



Healing & Development

Volume 71

Yearbook of the Medical Missionaries of Mary



Rooted and Founded in Love

2011 Edition



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“In the face of growing darkness, we journey together,
As we search for angels of hope, we journey together,
As we build our world out of chaos, we journey together,
As the world unfolds through new levels of meaning, we journey together.”

(Voices of Hope in Seasons of Prayer)



Front cover: In Uganda, the Clinical Officer takes blood for HIV testing at a rural centre. It is never too early to test for HIV.



Back cover: Zaffé Village, Benin.

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Leader's Letter

Dear Friends,

Since I last wrote to you our world has experienced a great deal of pain and loss. To name but a few, we experienced the deadly earthquakes in Haiti, New Zealand and Japan; the civil unrest especially in the Arab world as well as the global financial crisis.



As Medical Missionaries of Mary we are committed to working in this globalized world. We do our best to bring healing and relief to as many people as we can reach. Our task is to help them to manage the struggles of our times. I am in the privileged position of hearing the stories of the Sisters when they return to Ireland from our missions abroad. I also learn from our many younger members whom I meet when on Congregational Visitation. From them I hear of the little miracles that happen every day because of the kindness and compassion of others.

Many writers draw our attention to the fact that an 'old world' is on the way out while something new is being painfully born. There is an increased concern with quality of life and spirituality. People are realizing that our world depends on relationships because we are all interdependent. We are all co-authors of our future. You are co-authors with us.

In this Yearbook we try to give you an overview of some of our efforts in working with different peoples of many different cultures and nations. As you can see, the range of services we try to provide is wide, always responding to the needs around us. Yet our overall aim is to prevent illness, cure it where we can, and help communities in some of the most needy parts of the world to enjoy good health and develop their local resources.

We are blessed by the teamwork of very committed and well-trained co-workers, some of whom have been with us for years and also for our MMM Associates. We are encouraged by the many volunteers drawn from the local communities who also take on the work of healing and development alongside us.

We also feel blessed by the support and commitment of all of you who are our partners in this task through your financial support and through your prayers. Without you our mission would be impossible.

I hope this Yearbook will give you a picture of what has been possible with your help. Next year we will be celebrating 75 years since the foundation of MMM and we will be sharing many more stories of God's Presence with us as we continue to respond to the Call.

As ever, we send you our warmest thanks. Each evening as we gather in prayer in all our communities around the world, all of you who are our partners in this mission are remembered.

Sister Subhāw
Congregational Leader

World Mission Overview



Angola: It was another memorable year in Angola, another year of new beginnings. We currently have eight Sisters working there in two missions, one in Huambo, the country's second largest city. A small health centre in the parish of São Luis provides curative care and immunization for child welfare, while providing us with an opportunity for community health education in the area.

On the outskirts of the country's capital city, Luanda, a much awaited Health Centre was opened at Viana, one of the city's satellite developments. Below, on page 13 you can read about the hopes and set-backs that were encountered before the great Opening Day arrived on December 1, 2010.





Benin: January 8 marked the tenth anniversary of the arrival at Zaffé of the first team of MMMs in the Republic of Benin. Our community members have changed since the first of our pioneers – all African MMMs – drove up country to a great welcome from the people who were a long time waiting for a service. In 2010, they felt it was time for another celebration. Bishop Antoione Ganye of the Diocese of Dassa Zoumé came to celebrate a Mass of Blessing and exchange of gifts while the King of Glazoué, His Majesty Aronbyé, also honoured us with his presence. Members of our staff enacted a drama that told of the importance of health education and good nutrition. These are the two elements that MMMs and our co-workers at Zaffé have been stressing for the past ten years among the people. Along with a busy Health Centre, that serves 11,543 people in the immediate area, our community of six Sisters give food demonstrations to the outlying areas in an outreach programme that educates for prevention of disease, cures the sick and helps in the rehabilitation of the physically challenged in collaboration with the Liliane Fonds' Foundation.



Brazil: Our ten Sisters in Brazil are mainly located in the State of Bahia. Three are located in the inland town of Capim Grosso, about four hours' drive from the State Capital, Salvador. Their involvement in health care as part of the Diocesan health ministry, involves them in projects for the harvesting of water in this region that is frequently drought-stricken, as well as home-based care and education for prevention of disease. Five Sisters are located in the city of Salvador, where the lives of the majority are afflicted with poverty and violence. This community is also the residence of our Area Leader for the Americas, Sister Jean Clare Eason, when she is not travelling elsewhere. During 2010, a major study of the effects on families of the loss of a member through violent crime was undertaken and will form the basis for developing a community-based practical response during the coming year. The remaining two Sisters are located in São Paulo working among the people who live on the marginalized periphery.



Periphery of Salvador



Honduras:

MMM first went to Honduras in 1998 in the wake of Hurricane Mitch, which devastated the country. We settled originally in the rural area known as Marcala, integrating our skills in health care into the already well developed programme in agricultural development run by the Diocese. There are three Sisters in our community at Marcala now. About 5 hours further north, a second mission was opened in a depressed area of the town of Choloma, which suffers greatly from unemployment, exploitation and migration. The establishment of Casa Visitación as a place where healing services are offered continues to provide the three MMMs there with a base where a team of co-workers joins us and enables us to hold regular outreach trips to more distant communities in the mountains.



Kenya: Nairobi acts as a hub for travellers in East Africa and our community of six Sisters at Sports Road are rarely without visitors. It is also the residence of our Area Leader for East and Central Africa, Sister Kay Lawlor, when she is not travelling elsewhere, and provides administrative support to the whole area. Each member of the community has her own ministry in the city including healthcare, education and development support. The large slum known as Mukuru, near the International Airport, occupies the attention of three Sisters living in the neighbourhood known as South B. On page 14 you can read more about the challenge that was faced in fostering good health against all the odds of overcrowding and poverty. On the outskirts of the University town of Eldoret, in a neighbourhood called Kapsoya, five MMMs provide a range of health services to a population that has been devastated by political violence and HIV. Seventeen co-workers help us provide a programme that supports more than 1,400 orphans and vulnerable children.



A group of Mukuru Home-based Care Volunteers.



Sister Clara in the pharmacy store at Kasina

Malawi: As in Nairobi, our community house at Lilongwe has many visitors, and serves as a base welcoming those coming for shopping or business in the capital city. Further south, in the Diocese of Dedza, three Sisters supervise the work at Kasina Health Centre, a 60-bed facility that also reaches out to people who live in the rural mountain area. When we took over the work at Kasina, the centre was in a run-down state, but with the help of our co-workers it is running very well now. Further south, another

remote location off the main road to Blantyre at Chipini, is home to six MMMs. This Health Centre has forty beds.

A new Unit for the treatment and control of HIV was opened in 2010. On page 16 you can read about the wide outreach of Home Based Care to 78 villages, for which a team of dedicated Home Based Palliative Care Volunteers has been trained.



Nigeria: As MMM was founded in Nigeria in 1937, this is still the country with the largest number of Sisters – a total of 64 altogether. They serve in nine missions in six different States, Ebonyi and Akwa Ibom States in the East; Edo, Oyo and Lagos States in the West; Niger State in the North, and on the outskirts of the capital city, Abuja. The work includes two Hospitals, one in the city of Ibadan and the other at Mile Four, near Abakaliki – more on this can read on page 18. A special centre for obstetric fistula repair can be found at Itam in the south-east. In the city of Benin, the Mother Mary Martin Centre has been constructed to provide vocational training in an effort to offer young people an alternative to being trafficked abroad in search of work.



Our community in Benin city also provides a centre for Assemblies and is the residence for our Area Leader in West Africa, Sister Gladys Dimaku, when not travelling elsewhere. Health services to densely populated urban communities are provided at two locations on the outskirts of Lagos, as well as a dedicated centre for the treatment and prevention of HIV. As well as running the Health Centre at Fuka in Niger State four Sisters provide a service to the outlying rural population including the nomadic Fulani tribespeople. We also have two communities for the formation of new MMMs, one pre-novitiate house in the East, and our inter-cultural novitiate in the city of Ibadan.



Rwanda: MMMs first arrived in Rwanda in the wake of the genocide in June 1994, and today our work is established at the Health Centre of Kirambi near the western border with D.R.Congo. Four MMMs are located there. The curative work and Maternity Unit at Kirambi is extended by the nutrition programme and development work in the catchment area, including a seed nursery and work with communities to protect water sources. The marginalized Batwa people who inhabit the area have been helped to improve their housing and nutritional status. Mobile Mother and Child Welfare clinics are held weekly and plans have been made for an MCH outpost to be constructed at Cyahafi, 7 km away, to save mothers the long walk to Kirambi.



Bosco, small for his five years, is helped to walk by Nurse Alphonsine.

Tanzania: MMMs have been in Tanzania since 1947. Today there are 24 MMM Sisters most of whom are in five missions. Makiungu Hospital is a 150 bed facility where eight Sisters form the community, and 300 co-workers are employed. As well as routine curative services, specialist surgery is provided by the Flying Doctors whose small plane can be seen landing on the hospital airstrip every few weeks.



In the town of Singida, some 25 km away, four Sisters run the Faraja Project – this is a service to people living with HIV or AIDS, with wide-ranging services to educate people for the prevention of HIV and a Home Based Care programme. In the village of Nangwa near the foot of Mount Hanang, three Sisters run a Health Centre with outreach services among the Barabaig people.

In the city of Arusha, we have a community of three Sisters down-town, while four others run the Residential Training Centre known as Mapambazuko, at Ngaramtoni, 15 km outside Arusha. Two other Sisters work in collaborative ministries, one teaching in the Dept. of Psychology at the University of Dar es Salaam, and the other is a pharmacist working with the production of intravenous fluids at the Infusion Unit attached to Kilimanjaro Christian Medical Centre.



Sister-doctor Carla Simmons provides home-based palliative care

Uganda: Our community in Uganda numbers eleven, six of whom are based in the town of Masaka, 80 km west of the capital, Kampala. They live in two separate communities, one surgeon working at Kitovu Hospital, and two other doctors working in the Mobile Outreach to people living with HIV and AIDS, including an extensive programme bringing antiretroviral therapy, and palliative care to several thousand people in remote villages. You can read more on this on page 20. The community at Masaka also provides care to prisoners and street children. Five Sisters are located 50 km further west, at Makondo, at a rural mission where we manage the Health Centre and a nursery school mainly for children who have become orphans through AIDS. Mobile teams bring health care, development initiatives and support to people with physical disability in the outlying areas, supported by a dedicated team of volunteer Community Health Workers.

Support from Ireland, UK and USA

Our overseas missions are supported by a large number of older MMMs. All with extensive experience of our work abroad, they are now retired at our Motherhouse at Drogheda, or in smaller communities in Ireland, England and USA. At Artane the office of our Area Leader for Europe, Sister Dervilla O'Donnell, can be found. Our Motherhouse provides accommodation to Sisters when they come to Ireland on leave from overseas. It is also the venue where many events are celebrated, including jubilees.

As well as supporting our global work through prayer, several of our Sisters in these countries are engaged for much of the year in fund-raising activities of one kind or another, and in meeting our many donor groups. They are also engaged in some form of ministry or service. Some Sisters work with various parish groups, in hospice care, as hospital chaplains, or visiting the sick and housebound.

Our communities in Ireland, England and USA also provide personnel for the Mission Awareness programme organized by the Church in these countries. This gives scope for Sisters who have returned from work overseas to visit vibrant parish communities to bring news about our work at the coalface and ask for support - which inevitably comes with great generosity.





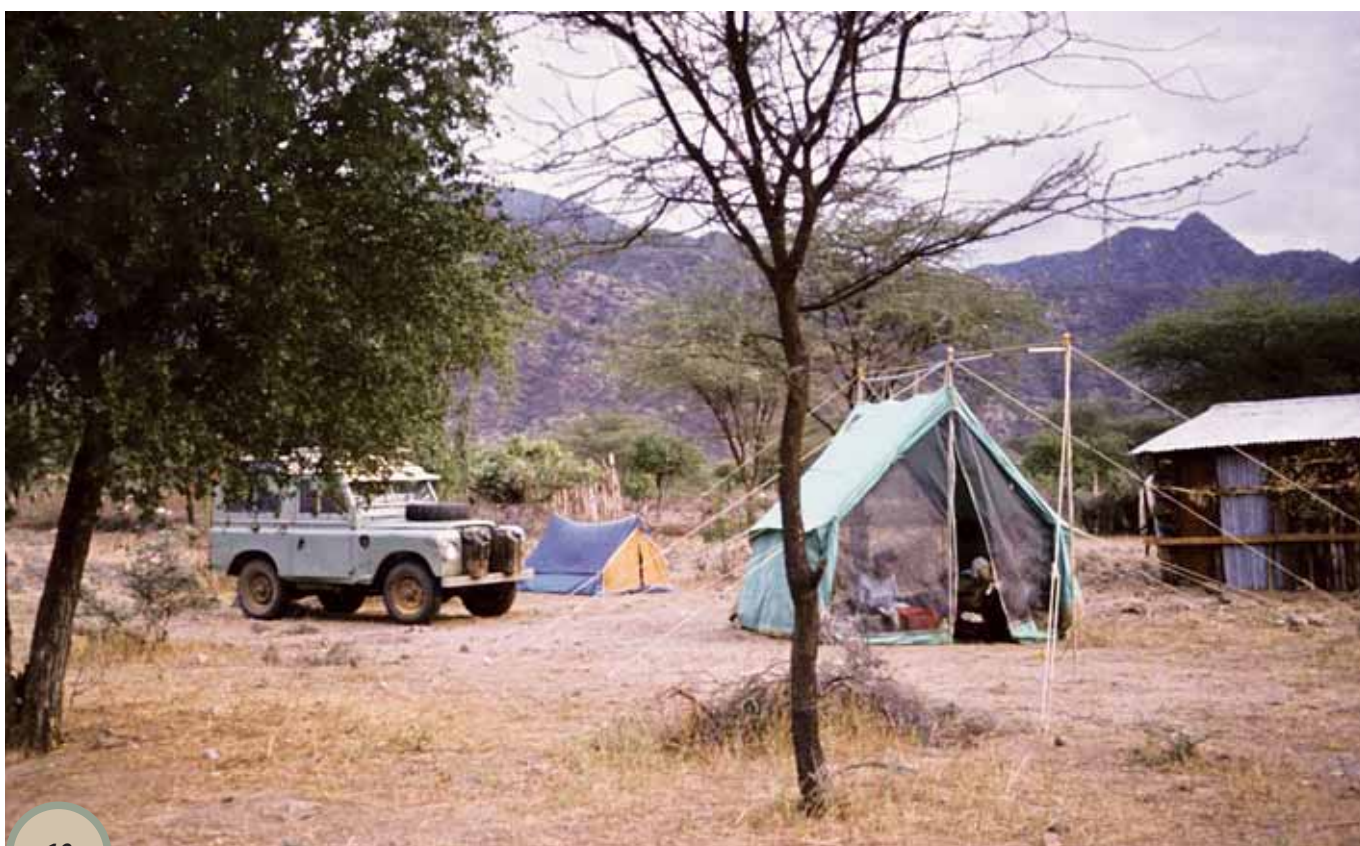
Ethiopia 1960–2010

The first MMM Sisters flew out from Ireland in 1960 and were met at Addis Ababa airport by Monsignor J. McGeogh who served at the Apostolic Inter-Nunciature. For historical reasons, particularly the Italian occupation, Roman Catholic missionaries had not been welcome by the government or the Orthodox Church. MMMs remained at the Inter-Nunciature until 1969, while opening up health services at Metcha (1962), Gambo (1965), Finote Selam (1969) and Bisidimo (1970).

A major famine struck the north of the country in 1972, leaving about 200,000 people dead. University students in Addis Ababa and Asmara were aware of the extreme poverty of the majority of the people. They were supported by secondary school students in voicing the urgent need for liberation from feudal and semi-feudal systems. For decades, Russia had been involved in education about socialism through the Russian Hospital in Addis Ababa founded in

the early 1900s. The students accelerated their struggle, with the leadership of the Armed Forces. In February 1974, imperial rule was replaced by a new government. 'The Derg' was formed in June 1974, and announced the 'Zemetcha' – Campaign for National Development Through Cooperation.

The Universities of Asmara and Addis Ababa and the 11th and 12th grades in Secondary Schools were closed while students were sent to participate in the Campaign with only ten days' preparation. In effect, they acquired power without an appropriate sense of responsibility or experience. A group of Zemetcha students was assigned to Gambo, where they took over a hospital ward for their accommodation early in 1975. They felt it was their duty to educate the people on atheistic socialism. They felt it was also their right to hold weekly interrogation sessions with the MMM Medical Director in the presence of loyal



Sister-doctor Maura O'Donohue camping during Nutrition Survey at Karo.



hospital staff, lasting more than five hours at a time. No matter what answers were given, the accusation would be levelled that the Sisters were exploiters and imperialists. This continued into 1976.

Eventually, the Sisters were forced to evacuate and sought the assistance of the Secretary of the Ministry of Health. He understood the zeal of the student cadre was misguided. He took immediate action to have them removed and negotiated the safety of the Sisters and our co-workers. We finally withdrew from Gambo in 1977 and developed services in Jinka, Dadim and Mikke.

When another serious famine struck in 1984, MMM was asked to assist in co-ordinating the Catholic National Famine Relief Programme from Addis Ababa, an operation which continued for three years.

In 1992 the MMM Counselling and Social Services Centre was established in Arada Kifle Ketema, in Addis Ababa, to address the problem of HIV and AIDS. Over the years the services expanded to respond to identified needs including home based care, HIV education, capacity building and support groups, orphan support and community-based rehabilitation for children with disabilities. In the year 2000 we assumed responsibility for St. Mary's Laboratory, which provided laboratory services, counselling and HIV education.

In 2001, when a Hospital was opened at Wolisso, MMM provided a general surgeon to join the inter-congregational team and two MMM nurse tutors staffed at the adjoining Nurse Training College.

When it was decided that the time had come for MMM to withdraw from Ethiopia, a historical review of ministries was carried out. Under twelve headings, lessons were outlined that could be useful elsewhere.

These included criteria regarding personnel, consolidation and withdrawal, record keeping, contracts, support under stressful and hostile



conditions, importance of sabbatical leave, knowledge of labour laws and communications in remote locations.

As we look back, we know that our years in Ethiopia included some of the hardest times, but there were good times too. Sisters covered thousands of miles by jeep and by mule, often remaining away from their base mission for a month at a time, living in tents among the people in their villages.

Our work with people suffering from Hansen's Disease, with the disabled, with pastoralists, with the struggle to prevent the spread of HIV and care for those infected and affected by it, has been rewarding and has enabled us to form close bonds with our co-workers whom we will never forget.



Sisters Bernadette Freyne and Catherine Young visit neighbours at Mikke.

Sister Colette Ryan travelling in Ethiopia by mule.

Water point during famine relief.

Case Study — Angola



Sister Brigid Archbold from Ireland, has supervised the development of the Viana project from the very beginning. She has wide experience in Angola, having served at Chiulo Hospital in the Southern Cunene district, and having supervised the development of MMM work in Huambo and Lubango.



Sister Rosemary Akpa from Nigeria is Business Administrator of the project.



Sister Josefina Lissimo



Patients in queue for clinic



Opening of Viana

Viana is a satellite town of Angola's capital city, Luanda. The dream of having a Health Centre in the neighbourhood known as 'Os Mulvenos de Cima' took many years before it came to fruition. MMM was invited by Bishop Joaquim Ferreira Lopes to come to the parish of Nossa Senhora de Boa Nova to undertake this project. But many difficulties were encountered along the way with delays in obtaining Government planning, and meeting with all the requirements laid down.

Apart from the challenge of raising financial support for the work, there was no electricity and no running water.

"We depend on a generator for our electricity supply. This is an added expense for us. In the future we hope to get electricity from the public supply, but the infrastructure for this is not yet in place."

One by one the obstacles were overcome. On December 1, 2010 the blessing and commissioning of the new Health Centre took place. The very practical Clinic is set around a square with an open centre with back and front entrances. There are sixteen rooms which are used as follows:

- Reception area
- Two Consulting Rooms
- Treatment Room
- Observation Room
- Antenatal Clinic
- Counselling Room
- Laboratory
- Education and Immunization
- Pharmacy
- Pharmacy Store
- Sterilisation Room
- Staff room
- Oratory

There are two indoor toilets and showers, as well as outdoor VIP latrines.

A large Annex, close by, includes a room for sponging children with high fever. This building also has a laundry and hardware store.

In the first month after opening the Health Centre, patient numbers reached 70 per day. The most typical ailment is malaria. Many patients present with a very serious form. Some children come with very high fever and convulsions. Other conditions include typhoid fever, chest infections, pneumonia, diarrhoea and vomiting. Victims of road traffic accidents have also been treated. As in all MMM services, ante-natal care is a priority.

Nine local staff are employed including one Laboratory Technician, three nurses, an administrative assistant, a cleaner, a driver and a security supervisor.

The response from local leaders and people has been very positive, with many sentiments of gratitude expressed by the local Chief, as well as from neighbours.

It is a sign of just how significant this health facility is that houses are now mushrooming up all over the place. Just five minutes from the Health Centre a big market is now operating, selling building materials, plastic wares, food products and fruit, vegetables and second-hand clothes.

It has often been observed that the first step in development of a local area was the construction of a mission school or health facility. But while Mulvenos de Cima is a rapidly developing area, the infrastructure is not yet in place.

"Water remains a very big problem. Although we have a borehole, its use is limited because of the high content of salt it contains. We do not have much rain but when it falls it can be torrential. We have two tanks to collect rain water."



Sister Alice Ashitebe, from Nigeria, previously served in many other missions as a nurse tutor.



Sister Margaret Quinn from Ireland is taking care of the Pharmacy.



Mukuru Kwa Njenga

Sisters Colette Ryan and Bridie Canavan who administer the MMM Central Dispensary in 'Mukuru Kwa Njenga' put the estimated population within their catchment area at about 20,000.

Their reports for 2010 give some idea of the challenge of keeping such a population in good health, given the poor hygiene, overcrowding, migration and other social problems. However, these reports also outline a high level of achievement.

As the Project is situated in a slum area, most of the diseases seen are communicable. Prevention and mitigation of their effects is very important.

There was no major disease outbreak during 2010, and the fact that there was no recurrence of the cholera outbreak of 2009 was a sign of the learning that had taken place in the community.

The curative department networks with the other components in the project together with the Ministry of Health.

There was a big demand for services during 2010. Of the 17,268 people who attended the Dispensary for curative care, 98.3% were treated and recovered. The other 2.7% were referred to hospitals. 3,617 patients were sent to the laboratory for routine investigation, while 223 patients were sent to the TB laboratory for sputum examination.

The most common diseases treated were respiratory tract infections (6238), malaria (1280), diarrheal diseases (1164), skin conditions (1156), urinary tract infections (827) and amoebiasis (631).

The past year saw 5,940 ante-natal visits. The opening of a new building to care for this sector was a great achievement. There were 17,996 child welfare attendances with corresponding rates of immunization.



Mukuru is a densely populated slum near Nairobi International Airport.



Makuru in the mud.

One staff member successfully completed her training for a Higher Diploma in Counseling and graduated in November 2010. One staff nurse began upgrading from a Diploma to a Degree in nursing. One staff member was trained on prevention of mother-to-child transmission of HIV and also sensitized on pharmaco-vigilance.

The employment of a Pharmacist lifted a big burden from the nurses. A cashier was also employed to deal with cash collection and issuing patients' cards. This has tremendously relieved those in consultation and treatment rooms.

HIV is a major challenge in Mukuru. People living with the disease in the area number 851. They were treated for opportunistic infections as necessary. An individualized care approach was used for maximum effectiveness. Patients who were eligible for Anti-Retroviral Treatment (ART) were appropriately prepared.

The remainder continued with therapy to prevent opportunistic infections. Patients who required specialized care were sent to major hospitals. People treated for opportunistic infections on time were relieved from debilitation. They recuperated and could perform activities of their daily living. The majority have been able to work within the nearby industries, while others run small businesses to cater for their daily needs.

Nutritional support is a key factor in management of HIV/AIDS. Maize flour and beans were

provided to 75 households with people who were either in ART or TB treatment, or both.

Support group facilitation on topics such as HIV status disclosure and stigma reduction has helped patients become more open regarding HIV infection. A seminar for discordant couples was a benchmark activity of the year. Persons empowered in economic independence became optimists, realized their potential and worked to earn their living. People have accepted their HIV status and adopted positive living. They can talk openly and share information on HIV/AIDS due to reduced stigma. They have regained their self-esteem and dignity. No case of family break-up as a result of HIV was reported. This is due to improved understanding of the HIV phenomena and reduced stigma.

One of the most impressive achievements at Mukuru is the community participation in taking care of their own health. The Reports tell us:

"Because of its workload and the area coverage, we trained twenty community health workers who will help us to do intensive follow-ups with patients who are on TB drugs and on ART. They are also given in-service training annually. These Community Health Workers are part and parcel of our work. It is a strong unit that serves the whole area of Mukuru community by referring the very sick to the dispensary, by finding defaulters, locating malnourished or challenged children, and accompanying orphans and vulnerable patients to major hospitals in cases referred."

The team also creates awareness among community members through door to door campaigns, home visits and at Chief's office. The messages passed are based on prevention of communicable diseases, HIV and AIDS awareness, Tuberculosis, one-to-one health education and home-based care skills. See also page 25.





Community Based Palliative Care Volunteers

At Chipini Health Centre, the Home Based Care Programme was initiated in 1993 when our first Home Based Care Volunteers were trained. By 2010, 64 volunteers were trained, which included special training in palliative care. They cover the 78 villages in the catchment area of Chipini Health Centre. In 2010 they were provided with bicycles, uniforms and protective clothing for bad weather.

Volunteers meet monthly and elect their Executive Committee. Volunteers commit to making two home visits per week, but during the farming season this may be reduced. In 2010 they registered 282 sick people, 672 incapacitated elderly people and 1,558 orphans. They averaged 405 visits per month, and referred 294 patients to Chipini Health Centre.

Home Based Care Volunteers treat their patients for simple ailments using the Kit provided. Twice each week, a Nurse or Doctor or both, visits one of the eight Village Clusters and conducts a round, visiting homes of patients who have

particular problems. Patients needing more intensive care or investigation are referred to Chipini Health Centre, using either a bicycle or bicycle ambulance to get there, usually accompanied by a Volunteer.

Back in 2004 the Voluntary Counseling and Testing (VCT) Unit was opened. By the following year those testing positive were being referred to Staging Clinics. Patients living with HIV/AIDS who were eligible for Anti Retroviral Therapy (ART) were referred to Tisungane ART Clinic 40 km away – founded by the NGO 'Dignitas'. In 2006 a satellite ART site was opened at Chipini Health Centre, with the Zomba Team visiting monthly. It became a stand alone site the following year, and by 2008 was also taking care of children needing ART.

The concept of Voluntary Counseling and Testing (VCT) has been replaced by Provider Initiated Testing. All patients visiting the Out-patient Department at Chipini Health Centre are encouraged to present for testing. This is



Home Based Palliative Care Volunteers care for chronically and terminally ill patients, those disabled through stroke, injury or other disease and the elderly who are incapacitated.



offered five days a week and is seen as the gateway to the proper management of those infected with HIV. It is one of the strongest tools available in the process of HIV prevention through behaviour change.

All ante-natal mothers testing positive receive Cotrimoxazole Prophylactic Therapy (CPT) as do all babies born of infected mothers from 6 weeks until 18 months. All these children attend the Exposed Infant Clinics until they reach 18 months when they undergo HTC. If negative they are discharged from the programme. If positive they undergo staging, continue on CPT and attend the ART clinics for two-monthly monitoring. All pregnant mothers testing positive and patients in Stage 2 as well as all patients being treated for TB, are advised to have their CD4 count done. In 2010, 649 blood samples taken at CHC were sent to Zomba Laboratory.

Patients eligible for ART are booked for group counselling when they learn more about the drugs they are to receive, their side effects, the implications and above all the importance of life long adherence.

Nutrition and Education

Nutrition plays a vital role in the care of people suffering from HIV/AIDS. When the Body Mass Index is below 18, patients are registered for the supplementary feeding programme.

Preventive measures include visits to primary and secondary schools by the Home Based Palliative Care Volunteers who address the implications and prevention of HIV. There are also teaching sessions with various groups. During 2010, there were 524 such sessions, reaching 4,274 children and 2,386 adults.

Children who have become orphans through AIDS are a special concern. They are registered in their villages. Those beginning Primary school are provided with their uniform, which is essential for entry. In 2010, this included 180 children. Those eligible for secondary schooling are sponsored for school and examination fees. This included 136 children for the school year 2009-10 and 123 for the school year 2010-11. Those who are successful in their Malawi School Certificate Examination have been sponsored

for Teacher training. To date, 13 have graduated, while a further 9 are at the Teacher Training College. On-going training for members of the Care Team is also seen as very important. All staff attend the Health Management Information System meetings at which monthly statistics are reviewed and discussed and resolutions are made to improve services.

Information, Education, Communication

These are keywords at every level of the programme. It is stressed that this is the responsibility not only of the care team but also of the patients themselves, who are charged with bringing education about personal and environmental hygiene back to their own communities. The cooperation of Village Chiefs is paramount.

Workshops and meetings are also organised by the District Health Office. A representative of the Counsellors attends the quarterly meeting of the Southern Region Counsellors Network.

Malawi's National ART Programme is well organised, well supervised and well monitored. There were times when shortages of drugs were experienced, but no patients went without their treatment at any time. Supervision is done quarterly, and Chipini Health Centre succeeded in gaining the Certificate of Excellence at every visit.



Bicycle ambulance

New HIV Unit

On May 22, 2010, Bishop Thomas Msusa celebrated the Mass and blessing of the new HIV Unit which has a large meeting hall, two consultation rooms, two treatment rooms, a day care room, screening room and store.



New Unit for treatment of people living with HIV/AIDS.

Sister Cecily says: "It enables us to increase the number of clinics held. The large hall provides adequate waiting space for the patients and is also used for meetings and workshops".

It is hoped that in 2011 ART sites in the area – at Chingale, Chilipa, Nkasala, M'mambo – will be initiated. This will relieve patients of the need to travel for treatment and will relieve Chipini Health Centre of much of its patient burden. See also page 24.



Mile Four Hospital

St. Patrick's Hospital is commonly known as 'Mile Four' as it lies four miles outside the town of Abakaliki in Ebonyi State, Nigeria. The first health service that started at Mile Four back in 1946 was for the detection, eradication and treatment of Hansen's disease.

At that time it was estimated that there were over 50,000 people infected. Then, to cater for the pregnant wives of leprosy patients, a small maternity unit was built.

The demands for proper maternal and child care from women in the rural area and from the urban area in the nearby town led to the expansion of services and buildings.



Leprosy and TB Control

Since 1985, leprosy has been controlled by multiple drug therapy. During that time, up to the end of 2010, 9432 patients completed treatment. In 2010 there was no registered case of relapse, leaving the number of relapses in the programme since 1985 at ninety-seven.

The Leprosy Unit today has a total of 60 beds. Five Residential Villages with treatment centres are still in operation, though there were only 18 adults resident at the end of 2010, all of whom have been discharged but with deformity. A further 45 centres for treatment only are also covered. In 2010, the Leprosy Control team examined 21,036 people who were referred, or reported voluntarily, or through awareness raising campaigns or contact surveys.

The number infected was 152, which represents 1.11% of the population in the catchment area.



Health education at Mile Four



Of these, 20 were classified Paucibacillary and 132 Multibacillary. Among the latter, 17 suffered Grade 1 disability and 14 suffered Grade 2 disability.

During 2010, there were 765 new cases of TB. A treatment success rate of 90.13% was recorded, which is the best ever recorded in the history of the hospital. It is believed that the research being carried out at Mile Four in collaboration with WHO has contributed to this success rate.

Maternal Care

The hospital has 53 beds in the Maternity Unit, while the Children's Ward has 32 beds and the Nursery has 7 cots.

Antenatal clinics are held three times each week, comprising ante-natal care and information about HIV and AIDS. In this part of Nigeria, there is a long-held tradition of attending Prayer Houses during pregnancy. Women attending Mile Four Hospital expect something in this nature. Consequently, ante-natal clinics are not just queues of women waiting to see the doctor, but are animated affairs, with prayer, dance, health rallies and nutrition information.

Child welfare clinics are held twice weekly in the hospital and a comprehensive immunisation programme is followed. The mobile clinic outreach includes mother and child care, clinics being held bi-weekly in various out-stations.

While Mile Four Hospital is not a training school, it accepts student nurses and midwives for practical experience from Ebonyi State University Teaching Hospital and from the Schools of Midwifery at Umuahia, Abriba and Afikpo.

Medical Superintendent, Dr. Sylvester Egbuka is assisted by three Medical Officers, three Consultant Gynaecologists, and a part-time Consultant Paediatrician.

Sister Deirdre Twomey, Consultant Gynaecologist, says: "Many of the women we see come

from outlying villages where life is still very difficult. A pregnant woman's husband may be away from home a lot while trading, or travelling as a driver. There may be no easy means of transport from her dwelling to the main road. Hence the important of well-trained traditional birth attendants.

"Because women who come to the gynae clinics automatically bear the blame of infertility or sub-fertility, I insist that their husbands also come to the Clinic while we investigate the problem. In this way a woman comes to realise that she is not the only one contributing to a fertile marriage. Lifting that psychological burden is such a relief for them.

"Childless couples come to a weekly infertility clinic for consultation and counselling and care. We try to leave no stone unturned in their investigation. In addition, we endeavour to instil hope and confidence in all who come. Many succeed and return with joy bearing good news.

"In more recent years we have been insisting on every woman's right to know her HIV status. This has increased our workload greatly, as it involves pre-test and post-test counselling, 'talks before talks' and a lot of education. But it is essential for women to know, and they in turn are now insisting that their husbands also go for testing.

The Maternity Unit statistics for 2010 show total births at 2,943. This includes 103 sets of twins and 2 sets of triplets. Of the total deliveries, 2,345 were normal. Sadly, there were 9 maternal deaths, 4 of whom were mothers who had not been booked and came to Mile Four after interference.

The statistics show attendance at the Hospital Ante-natal clinic was 22,742 visits, with a further 1,663 at gynae clinics and 17,046 at the general out-patient clinics. There were 3,816 ante-natal visits at the Mobile Clinic. See also page 25.



Driver, Augustine Nwidembia and staff Nurse Monday Nwokoye with Team of Health Extension Workers setting off to Amuda for Mobile Clinic. They go out three times a week to different villages for mobile clinics.



*Dr. Sylvester Egbuka,
Medical Superintendent*



Kitovu Mobile

Since 2004, treatment with antiretroviral medicines (ARV) has brought a new face to AIDS. Infected people are now able to live in a healthy way, return to work, care for their children and provide for their education. They can also be 'agents of change' in their community by their positive attitude and thus become a strong force for the prevention of the spread of AIDS.

However, ARVs do not cure HIV and AIDS. The number of people still being infected is unacceptably high. Providing antiretroviral therapy (ART) creates a challenge to successfully treat all who need them.

'Kitovu Mobile' was started by MMM in 1987 and is now administered by the Diocese of Masaka. MMM sister-doctors, Brigid Corrigan and Carla Simmons supervise the ART and Palliative Care programmes respectively. The service adopts a holistic approach to addressing the needs of both the infected and affected people within

their communities, especially in 'hard to reach' areas in south-west Uganda.

The organization currently provides HIV care to 4565 people living with HIV, of whom 1156 (25.3%) clients are on ART. All clients are seen at the outreach centres in the villages by Home Based Care clinical teams. These are assisted by 85 Expert Clients and 750 Community Workers covering 111 centres. The Community Workers are responsible to 16 Field Coordinators. Over 150 patients are also receiving palliative care.

The key thematic areas of Kitovu Mobile are:

- Prevention
- Care and Support
- Capacity Building

These are implemented through three main programmes:

Home Based Care for people living with HIV or AIDS – this includes pre-ART instruction before clients are initiated on ART, monitoring of ART for clients on ARVs, and palliative care for terminally ill patients.



Community Health Workers arrange for clients in rural areas to gather at an agreed place for consultation.



Orphans and Family Support – this includes Mobile Farm Schools teaching sustainable modern organic agriculture for teenage school dropouts, support of orphans and vulnerable children and grandmothers, and self-help groups for women who are poor.

Expanding ART Programme

The partnership of 'Expert Clients' is an innovative and key component of the programme. 'Expert Clients' are people living with HIV who have been stabilized on ART, have been trained in the management of HIV and AIDS care and support, particularly in relation to the action of ARVs and their correct usage.

The role of the 'Expert Client' is:

- To identify clients in their locality who may benefit from ART
- To educate those being prepared for ART
- To monitor and assess adherence among clients taking ARVs in their homes
- To monitor the possible side effects of ART, especially in those recently initiated
- To visit clients' homes and refer them to a health facility if necessary and to report any problems to the ART programme staff and Home Based Care nurses
- To attend at the Home Based Care centres on the days the clinical staff are seeing clients and learn more about the care and support management at these visits
- To share their personal experience of taking ARVs with others living with HIV or AIDS
- To act as role models for others in their locality by their lifestyle and be ambassadors for prevention of the spread of HIV.

This model of rural management of ART is an important one, preventing the large queues which can develop in urban facilities where people spend hours waiting for their medication.

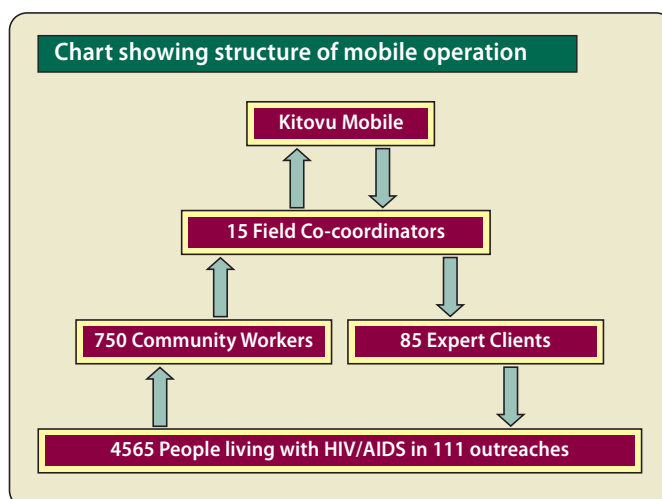
Logistic problems abound for those living in rural areas. When people living with HIV are poor and marginalized, they are in danger of not receiving ART if they have to rely on urban health facilities. Transport costs and lack of access to good treatment education are barriers to the expansion of ART programmes. The solution lies in having active community participation and meaningful involvement of clients living with HIV in the treatment programmes. These two strategies are proving vital in the success of the Kitovu Mobile ART programme.

ART is for life – it has to be started with careful precision regarding both the clinical and immunological criteria. Importantly, the psychological support given to PLHA starting on ART is proving very important to good adherence to treatment, and in changing the mind-set of people with a chronic illness – from dependency to a positive desire to return to work and become economically independent members of the community.

The coverage gap between those on ART and those who are eligible is still very wide, both locally and at a national level. To address this in the catchment area, Kitovu Mobile proposes to initiate training of a further 60 'Expert Clients' during the coming year.



Sister-doctor Brigid Corrigan and Sam Waliggo, leader of the ART Team, at rural clinic



Supporting Our Worldwide Mission



Fund-raising never stops!

The task of raising funds to support our overseas work never stops. This work, overseen by our Central Business Administration Department, is co-ordinated by Sisters based at our Communications Department in Dublin and our Mission Development Office in Chicago.

Our funds come from generous supporters some of whom have a long tradition of helping MMM, others are new donors whom we encounter along the way and who respond to our needs. We mail three Appeals each year to donors in Ireland, UK and mainland Europe. From our Chicago office, four Appeals are sent to donors in USA and Canada.

An important source of our funding is the access we are given, as Catholic missionaries, to speak at weekend Masses in parishes allocated to us by the Mission Office in a number of Dioceses in USA as well as in Ireland, England

and Scotland. The organization of this effort is an immense task. All available Sisters are drafted in to help as soon as the churches available to us are known. In USA this usually means that in teams of two, Sisters cover huge distances, appealing to church goers in places as far apart as California and New Hampshire, Minnesota and Louisiana. This work usually begins in May and continues to the end of September. In England and Scotland it is usually possible to return to base after each weekend and tackle the 'thank you' paperwork and the arrangements still to be completed.

We are also blessed to have the support of several donor groups, some of whom have a long tradition of partnership with one or other of our overseas missions. These are people who run small events regularly, or simply collect donations from their friends and send us the proceeds. Several parishes in England choose MMM among their partners for the Lenten Fast.

The Mission Appeal Trail in USA





Groups of professional friends – or sometimes students – also get together to raise funds for us and we are always delighted to hear from them and supply them with posters and other materials they can use to promote our needs. Another source of funding comes from our appeals to small donor groups. In 2010 we had projects supported by more than 100 groups whose support is greatly valued.

Then there are the larger groups and foundations – like Trócaire, Missio, Misereror, Raoul

Follereau – all of whom have been long-term supporters of the work of MMM. In Ireland, Misean Cara disburses money from the Irish Government's Overseas Aid Budget. In 2010 MMM submitted many projects for funding, resulting in substantial grants being made.

MMM is always happy to receive legacies, and during the past year, we have been blessed by many people who have remembered us in their Will.



Dr. Sharon Bennett and her friends Anne Higham and Carol Shread walked across England from Coast to Coast to raise funds for our new Maternal Care Outpost at Cyahafi in Rwanda.



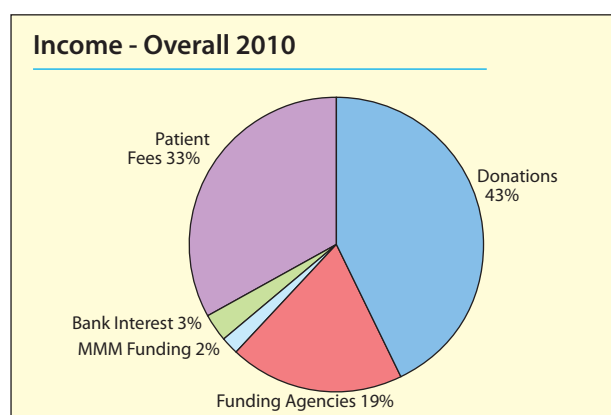
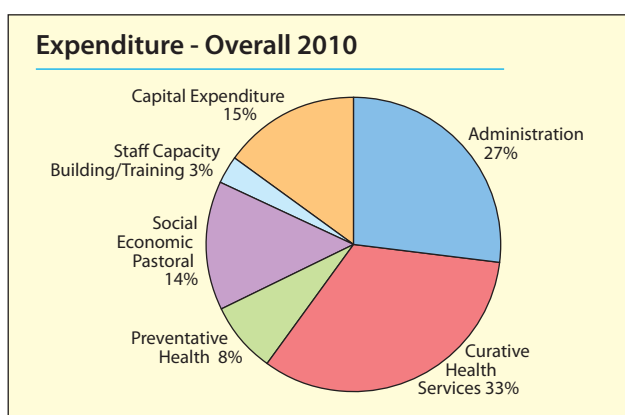
Students at York University carol singing to support our Faraja Project in Tanzania.



Illustration of Income and Expenditure

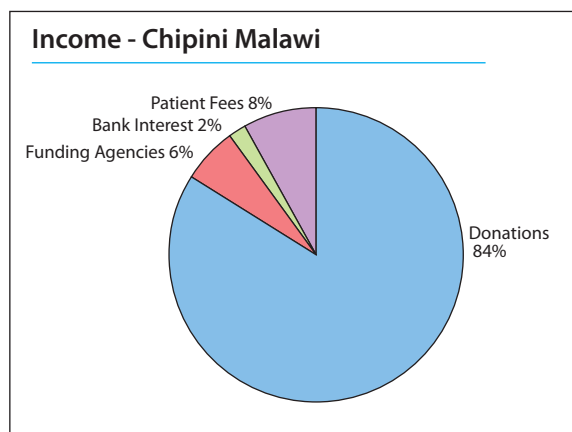
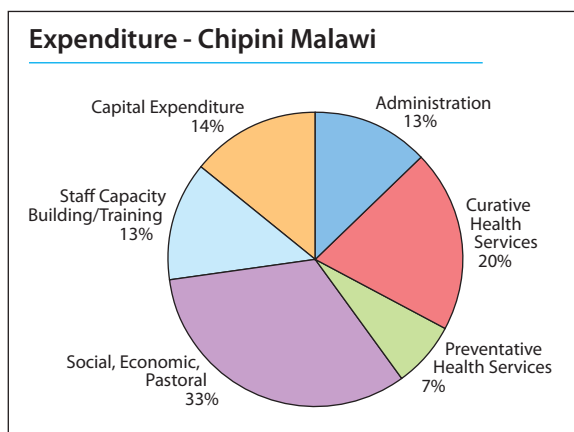
The first pie chart is a description of the total amount of Income and Expenditure used by MMM for the works of the Congregation during 2010. Included in the income are donations. We are deeply grateful to our donors who support our work and mission. We are also grateful to all those who collaborate with us and in a special way to the governments of the various countries whose contribution, classified here under donations, is invaluable to the running of our different works.

Building the capacity of our MMM Sisters and Staff is very important to us. You will see a great variation in the pie charts regarding the amount spent on this – due to the fact that services of capacity building are sometimes borne by other entities including our Congregation.



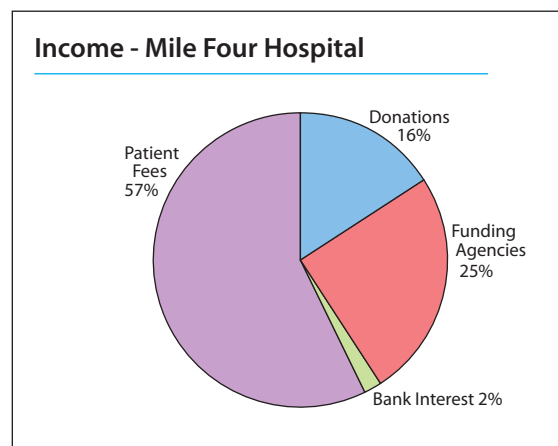
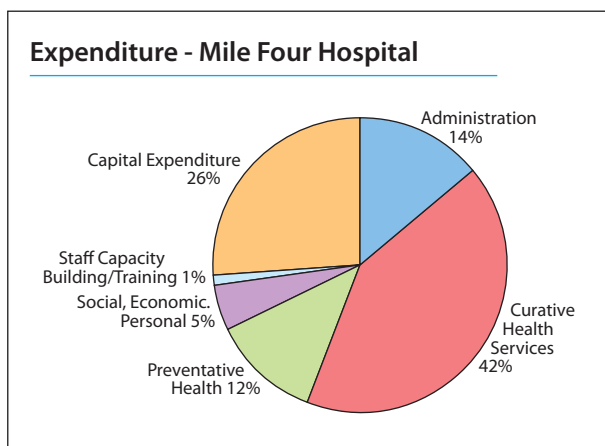
There are also pie charts which show the income and expenditure of three different works, a hospital, a bedded Health Centre and Primary Health Care Programme. You will find these charts quite different one from the other.

Chipini in Malawi is a bedded Health Centre with a large community home based care programme in a very deprived area thus a large part of their work is in Social Services. As you can see from the pie chart, they depend very much on donations as the people they serve are not able to pay very much in fees.

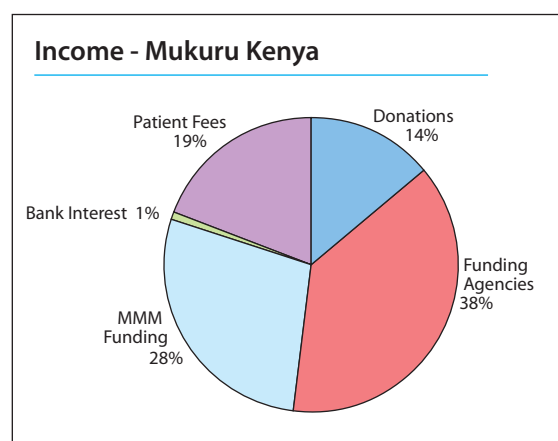
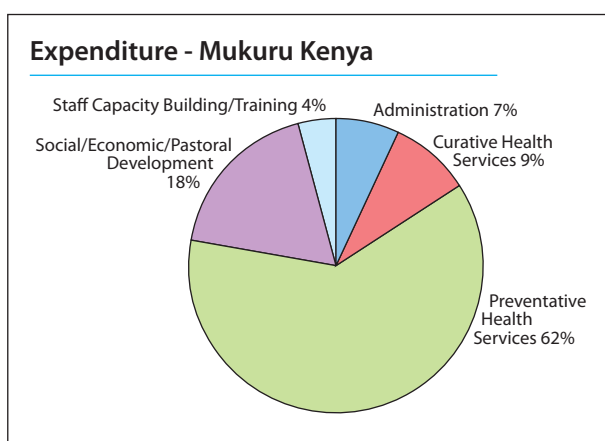




As a hospital, Mile Four's main service is curative as reflected in the pie chart. In this case, most of the patients are able to pay a fee for the services and this is reflected in the income. At the same time, provision is made for those who cannot pay their full fees and for this reason, the donations are very important. Funding Agencies have made possible capital expenditure including necessary renovations and expansion as well as the provision of solar energy.



While in Mukuru our main service is a Primary Health Care Programme which emphasizes prevention. As Mukuru is located in a huge slum in Nairobi, in that large population the greatest need is prevention. This is reflected in their pie chart. Mukuru has a good balance of donations, patients fees, funds from funding agencies, and was also given some funding from the Congregational Mission fund in 2010.





Sister Deirdre Twomey

Among the many events that took place in Nigeria as part of the celebration of 50 years of independence, Sister Deirdre Twomey was among four women who were honoured for their role in advancing women's development.



Sister Deirdre is an obstetrician who has worked in Nigeria since she was a young doctor. Some years ago a group of doctors at Ebonyi State Teaching Hospital, led by the then Chief Medical Director, Dr. C. O. O. Chukwu, (now Federal Minister of Health) began to plan an Endowment Award Foundation in her honour – to be known as the Twomey Awards, presented annually.

In November 2010, the first Award Ceremony took place - to the resident doctor with the best results in postgraduate fellowship exams, the midwife with the best results in the National Midwifery exams, and the medical student with the best result in Obstetrics and Gynaecology exams.

It was a memorable occasion attended by many dignitaries pictured above with Sister Deirdre. They include Mrs. Josephine Elechi, wife of the Governor of Ebonyi State. Elder Prof. Chigozie Ogbu, Deputy Governor of Ebonyi State and his wife, Prof. C.O.O Chukwu, now Minister of Health, Iyom Josephine Anenih, Minister of Women's Affairs and Social Development. The internationally renowned Professor F. Okonofua, spoke on the topic of "Reducing Maternal Mortality in Nigeria".

Sister Deirdre says: "Many of the women we see come from outlying villages where life is still very difficult. A pregnant woman's husband may be away from home a lot while trading, or travelling as a driver. There may be no easy means of transport from her dwelling to the main road. Hence the important of well-trained traditional birth attendants."



Sister Ekaete Ekop received the Professor Eugene Okpere Award of Excellence for Best Resident Doctor of the Year. This was no small achievement, given that there are more than 300 resident doctors at the University of Benin Teaching Hospital alone!

The Professor of Obstetrics and Gynaecology spoke of her dedication to patients - 'the best we've had in 35 years since the department was started.'

Sister Ekaete who has since graduated as a Consultant Obstetrician and Gynaecologist says the residency was the toughest thing she has done in life but it was very rewarding.

"Obstetrics is about decision making – there are no templates. Each woman is unique and sometimes the difference between life and death of the mother and/or fetus is a split second decision. This is a dynamic profession and there is no place for dawdling or laziness. There is nothing more rewarding than the birth of new life to a living mother. I am happy that my passion harmonises with the MMM dream of enhancing the lives of mother and child.

What keeps me going from one difficult day to another is the hope that the training I'm getting will make a difference in the life of women... It is my fervent hope that rural African women will come to see Safe Motherhood and good health as a right and not as the rare undeserved privilege many of them perceive it to be."



Sister Francisca Mwadike received her Higher Diploma in Community Health and was awarded the overall Trophy for Best Student in Child Health and Primary Care and three other Awards – for Best Student in Community Health, Nutrition and Reproductive Health. During her studies, Sister Francisca was part of our community at Amukoko, in the parish of St. Thérèse, where MMM established a Health Centre back in 1985. She carried out research in Amukoko among 100 families affected by HIV, and 150 people living with the infection. She examined the problem of stigma and the effects it has on people living with HIV and AIDS, and the hindrance this causes to the provision of care and treatment.



People living with HIV or AIDS claimed that their major stigma and discrimination was in the family, including ridicule, separation of dishes and cutlery, contact avoidance and isolation. They also experienced discrimination in hospitals; elsewhere some were subjected to violent assault and some received eviction notices from landlords. On the other hand, responses from families painted a very different picture - revealing a huge gap in perception between people who do not suffer from the disease and those who do. Her dissertation and research findings are available on our website.

Sister Magdalene Umoren obtained her Master's in Obstetrics & Gynaecology. In Uganda, at Makerere University's Mulago Teaching Hospital she researched the risk of an infected mother transmitting HIV to her baby. This risk ranges from less than 2% in the United Kingdom and North America to 45% in sub-Saharan Africa. The general objective of her research was to determine the risk of vertical transmission of HIV among infected mothers whose pregnancies were complicated by pre-labour rupture of membranes, which is one of the risk factors for women with HIV. Antiretroviral drugs given to HIV infected pregnant mothers have been shown to reduce the risk of vertical transmission. Her dissertation is available on our website.



As young women, Ekaete and Magdalen studied in the same class at the University of Calabar Medical School. Later they met again in the MMM Novitiate! After religious profession, their paths parted as Ekaete pioneered a new mission in the Republic of Benin and Magdalene headed to Tanzania where she served for several years before post-graduate studies.

An MMM Sister whose dissertation was awarded a first-class honours M.A. in Theology at the Theological Institute of São Paulo linked to the University of Santo Anselmo in December 2010. The city of Salvador, where she is missioned, sees up to 1,000 violent deaths among young people each year. She refers to mothers whose sons and daughters were murdered as 'orphaned mothers'. The violent death of those children and its consequences in the life of the mother, the family and the society were the kernel of her inquiry.

Police abuse, drug trafficking, the lack of family structure and a precarious justice system underlie the problem. She suggests initiatives in the accompaniment of the women who suffered the loss of their sons and daughters as well as enabling them to cope with violence and confront it.

Emphasis is given to the role of memory in the processing of bereavement. It is hoped this will lead to the elaboration of a theology of reconciliation and hope, the appropriate context for the missionary effort to build the Reign of God. She draws on the writings of theologians Johann Baptist Metz, Jon Sobrino and Jürgen Moltmann, and social scientists Rosa Maria Moreno Rodriguez, Walter Truett Anderson, Maria Antonieta Pisano Motta and Luzia Fátima Baierl. Her thesis, written in Portuguese, is available on our website.



Sister Margaret Hogan has been lecturing in the Department of Clinical Psychology at the University of Dar es Salaam for many years. But her work takes her travelling to many venues in East Africa lecturing on psychotrauma, cognitive behavioural therapy and related subjects.

After much effort, 2010 brought approval to begin a Master's Programme in Clinical Psychology, the first in Tanzania which has kept her busy preparing the curriculum, with a group from San Francisco doing curriculum review.

The year 2010 also saw publication in *The Journal of Child Sexual Abuse* of the first of two papers for which she has been supervising the research.

The specific aims of the study were to describe the roles of various key players handling Child Sexual Abuse (CSA) cases, to explore the factors that facilitate or hinder just/fair handling of CSA cases and to discuss possible changes for improving the legal system's handling of CSA cases.

This was a qualitative study using interviews with key informants to capture their experiences of managing sexual offences involving children. It looked at laws pertaining to sexual offences involving children, reporting a sexual offence and the role of NGOs in legal matters.

Five themes and 20 categories corresponding to specific research questions were derived from the analysis of interviews carried out. It is evident from this study that a huge deal of work remains to be done in order to safeguard children.

This research will be of great interest to anyone involved in the area of child protection in sub-Saharan Africa. The study is available to those working or studying in this field*.

Business Studies



Sister Maria Gonzaga Namuyomba, who comes from Uganda, spent many years as a missionary in Kenya, Malawi and Nigeria, involved in her profession of business administration. She travelled to Ireland to study accountancy at the Dundalk Institute of Technology. She was one of eight final year students to be awarded a certificate of special merit from the Institute of Certified Public Accountants for outstanding performance in their research assignments. Maria was also named 'Best Speaker' in the Institute's series of debates. She is now missioned to Honduras.



Sister Saratu Benjamin graduated from the University of Benin with a B.Sc. in Accountancy. She is now missioned to Tanzania.



Sister Cecilia Nchekwube graduated in November 2010 at the Federal Polytechnic Idah in Kogi State, Nigeria with a Higher National Diploma in Business Administration and Management. She is now missioned to Malawi.

* See Kisanga, Felix, Mbawambo, Jessie, Hogan, Norah, Nystrom, Lennarth, Emmelin, Maria and Lindmark, Gunilla (2010) 'Perceptions of Child Sexual Abuse – A Qualitative Interview Study with Representatives of the Socio-Legal System in Urban Tanzania', *Journal of Child Sexual Abuse*, 19: 3, 290–309.



MMM Protection Policy

Medical Missionaries of Mary

Child and Vulnerable Adult Protection Policy

Policy Statement

As Medical Missionaries of Mary, we commit ourselves to the fulfillment of Christ's healing mission: that the world may have life and have it in all its fullness. Abuse of children and vulnerable adults in all its forms, physical, sexual, psychological or emotional, or neglect, is unacceptable to MMM. We recognise our responsibility to protect from harm all people in our ministries so as to prevent present or future abuse.

Everyone, particularly children and vulnerable adults, has a fundamental right to be respected, nourished, cared for and protected. This right is embedded in:

- Gospel values.
- International law.
- Laws of individual countries.
- Canon Law.
- MMM Constitutions.

The MMM Congregational response regarding protection of children and vulnerable adults is embodied in this document and is binding on all MMMs wherever we work. The policy is developed within the broader context of MMM Ethics and Professional Standards and our deeply held beliefs and values. The attitudes and values enshrined in our MMM Constitutions are at the heart of our relationship with those to whom we minister, and those with whom we work.



This key message forms the basis of our policy which will be continually updated to reflect current best practice. It outlines ways to recognize, report, and respond positively to concerns of all forms of abuse. It also outlines ways to promote good conduct. It is a means of putting our beliefs into practice. In Ireland the policy adheres to the Standards and Guidance Document of the National Board for Safeguarding Children in the Catholic Church (NBSCCC)¹.

MMMs as religious women 'are missionaries sent out to be among people of different cultures, religions and ideologies, to be with those who suffer, the oppressed, and those on the margin of life. They create in their hearts a space for others to be so that, unafraid, they may experience themselves as loved and so be healed.' (cf. Const. 9.6 and 7.3).

¹ National Board for Safeguarding Children, Standards and Guidance Document for the Catholic Church in Ireland, September 2008.



Guiding Principles

The MMM Child and Vulnerable Adult Protection Policy will be fulfilled through the following guiding principles:

● Gospel Values

Through the Paschal Mystery Jesus witnessed to the coming of the Reign of God and set a standard for our interactions with each other. While everyone is invited to enter the Kingdom, Jesus particularly invites the poor, the marginalized and the 'little ones'. By our deeds we imitate Jesus in respecting the gift of life, nurturing and protecting the integrity of the human family and thus proclaiming God's reign.

● International Law

The Universal Declaration of Human Rights² proclaims that 'childhood is entitled to special care and assistance'. The United Nations Convention³ states that 'in all actions concerning children...the best interests of the child shall be of primary consideration' and the child has a right to be protected from all forms of exploitation and abuse. Furthermore, Human Rights Law recognises that all people, including the elderly, have certain fundamental rights, as well as the right not to be discriminated against. However, as yet, there is no mandated international agency to address the protection needs of older people.

● Laws of individual countries

In countries other than Ireland, MMM policy on protection of children and vulnerable adults will be in line with the appropriate National and/or Church guidelines, where available. Where such a policy is unavailable or inadequate MMM will raise awareness on the need for such a policy.

● Canon Law on sexual abuse by clergy

Canon law has always considered the sexual abuse of a minor to be a grave crime and grievous sin. Canon 1395 of the 1983 *Codex Iuris Canonici* (the "1983 Code") establishes that sexual contact with a minor qualifies as one of four classifications of sexual offenses for which a man may be permanently removed from the clerical state. Provisions of canon law also envision penalties for ecclesiastical authorities who fail to apply canon law. Canon 1389 of the 1983 Code provides for a penalty, including deprivation of ecclesiastical office, for an official who abuses ecclesiastical power or who omits—through culpable negligence—to perform an act of ecclesiastical governance. A bishop who fails to employ the appropriate provisions of canon law in a case of sexual abuse of a minor is liable to penal sanctions imposed by the Holy See.⁴

In summary MMM embraces the duty to be aware of, and abide by, all the positive norms enshrined in the Civil Law of the country, the Protection Policies of the Church and Conferences of Religious wherever we are located.

● MMM Constitutions

Recognizing the inherent dignity of each person MMM makes it mandatory upon all members to familiarize themselves with this MMM Children and Vulnerable Adults Protection Policy.

Treat each person with the reverence due a child of God.

Honor the uniqueness of all, irrespective of race, religion, gender, sexual orientation, age or political persuasion.

Recognize the pre-eminence of justice in all our relationships.

(cf. MMM Constitutions 9.6 and 9.10).

² On 10 December 1948 the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights

³ United Nations Convention on the Rights of the Child (UNCRC)

⁴ Fr. John. C. Coughlin is professor on Law and of Theology, Notre Dame University.



Procedures

Adopting a compassionate and pastoral approach to safeguarding children and vulnerable adults, MMM is committed to:

- Put in place, implement and regularly monitor the procedures related to
 - recruitment of staff and volunteers;
 - staff orientation, training.
- Ensure that
 - behaviour of all staff and volunteers is in line with the MMM Ethical and Profesional Guidelines and in Ireland with the guidelines contained in "Safeguarding Children, Standards and Guidance for the Catholic Church";
 - any allegation of abuse is promptly dealt with, and referred on to the civil authorities;
 - victims are supported;
 - perpetrators are held to account;
 - that visitors to programmes and institutions are made aware of the MMM Child and Vulnerable Adult Protection Policy;
 - the MMM Child and Vulnerable Adult Protection Policy is posted in a public place in all our places of work. The names and telephone numbers for contacting the Designated Person/Deputy Designated Person will also be displayed.



Confidentiality

- Confidentiality is of paramount importance in our relationships with those under our care, unless the duty of confidentiality conflicts with an equal or higher duty.
- Safeguarding children, however takes precedence over an adult's right to confidentiality. Once information about child abuse has been reported it must be passed on to the civil authorities.
- A person disclosing information on alleged abuse must be made aware that what is revealed is done so to protect the victim from further abuse.
- Disclosure is only made to those who need to be informed. Only what is essential to avoid harm will be communicated.
- Confidentiality should never be used as an excuse for not reporting to those who should be informed.



Role of Designated Person

The designated person will be appointed by the Area Leader to initiate the processes involved in managing allegations of abuse.

- The Designated Person or in her absence the Deputy Designated Person will
 - take responsibility to follow the procedures as appropriate to the case as explained below;
 - report to and ensure that the necessary Statutory bodies, Canonical authorities and the Congregational Leadership Team are informed about each formal complaint of abuse received;
 - in Ireland, initiate consultation with the National Board for Safeguarding Children and follow their guidelines. Elsewhere, call on appropriate professionals to provide assistance;
 - ensure that all allegations or rumours are dealt with in an immediate, compassionate, confidential and responsible manner.

The Area Leader must ensure:

- that there will be no attempt to redeploy a person against whom an allegation has been made to another area of ministry with access to children or vulnerable adults during the period of investigation. Support should be shown to him/her;
- that the accused will be advised of the legal implications and ramifications attendant to the report of the alleged abuse;
- that there is full cooperation with any public authorities that may be investigating the matter, and that there will be no interference with any investigations. Where necessary ensure cross-country border notification;
- that where a complaint concerns a deceased MMM or a former MMM during her time of MMM membership, an appropriate pastoral response to complainants will be provided;
- monitoring, safeguarding, awareness raising and training.



Allegations

- A staff member or sister who receives an allegation will carefully listen, and record the complaint. He/she checks that the written record accurately states what was reported and immediately brings this matter to the attention of the mandated MMM Designated Person, who has responsibility to inform the Area Leader.
- The Area Leader must ensure that the greatest possible care is taken to prevent the potential victim from further risk.
- The Area Leader or designated person will consult and seek guidance as required.
- If an allegation is made against a member of staff employed by MMM, MMM will not be responsible for financing any legal advice obtained by the employee.
- The Area Leader will ensure that a pastoral response to the alleged victim and his/her family will be offered, treating them with respect, openness and compassion. They will be assured of a prompt response and informed of the procedures that will be taken in the investigation.
- The Area Leader will ensure that a support person is appointed for the victim and an advisor for the respondent, who is informed of her legal rights.
- When the accused person is an MMM the Congregation's response will be explained to the sister.



Area Policy

The Congregational policy and guiding principles as outlined above apply to all MMMs. These procedures are adaptable for each ministry and will serve as a framework for ministry policies in each Area. We encourage Area Leaders to ensure that all MMM institutions/ ministries have a written policy dealing with abuse and neglect and that it is publicly displayed.

It is important to note that in cases where MMM is administering a Diocesan Institution that MMM enquires whether the Diocese also has a written protection policy. Should the Diocese not have a policy all staff and volunteers will indicate in writing their acceptance of the MMM Child and Vulnerable Adult policy.

Prevention

MMM will apply a scrupulous screening process for future members and be especially attentive during the formation period to psycho-social, moral and professional development. This process will be implemented by professional consultation and input and will include recruitment, selection and management for MMM personnel, staff and volunteers.

The Congregation will continue to provide for the education of members regarding sexual or other misconduct. Members are encouraged to learn about causes, symptoms, and prevention and occasions that could promote abusive behaviour, as well as relevant legislation, required reporting procedures, and responsibilities of employers.



In keeping with best practice, this Congregational policy is regularly revised and updated for use in the various regions of the world where MMMs are located.



APPENDIX

Definitions

A child for the purpose of this Protection Policy is any human being under the age of 18 years.

A vulnerable adult is a person of 18 years or older who because of impairment in mental or physical function or emotional status, or because of a status or power differential, is unable to report abuse, neglect or exploitation without assistance. Such persons include but are not limited to: refugees, internally displaced persons (IDPs), persons with disabilities, war victims, prisoners, trafficked persons, frail, isolated and other non-independent or institutionalised adults.

Abuse may be physical, sexual, psychological or emotional in nature, or may occur through neglect. It may form a continuum which ranges from minor breaches of policy or rules to indecent assault. It may consist of a single act or a catalogue of incidences.

Physical Abuse is any form of non-accidental injury which results from a willful or neglectful failure to protect.

Sexual Abuse occurs when a child is used by another person for his or her gratification or sexual arousal, or for that of others. Any form of sexual behaviour engaged in by an adult with a child or young person is sexual abuse, and is both immoral and criminal. There may also be 'indirect abuse' of children, for instance, where children have been photographed, videotaped or filmed for Pornographic purposes. Indirect abuse also includes the subjecting of children to gross and obscene language or indecent images.

Emotional/Psychological Abuse occurs when the need of a child for affection, approval and consistency are not met causing severe and persistent adverse effects on the child's emotional/ psychological development. Emotional abuse is normally found in the relationship between a care-giver and a child rather than in a specific event or pattern of events.

Neglect is an omission, where a person suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, medical care, intellectual stimulation, supervision and safety, attachment to and affection from adults. Neglect generally becomes apparent in different ways over a period of time rather than at one specific point. It is the persistent failure to meet a child's physical, emotional and/or psychological needs that is likely to result in significant harm.

Bullying is repeated aggression be it verbal, psychological or physical, conducted by an individual or group against others.

(Our Children, Our Church, Child Protection Policies and Procedures for the Catholic Church in Ireland)⁵

⁵ From – The Irish Bishops' Conference, Conference of Religious of Ireland, The Irish Missionary Union



Mother Mary Martin, foundress of Medical Missionaries of Mary



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