach programme, some of her team visit two prisons housing 7,500 women, where HIV prevalence is 75%. Prisoners serving life sentences are invited to train to become volunteers at the bedside of prisoners who are dying. This has turned around the lives of many of the inmates, who feel a new sense of purpose as hospice volunteers.

As Nancy prepared to leave Fresno to join us at the Nairobi Conference, among her patients was a young man in his twenties. As he neared death from AIDS, he had been released into the care of her Hospice Home from the prison where he had been serving a life sentence.

Mrs. Nancy Hinds

'Try to rest now. I want you to know that you are loved here', she assured him, after he was admitted. He looked up at her and said:

'That is the first time in my life that anybody has told me they love me. If I had met you when I was younger, I am sure I would never have ended up in prison.'

COMPASSION FATIGUE

Awareness of compassion fatigue was emphasised by Sister Kay Lawlor in her presentation on Stress Management. Some of the symptoms of compassion fatigue might include increased anxiety, intrusive thoughts or images of clients' trauma, difficulty separating work from personal life, lowered frustration tolerance, increased outbursts of anger or rage, dread of working with certain clients, depression and feelings of sadness, hyper-vigilance or feeling 'on guard', decreased feelings of work competence, diminished sense of purpose and enjoyment with one's career, relationship problems, loss of sense of humour, lowered functioning in non-professional situations, loss of hope.

As well as dealing with compassion fatigue, Sister Kay taught us much about stress, distress, burnout and trauma. Understanding these is important when relating to our staff and family caregivers as well as in taking care of ourselves.

Cumulative stress, or the prolonged exposure to numerous daily aggressions, even minor ones, may lead to anxiety, depression, deep emotional wounding and burnout. This is something that comes to the fore a lot when dealing with HIV and AIDS.

In other situations of trauma, we talk about 'post trauma' or 'post stress', but with HIV and AIDS there is no 'post' period, so it becomes cumulative. This is where we begin to get into trouble, because ordinary stress mobilizes our energy, it is not overwhelming, one bounces back. Distress takes a bit longer. But cumulative stress is something of which we have to be aware and with which we have to deal.

Organizational acknowledgement and recognition of secondary trauma can help, but those involved also need to build up their resilience through self care, she said. Those involved in ongoing situations where they have to deal with trauma need regular emotional first aid. Debriefing with others and community support are very helpful in this process.

Sr. Kay inspired many liturgical celebrations to help us heal our broken world.

Sometimes our staff members are caregivers in their own families as well as caring for others through their work. We need to be sensitive to reactions that may be coming from stress and trauma.

Home Based Care

Among the expectations listed at our opening session, **Sister Carla Simmons** voiced the feelings of several of the more experienced participants when she said 'I want to pass on my passion for palliative care'. This is part of the service provided in our Home Based Care Programme in Uganda. It involves an extensive Mobile Outreach Service of which Sister Carla is the Medical Director, with 4,000 patients under her care.

Since the Kitovu Mobile AIDS Home Care Programme started in 1987, 14,000 patients have received care at home. This service covers home visiting and Treatment Centres in three districts, Masaka, Rakai and Ssembabule, which include 26 sub-counties with a combined population of 1,423,743 people. Almost 93% of these people live in poor rural areas with inadequate health services.

The reason for the Home Care programme is because the distance between their homes and the services in the towns is so great. The poverty and gender issues make Home Based Care the best option. The patients themselves suggested meeting in Treatment Centres – this was seen as a great step towards breaking down stigma. So, every two weeks 128 Home Care Centres are visited.

This programme started with two people, Sister Ursula Sharpe and a nurse visiting patients in their homes because they saw the need. Today, the team includes 45 professionals and nearly 800 trained volunteer Community Health Workers. Services offered include Voluntary Counselling and Testing, ongoing counselling, treatment of opportunistic infections, TB testing and treatment, anti-retroviral treatment where indicated, social welfare and palliative care.

Sister Carla reminded us that while oral morphine is the mainstay in the WHO 3-step ladder in the management of the pain in the terminal stages of AIDS, there is a serious problem regarding the number of countries where morphine is not available. Both Sister Carla and Sister Brigid are members of the Africa Palliative Care Association.
At a recent meeting they found that of 22 African countries represented, only three had morphine available.

Listening to Children

Sister Itoro Etokakpan told the Conference about the work she and her team started in April 2002 to provide school teachers with enhanced skills in listening to children to have suffered trauma through the loss of parents from AIDS.

Since then 1,065 teachers have been trained in Basic Counselling Skills, with an almost equal gender balance. In addition, 156 teachers were trained in Trauma Counselling and there are currently a further 89 teachers in training.

The courses offered include skills in stress management, in the formation of peer counselling groups, in the Education for Life programme, and children's rights, family law and law of succession.

It also covers counselling of children with disabilities, human sexuality, gender issues and self-reliance.

The impact of this work means:

- Teachers feel more confident in working with children who have suffered loss
- There is a reduction in the use of corporal punishment
- Teachers have shown interest in receiving further training
- Children know where to go to get help
- There is improved communication between teachers and pupils
- Peer counselling and support groups are in formation
- Counselling has been included in the time-table in some schools

Sister Onyinechi Onuoha presented her experience in Kirambi, south-west Rwanda, where Home Care was begun in December 2001 because a lot of TB patients and malnourished adults and children were being seen at the Health Centre. Often they returned with a relapse after discharge home. Many patients with AIDS-related illnesses were also noticed, but because of the fear of stigma they seemed unwilling to come to the Health Centre.

Listening to patients makes one aware of what they are going through, often abandoned and stigmatised. This led to the formation of support groups where problems can be shared and discussed, and income generating activities have been started, but the very poor who have no energy rely on us for their basic needs like food and clothing.

KENYA

The Riara PROJECT

by Sister Florence Njoku

The Kibera shanty district of Nairobi seems to be the most slighted slum in Africa. One quarter of population of Nairobi lives in Kibera.

Our programme is called the Riara Project, named after the place where our Novitiate for East Africa is located. Young women in our formation programme help us out when they are assigned to gain practical experience of missionary work.

The project was started by Sister Pauline Dean, *(bottom picture)* and continues now under the direction of Sister Breege Breslin *(centre picture)*.

Photo courtesy Derek Speirs

Photo courtesy Derek Speirs

Back in 1989, Sister Pauline began by going from house to house in Kibera, visiting people in their slum dwellings. When she realised there were many people in Kibera presenting with the signs and symptoms of HIV/AIDS she began to train volunteers from within the Basic Christian Communities among this densely populated area. We now have eleven staff members – including four nurses, two counsellors, two social workers, and fifty active volunteer Community Health Workers (CHWs) and a further nineteen volunteers waiting to be trained.

Work for us begins early in the morning at the parish where the Team has a small office. Each day a different village in the shanty town is visited. CHWs will be there to give a report of clients in the village. They know the people well because they live there themselves. They know the clients who are very ill and need a home visit, while those who are ambulant come to be seen by the team. Feedback is provided on those who have been referred to one of the city's three main referral hospitals for testing or further management. This year, the project has opened its own service of Voluntary Counselling and Testing, which is now the routine point of entry for new clients.

As well as seeing people living with HIV or AIDS, there are 496 orphans in the programme. These children are fully sponsored in local primary or secondary schools. Of course, this is added work for the nurses and social workers.

In each of the families, we try to identify a person within the household to help. These are people who prepare clients' meals, wash their clothes, sweep the house, and encourage them.

For people who are very poor and have no job, there is no sense in telling them about nutrition, so we supply a mixture of millet, maize, and wheat which they use to make their porridge. We also provide rice and beans. The problem is that you end up feeding the whole family!

Children who live in this enormous slum go scavenging to find things that will make toys.

If our clients are well enough, we encourage them to think about a small business, and offer Income Generating Activities. We are lucky to be able to call on the Comboni Brothers and network with them to train these people. Then we give them some money to start up their small business. Once they have been given money to start up a small business, no more food is supplied.

This programme is very vibrant, and we have a good network system. Whatever we cannot do ourselves, we network with other groups. So, although the situation of the residents of Kibera is far below anything that could be considered an acceptable standard of living, we find that with a lot of goodwill and helping people to work together, their struggle to survive can be made a little bit easier.

For the poor this illness is A Living Nightmare

by Sister Mary Dunne

Sr. Teresa Hogan and Social Worker, Lucy, on a home care visit to Beatrice

AIDS is said to be the 'poor person's disease'. They die of hunger and poor nutrition as much as lack of medicine for opportunistic infections. Until then, they suffer a living nightmare over what will happen to their children when they are gone.

Women are expected to nurse the sick, even when they themselves are ailing – all the while trying to cope with providing for their families. Even for the fortunate few who are in formal employment this is too heavy a burden, let alone for the masses of women who live by petty trade and subsistent farming.

In our Kitale AIDS Programme, we know we cannot do everything that needs to be done. So we prioritise our activities and aim to give quality service at all times. This in itself is a challenge. But we are blessed with wonderful staff whose commitment is tremendous.

There are five main components in our Programme.

- **Education and Training**

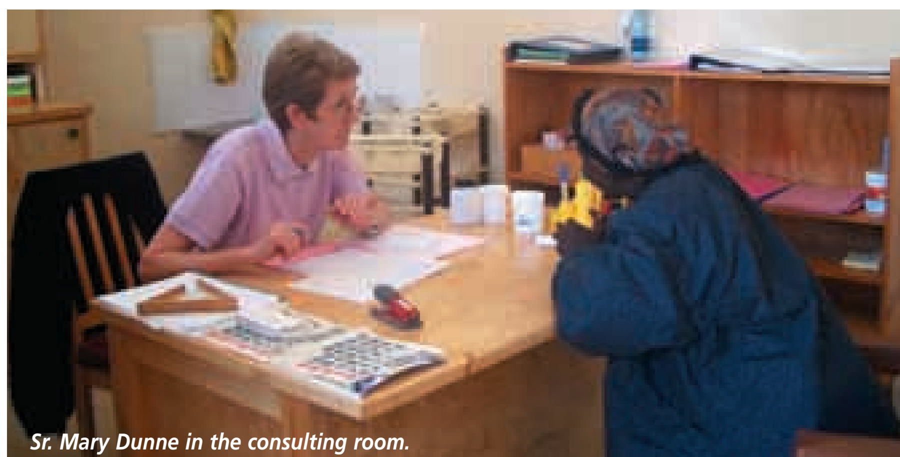
  Our emphasis is on training people from within the community as AIDS educators and Training of Trainers. We also provide continuous education for Home Based Care workers. Development of training materials is also important for us and we try to respond to requests from many organisations within the Diocese for education around HIV and AIDS.

- **Counselling and Testing with Follow-up care for people who are HIV positive**

  The number of people coming to us for testing has increased dramatically. We see clients of all ages from small infants to people over fifty years of age. The highest infection rate is in women aged between 25 and 40 years, of whom 36% are HIV-positive.

- **Home Based Care for the very ill and dying**

  About 2.5 million people in Kenya will develop full-blown AIDS and die without access to treatment and care. Currently, only six of our clients can afford the €21 per month for anti-retroviral drugs that will delay death. Even when we supply the drugs for them, they cannot be taken on an empty stomach, so we have to provide many with food as well as free treatment. We work closely with volunteers from within the community who have been trained in Home Care methods.



Sr. Mary Dunne in the consulting room.

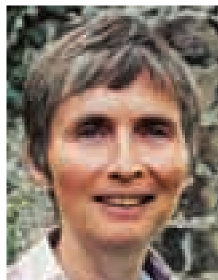
- **Supporting children who have been orphaned by AIDS**

  Kenya has the third highest number of children in the world who have become orphans through AIDS. In the past year we provided school uniforms and sweaters to 445 primary school children, and sponsored 26 others with Secondary school fees, uniforms and textbooks. A further 13 were supported in Technical Training.

- **Income Generating Activities**

  We were able to help 69 families with income generating activities in the past year. Of these 41 were helped to rent land, plough, buy seeds and fertilizer. They reaped a very good harvest and will have enough food for this year, and will be able to buy seeds for next year. The remaining 28 families were helped to start a small business, selling fruit, vegetables, second-hand clothes, water, etc.

Although we cannot do all we would like, we are confident that many of our clients are living longer, productive lives due to good basic medical care, counselling and good nutrition.



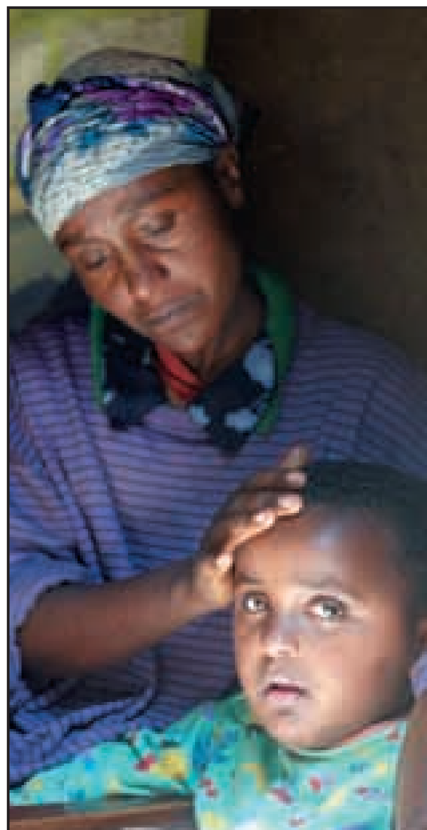
Looking back you may see how Obstacles become Opportunities

by Sister Carol Breslin

IN THE EARLY DAYS of our Counselling and Social Services Centre here in Addis Ababa, we experienced many difficulties in getting access to do work related to HIV or AIDS in the community. This was due to stigma and denial.

At our Centre, we were able to run programmes related to HIV, including Education, Counselling and Orphan Support, but we could not deal with issues related to HIV or AIDS where people lived their daily lives. This caused us much concern.

When we were invited by the local government to provide a community-based rehabilitation programme for disabled children we saw that this would be an entry point into the community. We felt that when the community was ready, we would be able to begin Home Care for people with HIV.



As well as our community-based programme for children with disabilities, we started a community development project which included sanitation, housing, latrines, kitchen construction and literacy. It took us many years before Home Care as we know it now could even commence – but this was a time when we were able to get to know the people well.

It takes a lot of patience! You have to be ready to listen to what is happening and to take advantage of opportunities to respond to people's needs.

Our staff involved in the Community Based Rehabilitation programme found that parents of children with disabilities began to ask for information and for education in HIV and AIDS. In due course we were able to do house-to-house education. Before long, people began to ask for Voluntary Counselling and Testing and also began volunteering to help in Home Care. Gradually, attitudes were beginning to change.

People with disabilities are particularly vulnerable to HIV. Many of them do not know how to protect themselves. They are left at home when parents go out to work. Mentally and physically challenged people are vulnerable to physical and sexual abuse. We realised that we needed to focus on the special needs of these members of the community.

We have now produced an Education Manual on HIV/AIDS in Braille, the first available nationally. It is written in the Amharic language, so is most useful in Addis Ababa. Two of our Counsellors are being trained in sign language for people with impaired hearing. This means that when having counselling for HIV testing, they can have confidentiality guaranteed.

Coffee ceremonies are very much part of the local culture, so we use this

opportunity to invite neighbours and friends to homes for awareness-raising about disability and about HIV. Another very practical way of getting our message across is the use of puppets. These show the causes, modes of transmission and consequences of HIV and AIDS to mentally challenged children. In school workshops, too, we have found puppets are a great way to encourage children to spread awareness.

Looking back now on the road we have travelled, we can see that what looked like an obstacle in the beginning has turned out to be a blessing, with patience and perseverance.

Dancing Goats teach us to enjoy coffee

by Sister Nuala Horgan

THE WORD COFFEE comes from a place called Kaffa, which is just two hours' drive down the road from our hospital here at Wolisso.

There is a legend around here which says that the coffee bean first came to light when a young goatherd called Kaldi noticed that the goats he was herding performed an amazing ritual. He set about investigating the origin of this strange phenomenon.

He watched the goats as they grazed and noticed that they were partial to some berries hitherto unnoticed. It was these berries which gave the sudden spurts of energy that caused the goats to jump and dance.

Kaldi decided to experiment with the berries himself. To his great delight, he found that he, too, was energized by these magic beans.

When word reached the nearby monastery, one of the monks came to see for himself. Like Kaldi, he experimented with the berries, finding the same result. It was not long until the whole monastery was taking these berries as part of the diet. One of the most beneficial results was that the monks could stay awake for prayer during the night!

For centuries, coffee was taken as a food to eat, not a drink. Berries were taken whole or crushed and mixed with ghee – butter which has been clarified. In the Ethiopian provinces of Sidamo and Kaffa, this custom is still observed. In time, people got the idea of using coffee as an ingredient in wine-making.

However it was not until the thirteenth century that the practice of brewing coffee became the established way of taking the beverage. From then on, the love of coffee spread worldwide.

Coffee-making Ceremonial

In Ethiopia to this day, the coffee-making ceremonial is a most sacred ritual. The woman who is performing the ceremony dresses in traditional Ethiopian costume. In order to capture the atmosphere of the outside environment she spreads some freshly cut grass and sprinkles it over the floor.

She seats herself on a low stool in the area of the cut grass beside a charcoal brazier, places the beans on a special concave pan to roast the beans, turning them gently

Meanwhile, guests are given something to nibble – like small biscuits.

When the beans have been sufficiently roasted, the hostess carries the pan around in front of each guest to smell the fragrance of the roasted beans. She then retires to pound them with pestle and mortar.

When ready she puts water and the beans in a traditional clay coffeepot (called *Jebena* in Amharic). It is round and wide at the base with a special spout for pouring. She brings it to the boil and when brewed, pours this into tiny cups without handles. Sugar and rue are added.

It is considered a very special treat to be invited to this ceremony, which is often performed as mark of honour for visitors.

The ability to adapt naturally

We were not very long established in Ethiopia when Sister Brigid joined the community in the very remote mission of Metcha. Her work as a nurse in this primitive health centre was a big contrast to her earlier experience at St. Loman's Hospital in Mullingar, Jervis Street in Dublin, Our Lady of Lourdes in Drogheda and at the Clinica Mediterranea in Naples. She had the ability to adapt naturally to whatever life asked of her.

Later she was one of the Sisters who nursed our foundress, Mother Mary Martin, during her final years of life. After that she went to Uganda and worked at Kitovu Hospital for a further three years.

In the latter years of her life she found great fulfilment through involvement with children's prayer groups in Drogheda. As this work became known, she received many requests to start groups in different places, and she loved it. When she died, at the age of 78, many of those children, now adults, came to Sister Brigid's funeral at our Motherhouse, and spoke with gratitude of all they had received through their contact with her.

May she rest in peace.

Golden Jubilees at our Motherhouse

Sister Patricia Ann Devine

Sr. Bernadette OíBrien

Sr. Bernadette Gilsenan with her brother Monsignor John

Sr. Clair O'Leary with nieces Elizabeth and Ann and grand-niece Emma

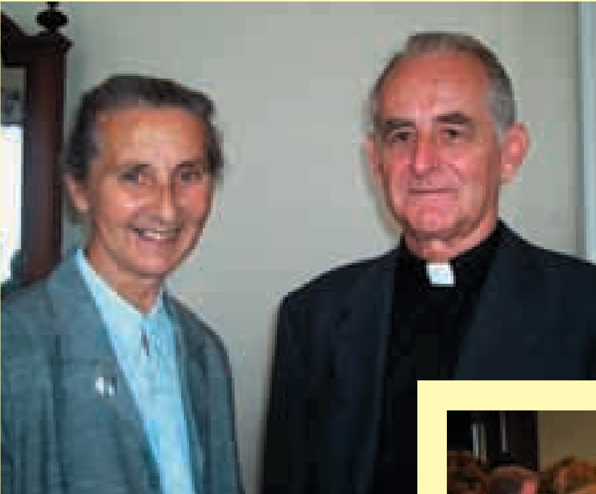
Sr. Mary Canty with her brother James

Tony and Maeve Cunningham with Sr. Marie Stella and their sister Terry.

Sr. Leonie McSweeney with her brother Bill

Sr. Therese Immaculee Headon

Sr. Rosaleen Levins with her sister, Monica McMahon and niece Monica



Sr. Aileen Doggett with her brother Fr. John, SPS

Sr. Giovanni McCormack with Pat, Beatrice, Noel and Frances Glynn

Sr. Joan of Arc Clifton with her grand-niece Sarah

Sr. Marie Flynn with her friend Mrs. Patricia Igini

Sr. Ancilla O'Reilly with her nephew Michael and his family.

Sr. Margaret Ann McGrath with sister-in-law Mary, brother Bill, and old friends Colette and Sean Wallace.

Our First American MMMs

Sister Madeleine LeBlanc

Sr. Julie Urban

LIFE CHANGED for Sister Julie Urban the day a colleague at the John Hancock Insurance Company asked her if she would be willing to make a monthly contribution to a new Congregation of Missionaries who had recently arrived in Boston. Before long, that monthly contribution from her salary turned into a life-long commitment! On August 5, 1951, Sister Julie, a native of Boston, became the first American to join MMM.

A few weeks later on September 8, she met her first companions on the long road ahead – Madeleine LeBlanc from Vermont and a young Irish woman called Peggy Driscoll (later known as Sister M. Damien) who was working in America.

Our archives give us the following revealing resume of those days:

"During this period our Congregation had barely come into its teens – fourteen years old. It was a time of expansion. We were opening new houses in Africa, our own here, and then soon in Naples. MMM was always breaking ground in new territories. It was a time of excitement, a time when we got letters from our sisters in Africa. We were in great awe, thinking that the day after we were professed we would go to the missions! We would hear of the different places where Mother Mary was asked to go and immediately we would think of ourselves on that mission!

"It was a time we were glad to have lived, because it was a beginning. It was a time when you realized that what you made it, what you put into it, you would get out of it. You could not rely on others… "

FIRST GOLDEN JUBILARIANS Celebrate in U.S.A.

Cardinal Cushing, who presided at their Reception into the Novitiate, told people present: 'The work is fascinating, the work is appealing, and the work has its countless consolations. These young people are on their way to that kind of life. I predict for them many blessings and unending happiness throughout the future.'

In due course, the young Sisters were assigned to overseas missions. Sister Julie served in Nigeria, and later as Secretary General at our Motherhouse and in a variety of administrative roles. The loss suffered by the John Hancock Insurance Company was certainly our gain!

Sister Madeleine spent a number of years directing our Formation Programme. She also served for years in Taiwan and Brazil, before taking up the tutorship of Clinical Pastoral Education in the US.

Sr. Madeleine LeBlanc

Sister M. Damien spent many years in Ethiopia. She became a victim of cancer while still quite young, and went to her eternal reward in 1977.

This year, our first Americans, Sisters Julie and Madeleine celebrated the Golden Jubilee of their First Profession when the community gathered for their Autumn Area Assembly.

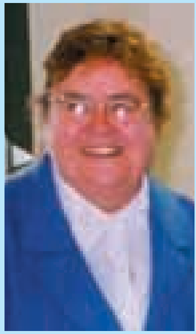
The Homily at their Jubilee Mass was given by Sister Ann Flynn, a native of Buffalo. She said:

"We are born with Original Blessing. God says: 'Before you came to birth I knew you, I formed you, I consecrated you, I have held you in the palm of my hand, you are mine.'

"When difficulties come, as they inevitably do, we may wonder is there anyone out there. Then comes the comforting reminder: 'I know the plans I have for you. I am listening to you. When you seek me I will let you find me.'

"The Gospel reminds us: 'I have sent you as prophets to the nations.' It is our mission to show people the love with which they have been loved. Our Jubilarians stand as living proof, giving all, demanding nothing back and freely giving the love they have received to others."

Mobile Healthcare gets Telemedicine



Awards presented to Sister Bernadette Kenny include Health Care Hero, Nurse Practitioner of the Year and the David Schuller Award.

Virginia's Governor Mark Warner has presented Sister Bernadette with a Telemedicine System for the Health Wagon she takes into the Appalachian mountains so that her patients in Dickenson and Buchanan counties can get a specialist's opinion. This enables them to connect face-to-face with top class professors in various disciplines. She says:

"We have the stethoscope on the patient's heart here and the sounds are transmitted six hours away and evaluated, just as in many of the developing countries. We also have a camera which can take a picture of the retina and transmit this to the specialist for an opinion. It is facinating and very humbling."

The past year has been another very demanding one. When bankruptcy forced the closure of the only hospital in Virginia's Dickenson County, 200 people found themselves out of work and residents had to face even longer journeys to facilities in neighbouring counties.

Through the Health Wagon she and her team provide physical and developmental assessment, laboratory services, immunizations, screening services, prenatal care, child welfare and routine care for the chronically ill.

There was much demand for eye tests and the provision of glasses at the Health Fair.

A major event in which they are deeply involved is the annual visit of the Remote Area Medical Volunteer Corps. For the fifth such Health Fair the venue was changed from Lonesome Pine Airport to the Wise County Fair Grounds, where there were more sheltered areas and some buildings that could be put to good use. Unprecedented crowds came to avail of the free medical services on offer. The *Washington Post* reported that at least 73 people slept in cars overnight to be there for the 6 am start on Friday morning. More than 800 dedicated volunteer doctors, nurses, dentists and other professionals drew a large crowd from all over Southwest Virginia and East Tennessee. They worked steadily through the entire weekend.

On the first day alone, 1,803 people were treated. By the conclusion of the Health Fair, a record 6004 patients had been seen. Dental care and the provision of spectacles is a big part of this service. But the diagnostic services are invaluable also, and medical problems like diabetes, hypertension and the early diagnosis of cervical and other cancers are also reported.

Teresa Gardner told journalists the services provided over the weekend could be valued at $998,000 "We have been looking for our numbers to decline, but that's never happened", she said. "There are still a lot of unmet needs out there."

Sister Bernadette agrees: "I wish we could see double the number of patients", she says. Many of her patients are ex-miners. Those attending the Health Fair were mainly adults or senior citizens who cannot afford medical insurance. According to the *Bristol Hearald Courier*, nearly 75 million Americans lacked health insurance at some point in the past two years, that is almost a third of all Americans aged under 65 years.

The Annual Health Fair has become renowned for the provision of dental care.

Sister *Mary Ellen Sambuco* talks about her life as A Visiting Nurse

The Visiting Nurses Association (VNA) is the oldest home care agency in the United States, over one hundred years old. About twenty years ago here in Pennsylvania, the Erie VNA dropped their Mother and Child Health (MCH) programme to focus on the geriatric population.

But after some years they decided to restart the MCH programme, and I was hired to get it up and running. Among the Erie population there is a very high poverty level, a high number of teenage pregnancies and lots of kids.

Our programme takes us into patients' homes for pre-natal care and teaching and whatever else we can do to get them ready for the new addition. Patients who are ordered bed rest can be seen by us. This saves some visits to the physician's office.

Post-natally we see them when they come home from the hospital and help with the adjustment. Our job is to make sure that both mom and baby are well and the family is adjusting well. We can see them two or three times or more if necessary. We weigh the baby, make sure it is feeding and growing well. Breastfeeding can be a problem with young moms and we can instruct them. We see sick children up to sixteen years of age.

Sr. Mary Ellen with Paulina, an immigrant from Iran, who had three miscarriages before her healthy twin daughters arrived.

One of the big problems now is children with diabetes – the numbers are escalating. We are starting a specific programme for both children and their parents. They learn a lot in the clinics but it is in their own homes that the real education takes hold.

Our health system gets patients out of the hospitals much too early – they aren't really ready to go home, so the need for home healthcare is becoming more valuable and necessary.

Sister Bridget

In 1984, while Sister Bridget Murphy was Sister in Charge at our house in Winchester, MA, Sister Andree Brow returned there from her mission at Kataboi in Turkana to take part in a renewal course.

No doubt they often recalled the 'old days' when, as young missionaries, they both worked in Nigeria. Sister Andree, an occupational therapist, worked at Ikot Ene, Abakaliki and Ndubia, while Sister Bridget was working in the administration of Ogoja and Urua Akpan.

Sister Bridget joined MMM in Ireland and Sister Andree in USA. Sister Bridget had a great interest in the history of MMM, so the coincidence hardly escaped her notice that both she and Sister Andree had been received into the Novitiate on the same day – 8 September 1955. They both made their first profession of vows on the same day two years later. They took their final vows on the same day six years after that.

Their missionary calling took them to far-distant parts. After her assignments in Nigeria, Sister Andree worked for ten years in Kenya, seven of which were spent in the Turkana Desert and three in Kitale. After she got cancer, she settled in Chicago and worked in a shelter for women and children, putting her great creativity to use there and part-time with the Archdiocesan Media Office. Her special gift of sensitivity towards the vulnerable, and her gifts of hope and truthfulness in the face of reality were an inspiration to those who knew her well.

Sister Andree

Sister Bridget's work took her to Liberia, where she was administrator of Ganta Leprosy Center. During the war there she was made prisoner but escaped and with other refugees crossed safely over the border to Sierra Leone. She recovered from this traumatic experience and subsequently volunteered to return to Africa to work at Chipini in Malawi for four years. She was thrilled when old friends at her mission in Liberia invited her to return so they could express their sadness at the way she had been treated.

In the year 2000, Sister Bridget returned to Ireland and was working in the administration department at our Motherhouse when she died, unexpectedly in the early morning of 1 February 2004, to the great shock and sorrow of us all.

At that very hour, our community in Chicago were watching by the bedside of Sister Andree, whose long and brave battle with cancer finally ended on the same morning. Surely, these two great missionaries are together again in heaven!

ENGLAND

Is there still leprosy?

By Sister Anne Curtin

'IS THERE STILL LEPROSY? I've always associated it with, you know, Biblical times!'

This is typical of comments I hear from people after I have spoken, usually at Mass, appealing for funds for St. Francis Leprosy Guild.

Indeed, many of us were introduced to this disease by the Biblical references, in both old and new testaments. St. Mark tells poignantly how, petitioned by a man to cure his leprosy, 'Jesus was filled with pity and stretched out his hand and touched him… and he was cured'. (1:41)

This detail is truly remarkable and one can imagine the shocked reaction of those who witnessed it. He touched him! A wonderful lesson.

Leprosy was first recognised in the ancient civilizations of China, Egypt and India and the first known written mention of it is dated 800 b.c. Throughout history, those afflicted (known as 'lepers' – a term still used derogatorily) have been stigmatised and isolated from society. This is perhaps understandable in view of the long-term effects of its dermatological and neurological complications on the faces and limbs of the victims. Ironically, some 95% of the world's population have natural protective immunity against leprosy. Moreover, a long exposure to active bacilli and a weakened immune system are required before one can develop the clinical symptoms of leprosy.

Thanks to the multi-drug therapy (MDT) recommended by WHO in 1981 as standard treatment for leprosy, the disease can be cured. Provided treatment is administered early and completely, there need be no ill-effects whatever. Furthermore, once treatment with MDT has commenced, a patients becomes non-infectious within 48 hours.

In 1895, St. Francis Leprosy Guild was founded in London by Kate Marsden, with a small group of ladies in Westminster Diocese. Miss Marsden had seen for herself the plight of leprosy victims during her travels in Siberia. They endeavoured to raise money with the aim of helping sufferers everywhere and, in 1923, the Franciscan Missionaries of Mary undertook the secretarial work at their West London convent – a tradition still kept alive by Sister Eleanor Marshall FMM).

In Nigeria, the late Bishop Thomas McGettrick responded to the plight of many people afflicated with leprosy and totally uncared for – veritable outcasts of society – by inviting the Medical Missionaries of Mary to his diocese. There, St. Benedict's Leprosy Settlement was founded in Ogoja in 1945 followed by St. Patrick's in Abakaliki in 1946.

WATER

From the outset, the Sisters were supported by the St. Francis Leprosy Guild, whose annual grants still provide a reliable source of income. Similarly, MMMs involved in leprosy programmes over the years in Ethiopia, Angola and Liberia have benefited. In my years as Administrator in Abakaliki I well knew this invaluable assistance and also had several projects funded by the Guild, most notably a water supply.

Submersible pump is installe at Abakaliki.

While on home leave in 1997, I attended the AGM of the Guild, during which I mentioned our water problems. The outcome exceeded my wildest dreams. Thanks to a timely legacy, the Guild funded a new 100-meter deep borehole with a submersible electric pump, and accessories. Since then, patients and staff at Abakaliki have enjoyed a constant supply of clear running water throughout the seven-month-long dry season.

In March 2001, I finally returned to Europe and gladly accepted an invitation to give voluntary service as Honorary Secretary, at the office of St. Francis Leprosy Guild, now located in St. Charles Square. From there, some 87 centres in Asia, Africa and Latin America are given annual mainten-ance grants and – when funds allow – support for other specific projects.

The answer to my opening question must, then, be a resounding 'yes'. There is still leprosy, also known as Hansen's Disease, from the Norwegian scientist who first isolated the leprosy bacillus in 1873. An estimated 750,000 new cases are annually detected. Between three and four million recovered patients are in need of rehabilitation and re-settlement, which is a lengthy process.

The work of St. Francis Leprosy Guild continues. Jesus still stretches out his hand, using your hands and mine, to touch them, and they are cured.

Motherhouse happenings

Our Area Leader, Sr. Bernadette Freyne, coordinates the four communities who live at our Motherhouse, at Beechgrove, Drogheda.

At our Motherhouse in Drogheda, each year brings a succession of events that keeps the large community on their toes all year round! At the same time, Beechgrove has always been known to be a powerhouse of prayer.

The kind of hospitality associated with the spirit of St. Benedict is traditional at Beechgrove. Few know this better than the Sisters returning on leave from overseas missions. A special office has been set up at our Motherhouse to cater for all their needs. Upwards of seventy Sisters might avail of this in any year. Five retreats are arranged every year, to which many visiting MMMs are welcomed, as well as providing for those who live in Drogheda. There are also weekends of prayer held during Advent and Lent.

Our Motherhouse is the venue for celebrations like Golden Jubilees, where Sisters and their families enjoy a great reunion. Relatives of deceased Sisters also like to return to Drogheda on occasions when a special Mass of Thanksgiving is arranged and the graves in St. Peter's Cemetery are visited.

As well as individual ministries undertaken by members of the Motherhouse community in Drogheda, Beechgrove houses our Archive Department and our Philately Department. Stamp collecting

Sr. Muredach Hallinan, Sacristan

Hospitality is traditional at Beechgrove

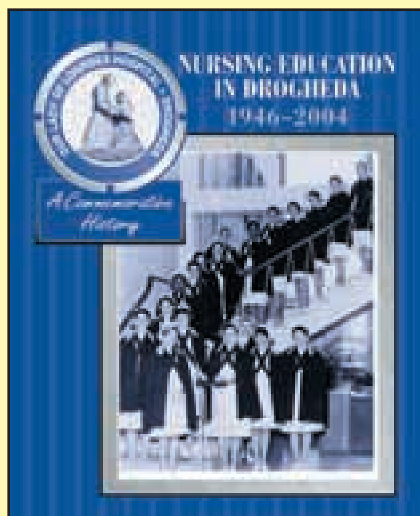
Sr. Maureen O'Mahony, Librarian

Sr. Patricia O'Kane, is the Liaison Person with our Drogheda Ladies Fundraising Committee

continues to be a very popular hobby. The Sisters who volunteer to sort and pack used stamps make a great contribution to our work.

A very active Ladies Fund-raising Committee involving women who live in or near Drogheda has been associated with Beechgrove since 1942. Each year, this Committee chooses a specific overseas mission which they will support, and the mission lucky enough to be selected benefits from the considerable funds generated from a series of coffee mornings, golf outings, bucket collections, bazaars and more!

The community also responds to special requests from time to time, such as the recent launch of *Nurse Education in Drogheda – A Commemorative History*. This is a history in which MMMs have been deeply involved. Now that nurse education is entering a new era in Third Level Institutes, it is fitting that the valuable contribution made in Drogheda over the years should be celebrated in this way.



Born in Ballinskelligs in Co. Kerry in 1909, Sister Patrick Maria Rahilly was already 45 years of age when she joined MMM. That is the same age that our foundress, Mother Mary Martin, had reached by the time she was able to make her first profession of religious vows and establish our Congregation.

Sister Patrick Maria never forgot her roots in Co. Kerry, and was a keen follower of her county in GAA matches. Unusual for an MMM, she spent all her years in Ireland. She was a gentle, patient, and very thoughtful person, and these gifts were especially valued in her assignments which involved caring for visitors over many years.

In the Rule of Saint Benedict, on which the MMM Constitutions are based, the chapter about the care of guests is longer than many others. It says 'Let all guests who arrive be received like Christ, for He is going to say I came as a guest and you received me.' Sister Patrick Maria lived the true spirit of Benedictine hospitality. Her quiet kindness will be remembered by all whose lives she touched.

'If thou art near, then I with gladness to death will go and to my rest' – these lovely lines from J.S. Bach's *Bist Du Bei Mir* sum up her readiness to answer her final call which came on 26 May 2004.

Sister Anne receives Honorary Fellowship

Sister Anne Ward, pictured with Professor Niall O'Higgins, President of the Royal College of Surgeons in Ireland, where she was presented with an Honorary Fellowship in recognition of her specialized surgical work in the cure of vesico-vaginal fistulae (V.V.F.) Sister Anne is already a Fellow of the Royal College of Obstetrics and Gynaecology.

Sister Celine Anikwem graduated with honours from the Dublin Institute of Technology with a B.Sc. in Business Management.

Sister Angela Anigbogu graduated at Trinity College Dublin with an honours Bachelor's Degree in Nursing Studies.

Our journey so far

Four busy years have passed since the pioneers of our new Millennium Mission in the Republic of Benin arrived in Zaffe. As they look back, they say 'So far so good, the journey has not been so easy, but we are grateful to all those who have stood by us'.

WHEN WE ARRIVED HERE in January 2000, our first job was to equip the Clinic which the people had already built in preparation for our coming. Then we set about making a Survey of the seven villages that make up the Zaffe community. We discovered that most of the health problems the people identified could be prevented with health education.

We started with the training of Community Health Workers and before long they began to give health education in their villages. They also help us when we go out to their villages for mobile clinics.

The Clinic at our base in Zaffe was opened on the 1st of March 2000. We have a busy Out-patient Department. We also started a Nutrition Clinic where mothers are taught the different ways of using locally produced crops like soya beans, groundnuts and maize to prepare nourishing food for their children.

By May 2003 we were ready to start laboratory services, which was a big step forward for us. However, we could see that many of the people coming to us were travelling from villages between 30 km and 50 km away. That was a big concern because some of them were very ill when they reached us. Often, we had to transport them to hospitals in the bigger towns. The only solution was to have some beds where we could keep a close watch on those whom we could treat ourselves if they could remain with us long enough. We achieved this in November 2003.

From the beginning, the people wanted us to provide a maternity service. While we knew this was important, we felt very strongly that if we began by providing a service without getting the local people involved in healthcare themselves through the education of Community Health Workers, healthcare would always be something provided by 'outsiders'. However, once the work in the villages was well established we were able to make plans for the maternity service the people wanted so much.

On the January 15th 2004, we opened this Unit with five beds. It was not easy to 'give birth' to our first baby girl, but she arrived safely on January 24, *merci Seigneur!*

We still have many more challenges to face! The most urgent is the lack of proper sanitation. Most villagers use nearby bushes and although we tried to discourage this over the years through the health education programme, we were meeting no success. Now, following several meetings with the Community Health Workers and Village Heads, and with some help from the MMM Small Projects Fund, we have been able to help the people to construct VIP latrines in some of the villages.

Other problems we have to face include the language. Before coming here, we had all mastered the basics of French, which is the official language of the Republic of Benin, but many of the local people do not speak French. The local language in Zaffe is Idaatcha, and some neighboring villages speak Fon. We are still struggling with these languages!

Another problem is that drugs are very expensive and sometimes even the essential drugs are difficult to get. So we still make the long journey across the border to Nigeria to buy drugs and medical equipment.

The lack of qualified staff also makes working here very difficult. The Republic of Benin is a very small country. We have tried to get a trained nurse to work with us but it has not been easy. They prefer to work in government Centres where there is not much supervision. So we have to be present in the Clinic ourselves all the time. This makes the work more demanding.

The local people are poor but they are very supportive and appreciative. We can call upon them at any time and they are always ready to help where they can. The participation of the staff we have is great and we try hard to work as a family.

AIDS is not spoken of openly, but we believe it is affecting a lot of people around us. We have plans to start something on that in a near future, if all goes well.

We also hope to dig a few boreholes for a better water supply, especially after the outbreak of typhoid fever which has almost become endemic.

We count very much on our faithful, supportive friends to help us to achieve these goals.

‘Sometimes you feel you are fighting a bush fire’

by Sister Agatha Ezeokoye

Sometimes the situation at our Health Centre at Kirambi feels like fighting a bush fire. All the time we are seeing increasing numbers of patients and new problems. Among the most worrying for us are TB and malnutrition. Both of these, of course, can be addressed effectively if taken in time.

There is also a serious problem of people with AIDS being abandoned. Sometimes belief in witchcraft leads a family to fear contact with the infected person, who can be left without food or shelter.

The very word ‘AIDS’ can lead to division among communities, families and friends in different ways. The fear and the stigma are a major problem. One woman was admitted to our Health Centre with severe gastritis while her husband was in prison. When he was released, he was wrongly told by neighbours that she had AIDS. This was entirely false, but he concluded that she had been ‘messing around’ while he was in prison, living a bad life, and he abandoned her leaving her homeless.

The demonstration garden attached to the Health Centre is one of the methods used to reduce the levels of malnutrition in the area.

We have now started a Home Based Care Programme for people living with AIDS and in this way we hope to improve health awareness in the community.

A great concern is the health hazard for staff and family members who are involved in caring for the infected person. While staff are trained to be careful, it is difficult to completely avoid these situations during surgery or if called in an emergency when a baby is about to arrive and there is no time to get gloves.

Even though we place great emphasis on taking care, we know that you cannot be involved in the kerosene trade without getting stains on your clothes, and likewise you cannot be involved with people who have HIV and AIDS without running the risk of picking up the infection yourself, for example, through a needle-stick injury.

I keep asking myself ‘How am I going to cope if this happens to any of our staff? How am I going to journey with them? Am I ready myself?’

Entering Kirambi Village

Ten Women Say Yes!

Ten Sisters preparing to take vows for life as MMMs, had the opportunity to retrace the steps of our foundress when they spent three months together in Nigeria. Pictured above, Sister Laurinda Bundo took time for reflection when she visited the Landing Post near Nsukara in south-east Nigeria. Back in 1921, Marie Martin set out from here and took a canoe along the Niger to meet Bishop Shanahan at Onitsha.

Twenty-one years ago, **Laurinda Bundo** first wrote to MMM from her home in Huambo, Angola. As she looks back to those days she recalls how difficult it was to travel from one province to another due to the terrible civil war in her country. Her city was bombed more than any other. "Despite that they came", she says with great appreciation. Sisters Cecilia Asuzu and Brigid Egbuna travelled all the way from Chiulo Hospital in the south of Angola to Huambo to meet Laurinda. A year later, she visited Chiulo and was motivated by the way of life she experienced there and the dedication she saw. It was not until she finished her studies in 1992 that she actually joined MMM. Since then, she says, "my experience has been challenging, enriching and has helped me to know more about myself and understand more about God in my life – the one who cares, loves, directs and walks along with me."

Magdalene Umoren is pictured above with her mother, Christine, and her sisters, Grace and Mary Agnes. She shares the feelings described by others on the brink of taking Final Vows when she says "I was scared." But like all the others, she decided to place the future in God's loving hands. Magdalene first heard of MMM at a vocation rally when she was at secondary school. She prayed, read more about MMM, and then went to Medical School at the University of Calabar, hoping that she would change her mind at the end of her studies. "But instead, I felt a strong inner yearning to dedicate my left to God as a missionary", says Magdalene. Her classmate, Ekaete Ekop, felt the same way. After their internship and a year's National Youth Service, they both joined MMM and worked in other cultures for a number of years. They have both now begun post-graduate studies in Obstetrics.

When **Irene Balzan** was completing a Foundation Course at the University of Malta, and embarking on studies for her B.Sc. in Nursing, she discovered that Malta had played an important role in the unfolding of Marie Martin's vocation to found the Medical Missionaries of Mary. She came to know Sister Maria Borda, already an MMM doctor working in Tanzania. Irene joined MMM in 1994 and made her final vows in 2004.

Emmanuel Balzan proposes a toast to his daughter Irene while her mother and her brother David join in.

At the port of Calabar the group are shown the place where our foundress landed when she first arrived in Nigeria in 1921.

Photo courtesy R.R. Hoeser

Regina Reinart uses the words 'unattached, yet bound to all creation' to describe her commitment. Her final profession in Gindorf, Germany was a celebration everyone will remember! When she returned to her home in Germany from her mission in north-east Brazil to pronounce her vows for life she found that not only her family but her whole village was involved in the preparations. Below, the family get a quiet moment together.

Photo courtesy R.R. Hoeser

Ekaete Ekop pictured here with her brother Otobong, believes that the seeds of her vocation to MMM were planted before she was born! "My parents met and fell in love while working with MMM at St. Luke's Hospital in Anua… I got a pleasant surprise last year when I saw their wedding picture in one of the old MMM albums from Anua.

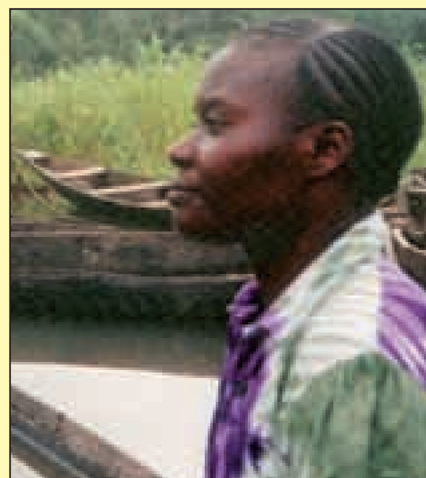
However, it was not until Ekaete was in her third year in Medical School in the University of Calabar that the thought of becoming a Sister entered her head. She says: "When it did, it planted its feet firmly and stayed put despite many efforts to push it out in the early days." As a young doctor Ekaete thought she would be another messiah and would save people from suffering, sickness, oppression, or whatever! Now she says: "I am making final vows knowing that religious life is not so much a call to serve as it is a call 'to be' – to be in relationship with God, to be loved by God, to be with people. Only then can we serve. It is not primarily about doing things. It is about being there first. The MMM Constitutions says it well: *Be among people of different cultures, religious and ideologies; be with those who suffer…* I am happy to commit myself to this relationship where I can be available to the whole human race as God's channel of healing.

Cordelia Nwaokike pictured above with her brother Ferdinand, met MMM when she went to Mater Misericordiae Hospital in Afikpo, Nigeria, as a student nurse. "There I was attracted by the simple life style of the Sisters, the dedication to duty, the interaction with people and the type of work which I loved so much." She joined MMM in 1995. "Since then I have experienced joyful, sad, difficult and challenging moments… I have learnt that it is better to take a day at a time. Facing the big step of taking final vows, I have fears, but am not overwhelmed by them. It does not depend on my own effort, but I am supported by the grace of God, my sisters, relations, friends and the people of God around me."

Emelda Ukaumunna says it was her older brother who told her about MMM. He was working in Lagos and knew the Sisters at Mafoluku. When she told him she was thinking of religious life, he encouraged her to visit Lagos and introduced her to Sister Sarto Farrell.

"One of the things that left a big impression on me is the hospitality – I was received as one of the family though none of the Sisters knew anything about me. I really felt 'this is the place I was looking for…' She also found that 'people like me who are not inclined towards science can contribute something in a medical congregation.'

Emelda went on to study business administration. She describes her life in MMM as the life of a sunflower. "I can tell you, following the movement of the sun has not been easy, but the shaping and re-shaping of who I am has helped me to have a greater awareness of God's love for me and to draw closer to God."



Betty Naggai was born in Uganda, and came to know MMM through our work at Kitovu Hospital. She trained as a nurse at the famous Rugaba hospital in Kampala and is now on mission in Malawi. See her article on page 46!

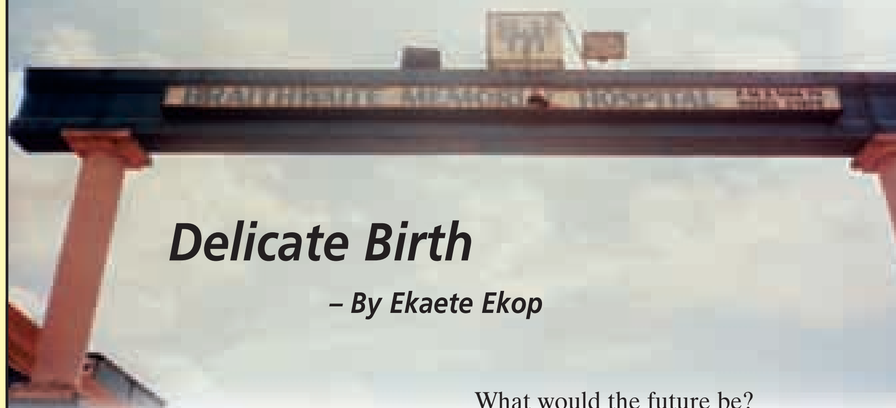
Martine Makanga qualified as a medical doctor in her homeland, Congo-Brazzaville, and specialized in paediatric surgery in France. When she made her Final Vows in June 2004, our Sisters working in Rwanda and Uganda joined her in Butare, Rwanda, where she is a surgeon at the University Hospital and teaches at the National University. The joyful but simple ceremony took place outdoors, and Martine signed her Profession Formula under the shade of a beautiful tree.

Ngozi Callista Ahunanya made her final profession on September 3 in her home parish of Christ the King in Mpan Owerre in Ahiara Diocese. A week later she flew to Nairobi to participate in the MMM Conference on HIV/AIDS. She was one of the 22 African Sisters at the Conference, and felt she could bring much of what she learnt back to her work in Nigeria.

Following in the footsteps of Marie Martin

During the three months of intensive preparation before making Final Profession of Vows, the ten Sisters had the opportunity of visiting the Braithwaite Memorial Hospital in Port Harcourt. It was here, on April 4, 1937, that Marie Martin pronounced her religious vows, even though at the time she was seriously ill and many felt she would not survive.

They also studied her 1921 journey up river from Calabar, reflecting on her calling to bring healing to the countless people who were without maternity and other health services. These memorable experiences have left a profound impression on the group, as they embark on their life's commitment and mission.



Delicate Birth

– By Ekaete Ekop

I keep imagining her
sick, weak, frail
yes, I imagine her
lying on that hospital bed
in one of those pokey cubicles

I imagine her
feverish, nauseous, aching
taking one bitter medicine
after another
drinking syrups and soups
trying to keep her energy up
clutching at straws of hope

And then the good news arrives!
Is it possible
that nineteen years of waiting
have come to an end?
that the dream had been given a chance
to become reality?

But what a chance!
How could she take such a step
when she was hovering
between life and death?
when her very life
seemed to be sucked out
slowly
by illness?

What would the future be?
Did she have a future?
Dare she make such a bold step
when frail health and circumstances
all screamed against it?

Frail health and circumstances
had never been her masters
frail health and circumstances
had played insignificant roles
during the waiting years

She had always coasted on the wings
of faith and trust
these had led her
and would lead her still

Her eyes on the Lord
her mind on his promises
being fulfilled
now
she went on

She stood alone, on a firm faith
a lone MMM
she grasped Love with both hands
she summoned all her strength
and declared
to the hearing
of six witnesses
MMM is born.

More than a Health Centre

by Sister Esther Onokayeigho

When our Health Centre was built at Amukoko on the outskirts of Lagos city, this was already a thickly populated area with very poor facilities. It was named St. Therese's Health Centre, but as it was attached to the local parish, the people always called it 'Father Hospital'. They have also found that this is a place where God is at work and when they come here they find it a place of comfort and solace, as well as a place where they can be treated for ailments.

The child welfare clinics, the antenatal care and the nutrition education, all bring women and children in their droves. Treatment for TB and other opportunistic diseases associated with HIV and AIDS, and the counselling services, are also much in demand.

Then there is the community outreach and follow-up care, the rehabilitation of clients, the organisation and facilitation of workshops and seminars, all of which keeps the team of nurses and health workers very busy indeed. For the past seven years, the health Centre at Amukoko has been under the leadership of Sister Sally Davis.

Apart from serving the huge population on our doorstep, clients have been coming from distant parts of Lagos. They say that they feel their healing starts as soon as they get inside the gate!

Sister Sally Davis

Our latest addition at Amukoko is our Day Care Unit. This is a place where people with TB, HIV or substance abusers can come for support. Some also come for rehydration. All staff members adopt a holistic approach and respectfully encourage the clients to tell their stories in order to discern where their actual pain lies. Sometimes their presenting ailments are symptomatic of other things that are causing stress in their lives. As a result, they are guided on the way towards full recovery, or at least to live positively with their situation. The Day Care Unit has facilities like TV and video to help relaxation. Many whose homes are very poor, are glad to avail of a shower in the Day Care Unit. Snacks are also provided and the whole environment contributes to their healing process and helps them to deal with the difficulties they encounter.

Back in 1940, career opportunities for young Irish women were few. It was quite an achievement for a young woman to become Secretary to the Managing Director of a large pharmaceutical company. But, four years into a promising career, Patricia Boyle changed course, joined MMM, and took the name Sister M. Francis Xavier – inspired by the famous Jesuit saint who was patron of the missions.

Following her first profession she went to Nigeria and spent most of the next 39 years there. She served in the administration of several of our mission hospitals during their growing years – including Anua, Obudu, Abakaliki, Ogoja and Ondo. She was Regional Superior in Nigeria during the very difficult days of the Biafran war. She also spent three years directing our Novitiate in Drogheda, and worked as secretary in the Apostolic Delegation in London and in Lagos.

Later in life, an accident in Ireland left her with a legacy of constant pain. She bore this with remarkable courage and good humour despite great discomfort. Like Saint Francis, her missionary call was ever beckoning. Her whole life was an inspiration to all of us and to her loving family.

Requiescat in Pace.

Life in the Manse

Associate MMM, Mhorag Macdonald, writes from Scotland

There are still cultural gaps in Scotland between people who come from different faith traditions. Perceived and real injustices linger long in the collective subconscious. Because prejudice works at gut level, it is impossible to challenge with rational argument. It is only when people see or experience a different model of relationship that they can be given the space to explore new ways of being together.

Sister Aideen O'Sullivan and I have lived in community now for almost ten years. She continues her listening ministry as a Counsellor in a general medical practice and I am an ordained minister in the Church of Scotland. In this ecumenical sharing, we do not see ourselves as doing anything extraordinary, because it seems natural to support

We are delighted with the news that MMM Associates, Moira and Eamonn Brehony, will continue their work at Ngaramtoni, Tanzania until 2007.

Anne Choon travelled from her home in Malaysia to Makiungu in Tanzania where she gave a hand at the hospital and while there renewed her Covenant as an Associate MMM. She was joined for the occasion by other Associates, Mary Hhayuma, Dympna Tsafu and Mary Coffey.

one another in the work we do. One of my church members was recently in hospital and when Aideen visited her, she said 'This is Aideen, she's a friend from my congregation.' It is wonderful when the distinctions can be blurred in such a natural way. God's Kingdom surprises us, not when the leaders of our institutions make policy decisions, but when ordinary people forge bonds of friendship. I think Jesus had a bit to say about that!

There is much hidden hurt in the lives of people around us. It is humbling and exhausting to be allowed to hear their stories. As we each in our own way try to respond to that hurt, it makes a difference to have someone around who will listen or laugh with you, prepare a meal or walk in silence beside you.

From time to time, we have been involved in shared liturgy in our local hospital and hospice. We are sometimes asked to help with training events. At the moment we are working on a prayer course for our local area for people who are Presbyterian. We are also involved with a group of women who are Catholic and who are considering associate membership of MMM. We also try to make the Manse – a Protestant name for where the minister stays – a place of Benedictine hospitality.

Neither of us knows what the future will hold. None of what has already come about was planned, but we do have a sense of God's guidance in our experience of lived ecumenical community. We certainly never have time to be bored!

Joseph's Dream

by Sister Noeleen Mooney

WHEN JOSEPH AWEDA arrived in Dar es Salaam he knew nobody. Hunting for student accommodation far from home is not made easier when you have an artifical leg. Luckily, his search led him to meet a kind family from Goa who helped him find a room in a safe area. Thus began a bond of friendship that lasts to this day.

The room needed a lot of repairs. No trouble to Joseph! Years earlier, when he had been chosen for sponsorship in his final two years of secondary school by the Institute of Management and Information Technology, he had to wait a while before his courses began. Now he was glad that he had spent that time teaching himself carpentry and building skills. Later, while on National Service, he developed these skills further.

Life had taught Joseph many things. Born in 1971 in the small village of Mara in Tanzania, relatives advised his mother to let him die because a child born with only one leg was looked upon with suspicion and fear. There had been talk of letting the cattle trample him to death. His mother, though very poor, would reply: 'God has given him to us and knows why… we leave everything to God.'

In those days, the MMM Sisters ran the nearby Dareda Hospital. We helped Joseph's parents to get him to Kilimanjaro Christian Medical Centre, where he was fitted with a rather rudimentary prosthesis. I well remember his prowess on the football field! Leaving aside his prothesis he would go speeding across the pitch with one leg and two crutches. He still talks enthusiastically of his first flight with Sister Aideen O'Sullivan, then physiotherapist at Dareda, in the Flying Doctors' plane to get his prosthesis replaced as he grew. When older, he discovered that if he managed to get there at exam. times, he could be used as a model and be fitted for free!

In Dar es Salaam, Joseph successfully completed the one year Diploma Course in computer studies and IT, which was being supported by a kind donor in Ireland. It was not easy for him to find a job with this qualification, so for the next two years he supplemented his income by again working as a carpenter and builder, as well as tutoring a group of twenty students in physics, chemistry and maths.

This fuelled a desire in him for further studies. In 1999 he applied to the University of Dar es Salaam, and was accepted for a four year programme that would qualify him as a mechanical engineer. He was able to get a student loan through the programme of the Tanzanian Government which paid for his tuition fees, for his meals and for accommodation.

At this stage, Joseph would have had no difficulty pursuing a lucrative career in the big city. But his sights were firmly set on returning to Dareda to establish a Workshop. This would allow him to use his many skills to benefit the people of his local area.

He spoke passionately to me of some of his plans to use appropriate technology:

- making small stoves which would use only sawdust or small twigs as fuel for cooking (instead of logs or charcoal).
- constructing a hand propelled maize grinding machine, which would save long journeys to the local grinding machines in the village, as well as ensuring that maize could be ground in small quantities, and without depending on an electricity or diesel supply that was often erratic.
- making openwork bricks which would fit into each other, use less cement, and yet. form a very solid structure which could be strengthened by putting steel rods through the openwork.

He dreams of establishing the Dareda Technology Development Centre. The dream is already well on the way to becoming a reality. With the help of some funding from the Small Projects enterprise administered by MMM from general donations received, the essential machinery required has now been bought and transported to Dareda.

The Workshop will be in the village, which lies at the base of a very steep hill. While he was still young, because of his parents' poverty, Joseph was adopted by a staff nurse at Dareda Hospital, Dympna Tsafu, who is an Associate Member of MMM. While he lived with Dympna, he still kept in contact with his parents. As he got older, he helped to educate his four sisters and twin brothers and built a better home for his parents. Dympna's house, where Joseph lives, is perched high up under the shadow of the escarpment, so Joseph's latest idea was to buy a second-hand three wheeled motorcycle to spare the wear and tear on his prosthesis. Need I say that he did all the necessary repairs to the motorcycle himself!

The Town I Love So Well

WE BORROW THE TITLE of Phil Coulter's well-known song to bring to mind another place, once beautiful, that has been 'brought to its knees' by bombs and guns more recently.

As we go to press, Sister Maura O'Donohue is setting out on her fourth visit to Grozny, the capital of Chechnya. While there, she will review from a medical perspective, some of the relief work being done among the stricken people of this war-torn region.

She goes on behalf of *Caritas Internationalis*, a confederation of 162 Catholic relief, development and social service organisations working to build a better world, especially for the poor and oppressed, in over 200 countries and territories. The work in Chechnya is co-ordinated by *Caritas* personnel based in Prague, who form the 'lead agency' for the work supported by this worldwide Catholic network.

Sister Maura's brief has two main aspects. The first is to review the current programmes run by *Caritas* for children. The second is to develop some specific ideas with regard to future strategies for a Crisis Centre in Grozny.

The Crisis Centre will provide services for adults and children who have suffered severe trauma in the current war. It will also deal with health problems and the growing issue of drug dependency and HIV/AIDS. Sister Maura will do workshops with staff to enhance their skills in dealing with these problems.

"The local Chechen people engaged by *Caritas* are a great inspiration to me", says Sister Maura.

"They carry out their professional duties amidst appalling conditions. While we are trying to rehabilitate several buildings destroyed by the bombing, they pick their way through streets littered with rubble to provide a cheery welcome to those they serve. I often say to myself that their smiles are the only sign of hope that I can see in this devastated country."

People who have lost their homes and all their possessions need legal assistance; they need to be put in contact with various organisations and groups which can provide support – whether social, psychological or medical. Many young people have become disabled as a result of the war. *Caritas* is also providing food assistance, because sixty-five per cent of the population live on less than $20 a month. With the country's infrastructure destroyed, 85% of the workforce is unemployed.

Visitors are not permitted to stay overnight in Chechnya, so Sister Maura stays in Nazran, capital of the neighbouring Republic of Ingushetia. From there she travels daily for 115 km each way, under armed guard, to reach Grozny.

Within Ingushetia, there are still a number of refugee camps along the border where many of Chechnya's 350,000 refugees are housed in tents. The Chechen leadership is using a mixture of incentives and threats to get the refugees back. But when they return, the conditions most of them face are sub-human.

In the refugee camps in Ingushetia, *Caritas* provides a number of programmes involving kindergarten education with health and nutrition components. Sister Maura will also help to evaluate this work.

Before travelling, Sister Maura said:

"The recent terrible atrocities for which Chechen rebels have been blamed can easily lead to the stigmatisation of all the people of Chechnya. I feel this is very unfair as it dehumanises an entire people, who are themselves victims of war and all its consequences.

"The absence of balanced media reporting of their situation adds to their anonymity, and can have the effect of turning them into a faceless, blameworthy and brutal nation.

"I have been given a wonderful collection of pictures that reveal the magnificence of their culture. There is only space here to show a few. Grozny was a magnificent capital city before the wars that have engulfed it for the past fifteen years.

"These ordinary people are just like us. They long for the day when Grozny can be rebuilt and the day when they can once again live in peace and freedom.

"But sadly, we have to agree with Andreas Gross of the Council of Europe who recently described Chechnya as 'one of the darkest places on earth'. We need to keep these long-suffering and lovable people in our prayers."

They call it 'An Easy Life'

by Sister Ursula E. Cott

LET ME CALL HER LIA. She is poor, illiterate and HIV positive. What could be worse?

As she unfolded her story to me, my heart was touched with each new revelation. I thought readers would be touched too, so I asked her if she would be happy to share it with you. She consented, even to showing you a picture of herself and her daughter.

"I never knew my parents. I was left with my grandmother at the age of two. We lived in a remote area so I never went to school."

At the age of fifteen, Lia decided to run away from her 'home' in the hope that life had more to offer her.

"I got a ride to the big city – Salvador. Being illiterate and not knowing anyone, I found out that the only option left to me was the 'easy life' on the streets. Someone showed me the historic centre, Pelourinho. Here I could make a 'living'. There is a 'programme' for young girls and women. It is offered by the Brothels…"

After three years, Lia met someone who took her in to live with him.

"I had a baby girl and soon after her birth found that I myself, my baby and my companion were all HIV positive."

The long struggle began. Lia was in and out of the Treatment Centre, where I first met her. Her husband died after the first year and she immediately 'joined up' with another man who was in the same position as herself. They had a baby girl together. But the romance was short-lived and she found herself on her own again.

"I had no choice but to return to the 'easy life'. Before long I found that I

was pregnant again. What do to now?" When she went back to the Treatment Centre, her two children were given a home there in the 'nursery' where HIV positive orphans are cared for.

Lia's health improved. While in remission, she was offered a job at the Centre. Her duties were light – taking care of the patients' food trays, cleaning the refectory after meals and helping when possible in the nursery. She loved this, as it gave her a chance to see more of her two children.

Lia is a kind and gentle young woman. In spite of her hard life of suffering, she has not lost her tenderness. She was outstanding in her care and diligence and the patients valued her presence. She gave birth to her third child, a baby boy.

All this time, little did she know that she was constantly being observed by one of the patients called Raul. Soon he let Lia know that she was the greatest! So began the present romance!

Raul is in his late 50s, HIV positive and a stroke victim. He responded well to treatment and received physiotherapy on a regular basis. This helped him a lot. Patients can stay at the Treatment Centre for a period of three months. Then they are helped to find alternative living.

The Centre arranges 'god-parents' to help with paying the rent. A weekly food hamper and travel vouchers are provided by the Centre.

When it was time for Raul to move on, he invited Lia to be his darling companion. She accepted and left with Raul, taking with her the 5-year-old Gisa, leaving behind the 3-year-old boy.

Alas, Raul was not the 'Prince Charming' of Lia's dreams. He has a serious problem with depression and spends any available pocket money on native gin to drown his sorrows. His burden is a heavy one too, with no family, being HIV positive and now paralysed on one side. He is very limited in his movements, hence Lia is on duty twenty-four hours as Raul needs her by his side at all times!

When we visit their tiny home they are overjoyed and profuse in their thanks. It is touching to see the living space, 3 x 3 meters, so small, and yet they manage to make it 'home'. The simplicity, poverty and cleanliness are impressive.

I felt that Lia was like a bird in a cage, trapped with no way out. It is hard for me to see that what she thought to be a dream has turned out to be a nightmare.

That is how we see it. But Lia seems grateful for her good fortune. She is one of so many – in fact her name is 'legion' here in the city of Salvador. Our pastoral presence is trying to make a difference in the lives of women like Lia. We thank God for the opportunity, and thank her for sharing her story.

One of the greatest needs in Capim Grosso is providing care for young children. A group of grandmothers from our Basic Christian Community came to us saying they found it overwhelming caring for the little ones all day while the mothers were at work. They asked our help in starting a Nursery School where they would volunteer as carers, taking turns so that all would have some free time. The local Mayor acknowledged this need and agreed to pay for one fulltime teacher. Our hope is that some day the government will assume responsibility for this great need.

Sister Ufuoma Ogigirigi sent us these pictures of the children dressed up for a local festival.

Everyone present at Sister Anne Moran's funeral Mass smiled when Fr. Pat Kelly said 'you could never imagine her sitting down'. During her whole life there was always something that urgently needed to be done for someone. She was always agile and very fit – while working in a Dublin office back in the war years of the 1940s, on many weekends she would cycle home to her family, a distance of more than fifty miles each way! Her first assignment as a newly-professed young Sister in 1948, was to promote our new film *Visitation* throughout England and Scotland. Always unassuming, she set about this task methodically and carried it out most successfully! She was then assigned to Nigeria where she worked at Use Abat and in the administration of St. Luke's Hospital in Anua for a number of years. She later filled the post of Secretary General and at different times was Regional Superior in Nigeria, and in Europe. When our foundress, Mother Mary Martin, became ill in 1968, she had the onerous task of leading the Congregation until the General Chapter that followed.

Sister Anne played a key role in opening up our work in Latin America, and was very happy when she was eventually free to join the community in Brazil in 1977. In preparation for her work there she studied Community Development at the Coady International Institute in Nova Scotia. She believed that life was a non-stop learning experience! She took several hands-on courses in clinical pastoral education, in teaching literacy, and in the ministry to people with AIDS, including the psychological and social repercussions of HIV.

When she retired from Brazil at the age of 69, she decided it was time for her to understand the world of computing. Following a summer course at University College Dublin, she became quite skilled at desktop publishing, database management and the use of the internet.

We don't know if she is 'resting' now that she has been called to her final reward, but she was buried on May 31, the feast of the Visitation – and that would have been a very significant and important date for her.

The Miracle on our Doorstep

by Sister Betty Naggai

A group enjoys a celebration of banana beer in Ugands

Gossip is a favourite pastime for people in my home village in Uganda. A good gossip is enjoyed more than ever when men and women sit together to share the local brew made from a special type of banana called *mbidde*. During such gatherings news spreads easily. Few secrets, if any, are kept. Such an environment facilitates the spread of the good news about the miracle on our doorstep.

When I recently completed my studies in midwifery at the Mater Hospital in Nairobi, I returned home for a short visit. On Sunday, as I watched the long Offertory Procession of people bringing their gifts of farm produce I noticed a middle-aged man carefully and attentively holding a transparent plastic bag. The contents seemed to be in the form of powder. I had never seen the like. As he bowed with maximum reverence and handed up his offering, the congregation cheered and clapped their hands. Afterwards I asked him what his special gift was.

"While you were away from home", he told me, "we started growing the Moringa tree. Most people in the village have one or more trees now. What I offered was powder ground from the leaf. Its purposes are many – it relaxes the muscles, relieves pain, prevents insomnia, improves the appetite, cures abdominal upsets as well as fatigue and many other complaints."

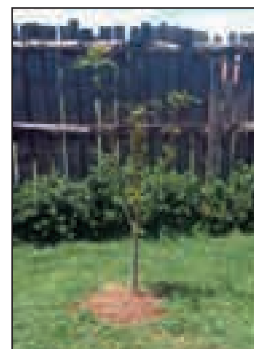
Soon after that I spent three weeks in Kenya with Sister Patricia Hoey at St. Mary's Medical Centre in Kapsoya outside Eldoret. She had the Moringa tree growing around the compound and showed me literature about it. There I read that a spoonful of Moringa powder added three times a day to the food of a malnourished

child produces spectacular results within ten days.

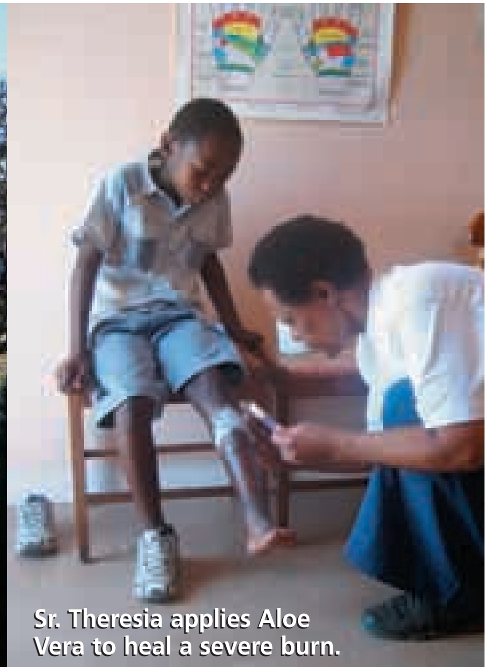
Sister Patricia had a client who was infected with HIV and had developed AIDS. She was weak, her body was wasted and she had no appetite. We collected the green leaves of the Moringa tree, dried and ground them. Each day for four days we visited her and added a teaspoon of the power to her daily food. On the fifth day, we were dumbfounded when we did not find her in her bed coiled as a bundle inside a blanket. Her sister informed us that she had gone to visit her friend in the next neighbourhood. It was unbelievable! Since then she has steadily improved. She feels more energetic, her appetite is much better and she had added weight.

Now I am packing my bags again for my new assignment in Malawi. Among the many gifts I received, Sister Patricia has given me Moringa seeds. As soon as I arrive I will plant, use and promote them. This nutritious tree is a real gift to humanity.

The Moringa Tree grows in the dry season and during times of drought, providing green vegetable when little other food is available.



- The leaves have more than three times the calcium of milk, more potassium than bananas, more than twice the iron of spinach, and more than twice the vitamin C of oranges.
- The flowers can be eaten raw or cooked and attract bees who in turn are a rich source of honey. The diced pods can be roasted, boiled or steamed and are rich in nutrients. The inner lining of the seed pod can be used like pasta or noodles.
- The seeds, crushed and tied in a cloth are used to purify dirty water, as they attract and absorb the impurities and pollutants, leaving clear water ready for boiling.
- The bark produces a gum that can be used in cooking and for food preservation all the year round. It also has a whole list of medicinal uses.
- The grown trees can serve as stakes for beans, yams, vanilla, pepper and other crops and provide a windbreak and shade that helps to preserve the moisture in gardens and fields.


Sr. Theresia applies Aloe Vera to heal a severe burn.

Ngaramtoni

At NGARAMTONI outside Arusha in Tanzania, the Moringa tree grows along with many herbs that have medicinal benefits. The Centre, under the direction of Associate MMM, Moira Brehony, is dedicated to the promotion of indigenous knowledge. It also provides courses in a range of complementary therapies and the skills needed to plan and develop successful projects.

Sr. Aloysia Lagwen assisted by Paskalina Shuri, provides complementary therapies in Arusha Town.

For many common complaints there are low-cost remedies that can be produced locally. Sister Theresia Ladislaus uses many of the plants from the herb garden at Ngaramtoni in treating clients. She says Moringa mixed with garlic is very good for people with HIV. She also tells us:

Spider Weed, which grows wild in Tanzania and Kenya adds nutritional value when mixed with other vegetables, because it is rich in iron, calcium and vitamins A and C. Rosella and Raspberry fruit are good for treatment of anaemia. Garlic is a natural antibiotic and has anti-clotting properties. Used as an inhaler, it stimulates the immune system. In the raw state it is very good for athlete's foot. It also helps to reduce cholesterol and is used for pinworm and tapeworm. Chewing parsley helps to get rid of the odour from the garlic.

A teaspoon of ginger powder in boiling water and honey helps relieve the common cold. It can also help to stop vomiting. Ginger is very good for dry throat and mouth. It contains phosphorus, iron, calcium, vitamins A and C. It is also effective for toothache. Turmeric which is related to ginger, can be used as an antiseptic.

Comfrey has many medicinal uses including relief of joint pain, fractures and for asthma. But It should not be used as a vegetable, as it is toxic. Aloe Vera is good for skin conditions. Elderberry is good for viral infections and for patients with HIV. Franjipani reduces the pain from shingles. The nectar is mixed with olive oil or sunflower seed oil. (But Lanolin or Vaseline are not recommended as an alternative to these oils.) According to Sr. Theresia, these plants should be harvested in the early morning, then washed, spread in the shade and collected when dry.

Group of Baptist Church members use the facilities at Ngaramtoni for their Workshop.

Farm Schools provide a unique answer

by Sister Ursula Sharpe

A mother, dying of AIDS, turned to me and said 'what will happen to my children when I am gone? Will you take care of them?"

Moments like this prompted me to think of ways in which we could help orphans who had been obliged to drop out of school to take care of their dying parents. As well as losing one or both parents, they find they have no money for school fees, uniform and books, not even for basic food for themselves and the younger brothers and sisters left in their care.

The orphans are all traumatised through witnessing the final illness of their parents. They are de-energized and suffer deeply from their grief and loss. Many of these boys and girls also suffer from depression and anxiety. Some have been physically or sexually abused.

Those who have been sent to live with relatives experience great difficulties in adapting in their new home, where they know they are an added burden.

Many of them tell us how difficult it is to go back to school and keep up with the pace of studies, when you have nursed one parent – or maybe both – through the last stages of AIDS.

For many, the only way forward that they can see is to beg on the streets or go into prostitution. We talked about this situation among ourselves and tried to see what were the positive elements in this dark situation.

First of all, there is the fact that the orphans have youth on their side. That means energy, ambition, young brains and the ability to learn. And then there is land. Putting these positive elements together, we saw that as well as grief counselling, we needed to give them some activity that would harness their energy, nurture their ambition and help them to acquire the skills that their parents would have given them if they had lived.

It was then that we came up with the idea of creating Farm Schools.

We started first with one Farm School. This idea proved to be so popular and effective that it was not long until we had to find premises for a second, a third and so on. Today, we are running six Farm Schools in the vicinity of Masaka, each with about one hundred boys and girls with the gender fairly evenly balanced.

The boys and girls come to the residential Farm School for one week each month. It is very obvious that they love coming and really enjoy this week. You can tell by their enthusiasm and eagerness to learn. They are proud to wear

their school uniform. This seems to help them in their ongoing search for identity.

During the week at school they learn to read and write if they had not already become literate, and to improve their literacy if they had already begun. They also learn basic mathematics, marketing, book-keeping and how to handle a bank account.

There is also plenty of time for games, peer counselling and individual counselling. In this way, they get a sympathetic ear as they try to work through their feelings of loss, anger, and fear. There is also ample opportunity to discuss HIV and AIDS and to grow in awareness of the virus that killed their parents and to try to avoid getting it themselves.

For the remaining three weeks of each month they return to their homestead and put into practice what they learnt during the week at the Farm School. Our Agricultural Instructors, two of whom are women, visit them on their land, to ensure that they are managing it well.

We have a small revolving Loan Fund, from which they can be granted money to implement any good ideas they may have. The Supervisors also check on how that small amount of money is being managed.

The Farm Schools have shown encouraging results. With over two million children orphaned as a result of HIV and AIDS in Uganda, the problem of orphan education is a huge challenge, not only to support the orphans themselves but also to look to the future economy of the country.

A Little Boy called Saddam

A little boy called Saddam *(above)* was brought to our hospital with the classical symptoms of a Burkitt's tumour. This is quite rare in most of the world, but is the most common childhood cancer in Africa. It is one of the most aggressive of all human cancers.

Saddam was only ten when I met him. His face had become quite distorted on the right side as the tumour had become very large by the time he came to us. He had a tough time, but his courage was admirable through it all. When we put him on the first line of chemotherapy, his condition got a lot worse, as the drugs caused perforation of his palate. We knew the alternative treatment would be much more expensive, so we appealed for financial help from the MMM Small Projects Fund and started him on this second line of treatment.
He is doing a lot better on that.

Another little boy called Shafik, aged eleven, came with a similar problem. His condition was more advanced, and before long his cancer had begun to affect his brain. This left him with paralysis of his lower limbs. We managed to get funding for a wheelchair for him, which enabled him to return to school. He is always smiling and happy when he comes to see us every three weeks to get his chemotherapy.

Shafik and Josephine with Sr. Maura.

As well as these two boys, we are treating Josephine for the same problem. She is thirteen, an age when girls want to look their best. That is not easy with a large tumour showing in her jaw. We have just started her treatment.

It always amazes me how cheerful and good humoured children can be even when they are very seriously ill. They teach me so much!

Angola

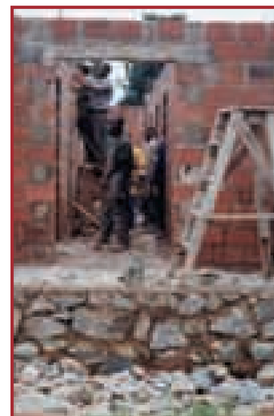
Sr. Margarida Mundombe

Sr. Jacinta Akonaay

The 27 years of Civil War in Angola, which ended in 2002, left major difficulties for the health services. Many people have been maimed by land-mines, and without sufficient rehabilitation services are confined to wheelchairs.

A lot of reconstruction work is needed. This is especially true in the city of Huambo, our newest mission in Angola. The problem of transporting materials for reconstruction slows down the work and the difficulty of getting medical supplies through is also hampered by the poor infrastructure.

For ordinary people life is simple. If their health is good they enjoy the challenge of re-building their country and look forward to greater prosperity in the future. In rural areas people use ox-drawn carts. Children make their own toys. But for those whose work involves travel, life can be difficult and stressful. While air services have improved a lot since the signing of the Peace Treaty, it can still be a daunting journey from our mission in Lubango to Huambo.



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