



IAFN

June 2017



Promoting Health in Families

Good news stories from around the Anglican Communion

International Anglican Family Network

celebrating the God-given potential of the family as a source of thriving relationships, identity, belonging, discipleship and reconciliation

Promoting Health in Families

Anglicans around the world, often in partnership with others, are working among families and in their communities to increase health and wellbeing as part of the Church’s holistic ministry.

The stories in this newsletter show how working for health and wholeness is shaped by local circumstances and contexts. Healthcare and outreach may mean HIV prevention or accessible care for those who are HIV affected. It may mean providing clinics and maternal health services and advice, counselling after trauma, assisting substance abusers to overcome their addiction, or drawing alongside those who are lonely or depressed.

The Church of England’s Bishop of Crediton, the Rt Revd Dame Sarah Mullally, is a former nurse. She had a distinguished career in her country’s National Health Service before ordination, culminating in her appointment as the government’s Chief Nursing Officer for England in 1999. In her Editorial, Bishop Mullally reflects on the complex issues of mental health and describes some of the ways in which churches are extending their pastoral and healing ministry to those affected.

Editorial: Life in all its fullness – spiritual, physical and mental wellbeing

By the Bishop of Crediton, Diocese of Exeter, Church of England, the Rt Revd Dame Sarah Mullally

In bringing us life in all its fullness (John10.10) Jesus’ actions demonstrate that wholeness is not just about the spiritual and physical but is also about our mental wholeness.

In the UK, mental illness affects more people every year than cancer or heart disease. One in four of us in this country will be affected by a mental health problem in any given year. Severe mental illness can affect anyone, although it often emerges during adolescence or in the early 20s.

Living with a mental health condition can affect many aspects of daily life, from physical health to home, work, managing money and our relationship with God. The impact of poor mental health can be reduced if there is early intervention and support. But it is still the case that you are more likely to receive the urgent support you need if you have broken your leg, than if you are experiencing a crisis because of a mental health problem. As a society we are also less likely to talk about our mental health than our physical health.

Families today may face complex challenges and dilemmas including poor health, poor housing conditions, low income, fuel poverty and stress. Increasingly families will encounter members with dementia and memory loss, especially with older people and for us in rural communities like Devon, where I minister, loneliness provides particular types of challenges. Young people face pressure from anxiety and forms of addiction. There are over seven million carers in the UK and often their mental well-being is overlooked and a lack of respite care makes this a key issue.

Families can offer solutions to poor mental health but they can also be part of the problem! In the UK there are specialist networks for siblings, parents and children affected by mental health challenges.

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International Anglican Family Network (IAFN)

IAFN networks across the Anglican Communion to celebrate the God-given potential of the family as a source of thriving relationships, identity, belonging, discipleship and reconciliation. Out of this celebration IAFN is an advocate for the family in the face of behaviours which diminish this potential, sharing stories of hope, promoting family care and sustaining the family as the cradle for human dignity.

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Churches are increasingly recognising how they can act as gentle therapeutic communities, safe spaces and places of belonging, valuing people at times of vulnerability whether that is short-term, chronic or lifelong.

Spirituality is deeply relevant to mental health: it shares much of the same territory, but seeks a holistic approach to life and recognises in some form an 'extra' dimension of transcendence or depth. While spirituality may be associated with religion, it is not confined to it.

We know that faith contributes to mental wellbeing including by offering people connections into a community. Churches and Christian groups provide a place of belonging and opportunities for meeting, sharing and caring across generations. Churches are increasingly providing cafés for people with dementia and enduring mental illness to meet and talk and support each other, as well as places to talk about bereavement and death. They are also working in partnership with organisations such as Age UK to provide community links to reduce loneliness.

We are good at praying for people who are ill but we need to be more engaged in challenging unhealthy lifestyles too. Churches are beginning to work with others to encourage better diet, more exercise and activity, as well as providing community meals and opening up church land to grow food.

Churches also have a role to play in encouraging people to talk about mental health. Many in the Diocese of Exeter joined in 'The Depressed Cake' initiative last year,* offering tea and cake and an opportunity to talk about mental health – bringing out in the open an area which benefits from being in the light rather than the darkness we create for it.

* See <http://depressedcakeshop.com> for more information about the Depressed Cake Shop initiative.

Celebrating every child: healthy timing and spacing of pregnancy

The Revd Gabriel Anyiko Owino is an Anglican priest in Siaya County, Kenya. He has combined a faith approach with family planning information and has been encouraging couples to think about safe spacing of pregnancies so that every birth can be a healthy event for mother and baby, and every child is celebrated. Here, he writes about his experience.

Charles received teaching about Healthy Timing and Spacing of Pregnancy (HTSP) and family planning at their church from the Congregation Hope Action Team (CHAT) members of St Mary's Ong'iende. He embraced the teaching and decided together with his wife that they will start to use one of the methods of family planning because they had many children (six) and he was not seeing himself capable of caring for them.

He said that he realized that a gap or spacing between his children will give him good chance to care for and educate them; he will have time to do his duties, and his wife will be strong and able to do her work or normal duties which she used not to do before. Charles says that in the local indigenous religion it is difficult for leaders to embrace such

teaching but as a leader and elder in the village he would speak to his seniors so that he could invite the pastors to train them and give the HTSP information.

Prior to 2014 in Siaya sub-county, Kenya, there were numerous reported cases of maternal and child deaths resulting from preventable health-related problems. Then World Vision Kenya Karemo Area Development Program mobilized pastors within Siaya sub-county and took us to Kisumu for training on Maternal and Newborn Child Health.

During the workshop we were able to get facts on conception, pregnancy, birth, new mother and new baby. At every stage we discussed myths and misconceptions and demystified them. We learnt what can go wrong and how to prevent problems. Finally, looking at the Scriptures, we were convinced that as faith leaders, individually and collectively, we had a role to play in transforming the lives of our people.

We made a work plan to take back to our churches:

- mobilize six Christians per congregation to form a Congregation Hope Action Team (CHAT) and identifying community health volunteers, youth leaders, men's leaders, Mothers' Union leaders, Sunday school teachers and opinion leaders;
- share with the members of our churches a sermon on the importance of stewardship of those whom God has placed in our care (1 Timothy 5.8 "but if anyone does not provide for his relatives, and especially for members of his household, he has denied the faith and is worse than unbeliever"), and create an enabling environment where children are given opportunity to grow like Jesus who experienced holistic growth in the hands of loving and caring parents (Luke 2.52 "and Jesus increased in wisdom and in stature and in favour with God and man");
- include in the premarital guidance and counselling curriculum issues of Healthy Timing and Spacing of Pregnancy (HTSP) which helps couples time their pregnancies to occur during a mother's healthiest years



Change was achieved by involving faith leaders

(age 18-34) and space pregnancies by three to five years, improving both maternal and child health;

- speak boldly on family planning methods and let people choose a method that is convenient for them in terms of health and faith;
- reach out to other pastors who have not gone through the training so that they join us.

CHAT teams went to churches and community groups as well as 'one on one' and also made referrals to the health facilities. We taught about birth plans. Pregnancy gives notice of nine months, thus it is not an emergency. Parents can know the expected due date of giving birth, know the health facility one wishes to deliver at in order to be attended by a skilled professional, and save money to pay for transport to the health facility or buy some essential items not provided for in the health facility.

We encouraged mothers to go to the antenatal clinic immediately they realize they have conceived and make at least four visits as this enhances healthy pregnancy and safe delivery. The people were informed about the importance of exclusive breastfeeding of the newborn as this immunizes the child, helps in the development of the brain, offers nutritional value, and is safe and readily available.

Change was realized as a result of the active participation of faith leaders in partnership with World Vision and the Ministry of Health.

Rose was giving birth every year. The spacing of her seven children was one per year or less. She had no time even to do her work as a woman and wife. She was always with child and her health was weak. CHAT members talked to her and she realized that she was in great danger and vulnerable to death if she would not take any action.

She embraced the teaching, saying that "If at all I could have known this before, I could have not had such many children". Looking at the children one could see how they follow each other so closely to the extent that one would think that they are twins.

Rosaline already has four children. A CHAT member took the initiative and accompanied her to the antenatal clinic. She was attended to and from then went to clinic without fail till her time of delivery. She was taught about exclusive breast feeding, which she embraced. Rosaline is strong, not sick as she has been with previous pregnancies. She is now using a method to protect her from conceiving again soon.

Emily has had four miscarriages after the birth of her first child. A CHAT member advised her to wait till six months are over before attempting another pregnancy because the womb was still weak. Emily embraced the teachings and uses a birth control method. Her husband is supportive.

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A calling within a calling: parish priest and nurse midwife

The Revd Fr Edwardimba describes how his two-fold ministry has been warmly accepted in a Zambian parish.

Mawanda Anglican Parish where I am the parish priest is situated 36km north of Petauke in the Eastern province of Zambia. The parish has 15 congregations which I try to visit as regularly as possible. I am also in charge of the adjacent parish of Mpanbongwe with ten congregations and an Evangelist living in their parish house.

I was ordained priest on 11 August 2013 and I have worked in the area for five years now. I am married to Esther Musondaimba and have a son John Mphatso.

I am a non stipendiary priest since I am also a male nurse and I have just qualified as a nurse midwife working in the local clinic next to the parish house where I live. I consider this to be a blessing to myself, to my family, and the Church to be both priest and nurse midwife - having a calling within a calling.

Mawanda Anglican Parish, with support from the Diocese of Eastern Zambia and the Zambia Anglican Council, is involved in health delivery to the families of Mawanda in the areas of:

a) Malaria Control programmes: The Church is working hand in hand with the clinic, focusing on prevention and treatment programmes through training Malaria Control Agents. Their responsibility is to sensitize the community on how to prevent malaria and the need to seek medical treatment early.

b) HIV/AIDS: HIV/AIDS is one of the challenges in our parish affecting families within our church membership and the community at large. We have opened our church building to the community for Anti-Retro Viral Treatment as there is no space in the clinic to cater for the clients, and to help fight stigma and discrimination. We show them Christ's love towards the sick, a challenge that affects us all. We have a



Fr Edwardimba at work

Church social group of men and women called Tilibike ('let us be strong') who have been active in running past HIV/AIDS support programmes. Mawanda parish has also some social groups concerned with gender and development and gender and governance.

In 2013, Petauke District AIDS Task Force awarded the Anglican Church in Mawanda a Certificate of Excellence for the best Gender, Human Rights, and HIV/AIDS programme at grass root level.

c) Maternal and Child Health: As a church, we have encouraged our members to take up voluntary work at the clinic to monitor closely children under five years, and also help mothers with safe delivery. This reduces the maternal and neonatal (infant) death rate.

d) Priest experience in health delivery: When I was first deployed in my parish, I thought that my parishioners would be uncomfortable to be screened and examined by me. After a few months I found the opposite to be true. Pregnant mothers preferred and demanded that I conduct delivery of their expected babies. Since 2012 I am actively involved in Maternal and Child Health (MCH) services like antenatal, postnatal, deliveries, child growth monitoring and immunization. As a result of this, the District Nursing Officer/MCH Co-coordinator recommended me for midwifery training during the annual appraisal for the year ending 2014. I had a heart to serve the community which has a high rate of neonatal and maternal deaths.

Now that I am a nurse midwife, it's time for more hard work, especially as on 21 December 2016, I was appointed as Mawanda Rural Health Centre In-charge. As I witness peoples' challenges, my desire to further my education in midwifery grows, and as I source support, I will pursue it.

I have also enjoyed counselling HIV positive clients and those with chronic illnesses and dying patients. I have found it easy to help clients with both medical and spiritual advice.

Finally, I thank my bishop, Rt Revd William Mchombo, for allowing me to work in Mawanda parish both as a priest and as a nurse in charge of a clinic with far ranging health activities. I also thank my family and others who have supported me in my work.

Editor's note: Since receiving this article, we have heard that Fr Edward Zimba has become Dean of St Luke's Cathedral and Archdeacon for Central Archdeaconry in the Diocese of Eastern Zambia. Our prayers are with him as he begins his new ministry.

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Religious leaders and HIV Testing

Fewer than 50 per cent of people living with HIV know their HIV status. Church leaders can be tested publicly, leading by example. Read about the World Council of Churches' #KnowYourStatus campaign at <http://bit.ly/2s44dbz>.

When a parish nurse joins the ministry team...

Parish nursing, sometimes known as faith community nursing, is operational in over 30 countries around the world. In each place the training and support are adapted for that country's context but the basic principles and the core training remain the same. Here, the Revd Dr Helen Wordsworth, a nurse educator, ordained minister and founder/director of Parish Nursing Ministries UK describes how parish nursing works.

Most people in the church know someone in the local community who is suffering from dementia, someone who is caring for a family member, someone who has been recently diagnosed with cancer or diabetes, or a young single mum who needs some support, physically, mentally and spiritually. But does the church really know how best to help?



Revd Dr Helen Wordsworth, founder/director of Parish Nursing Ministries UK

One way of addressing this is to appoint a part-time registered nurse to the church's leadership team. They know about maternal and child health, disease processes, and the kind of help that is available through the local health services. They can offer evidence-based advice, liaise with other health professionals, and link church volunteers with people in crisis.

They can do all this and, if desired, may offer Christian prayer with people, even those who never come near a church.

In the UK, you will find a registered nurse in most church congregations. With just one day a week, working for the church paid or unpaid, they can form a church-based health ministry team that reaches out into the community, making the link between church and health providers, visiting, signposting, listening, and more.

It's a great way of reaching the community because everyone has health needs in their family at one point or another.

Take Julie, for example, who is a parish nurse based in the county of Kent, UK. She says:



A parish nurse/midwife is commissioned in Brixton, London

"I make, and take referrals to and from many other health-related agencies. I have a trusted relationship with all of them due to my previous nursing work in the town and am approached at church and in the street for advice on various health issues.

"I develop support groups and train and coordinate volunteers. Our mental health drop-in group has been held up as an example throughout the region. I run a Teddy Bears Clinic for local pre-schoolers to familiarise them with the Minor Injuries Unit and teach them accident prevention, and I promote healthy life styles at the youth club.

"I can also offer prayer and spiritual support. Most of our clients are unchurched but will often end up asking about faith. Involved alongside me are Christian volunteer drivers who can listen and pray on the client's journey to and from appointments. All my work is prayer-led. Parish Nursing Ministries UK not only offers me the initial training, but also quality assurance, professional resources, networking opportunities, a regional coordinator, and study days to keep me up to date."

All Parish Nursing initiatives are connected through the Westberg Institute for Faith Community Nursing, via an international coordinator.

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Lusaka Diocese, Zambia: the Mothers' Union contributes to family health

Dr Frida Kazembe, former Mothers' Union President for the Anglican Diocese of Lusaka in Zambia and trustee for the Mothers' Union worldwide, describes how Mothers' Union members faithfully serve the well-being of families in their communities.

When the AIDS epidemic struck in the 1980s, families were devastated. In the Lusaka Diocese of Zambia, church services were used to raise awareness and ways of preventing the spread of the disease. Trained personnel in congregations, many of whom were members of the Mothers' Union, gave health talks during church services, offered psychosocial counselling services and provided home-based care.

The Diocese of Lusaka and the Mothers' Union work together to share information on important medical conditions, offer voluntary counselling for patients and also provide screening for diseases such as hypertension, diabetes mellitus, cervical and breast cancer and testing for HIV infection.

Members are making a difference in homes and churches as they build up their communities through their various activities and services. The sick are visited and prayed for in their homes and in hospitals. Some Mothers' Union branches support neonatal units and the Diocese runs a 'hospital bag' initiative whereby linen, baby blankets, clothes and toiletries are given to mothers of newborn babies. Bereaved families are visited, and orphans and vulnerable children are cared for. Members trained as agents of the Zambia Anglican Council Malaria 'Nets for Life' prevention programme distribute nets to families in need of them.

The belief that stable family life is a basic ingredient for positive family health motivates this strong partnership between the Mothers' Union and the Anglican Church in the Diocese of Lusaka.

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Mothers' Union members during the Anglican Consultative Council meeting in Lusaka, 2016

Drug overdoses: clergy in Ottawa diocese, Canada, among those saving lives

The Revd Monique Stone has been leading the Diocese of Ottawa's response to overdoses involving counterfeit opioid drugs sold illegally. She describes what has been happening.

On 31 December 2016 in Ottawa, Canada, a news article urged citizens to go to their local pharmacy to pick up a free naloxone kit. Naloxone is an antidote that assists in counteracting the effects of opioid drug overdoses. The announcement was an effort to bring awareness to the reality that counterfeit opioid drugs containing high levels of death-causing fentanyl had hit the streets of Ottawa. The availability of the kit at no charge was, and is, an effort by Canada's Ministry of Health to encourage the public to help in a battle they are not sure they can win on their own.

The invitation that day was for anyone - parents, teachers, government organisations, and yes, even clergy - who might come in to contact with a person who had taken an illicit opioid during New Year's Eve festivities, to try and save a life.

That is what naloxone can do. It can save a life. It doesn't reverse the impact of an opioid overdose but rather it delays the effects, namely respiratory depression and heart failure, hopefully long enough for an ambulance to arrive.

A mere six weeks after the New Year's Eve announcement two teens died of apparent overdoses. Though these deaths were not the first, the media attention surrounding the tragic loss of the 14 and 18-year-old girls acted as a catalyst for broad range attention and action.

The Anglican Diocese of Ottawa, having already been inspired to be part of solution by arranging to train over 20 clergy in naloxone administration, responded by launching free drug overdose prevention workshops for the public.

Our diocese has embraced the call to react quickly, open our doors, foster dialogue and enable solutions. Within an eight-week time frame it is expected that over 200 people will be equipped with a naloxone kit through one of our diocesan hosted events.

Each event is a partnership between the host church community, a local pharmacist who will distribute naloxone kits and train each attendee on how to use it, the local public health organisation who will provide insight on what to look for when identifying a drug overdose, and the local community resource centre which will provide support to adults, parents and youth who might be grappling with the knowledge that the risky use of opioid-based recreational drugs is on the increase.

Most of the attendees are not church parishioners but rather members of the broader public, many communicating a high level of gratitude that the church would play such an important leadership role in partnering with others to battle a crisis that is affecting a diversity of people in our communities.

The hope continues to be that lives are saved and that families, adults and youth become aware of the risks of opioid use, particularly counterfeit drugs purchased illegally. It is a work in progress and will take continued efforts of partners throughout our community.

As with any ministry work we do as the church we never know how the seeds we plant will make impact directly or indirectly. Just last week a car was stopped by Ottawa police and the officer quickly recognised that the driver was in the initial stages of an opioid overdose. Paramedics administered naloxone and stabilized the man as he was driven to the hospital. A life was saved by the naloxone kit. There will be more stories of the impact of naloxone throughout our communities but even just one story will inspire us to continue our work.



Revd Monique Stone with a naloxone kit

As the clergy person leading the diocesan response to this crisis I have been interviewed by many media reporters. An interesting question that has been posed to me each time is why the church would be involved in this issue when, according to the reporters, society would assume that religious institutions are solely focused on an individual's spiritual life.

My reply to this question is that the church has always and will always be focused on the entire health and wellbeing of the people, families, youth and children who are both inside and outside our walls.

"The church participates in the journey of people's lives from their birth to their death," I tell them, "so when a crisis such as this demands action so that lives can be saved and journeys strengthened we have always, and will always, be part of that response."

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Open doors and therapeutic support for refugees

Canada has welcomed over 30,000 refugees from Syria in the past year bringing both joy at new beginnings and the need for a broader infrastructure to incorporate people into the fabric of Canadian life and society. Children who have been without schooling in refugee camps and families which have one or more members in traumatic circumstances require sensitive interventions, medical treatment, language classes, and support systems, including therapeutic help.

Diane Marshall is a registered psychotherapist and registered marriage and family therapist. As well as being a consultant to Christian ministries and social justice organisations and serving on human life task forces for the Anglican Church of Canada, she provides clinical supervision to therapists who themselves have been refugees or recent immigrants to Canada.



'Changing the World': A gift from a Romero House family

Diane shares with us stories about the work of three such therapists.

Wafaa, a former family doctor from Egypt, is now a registered psychotherapist and supervises other Arabic-speaking therapists. She has worked with Diane at Romero House.

"We have seen a sharp increase in the number of refugees from political unrest or religious persecution in the Middle East, mostly from Iraq and Syria (first displaced to Turkey, Jordan or Greece), as well as from Egypt, Lebanon, other parts of North Africa, and Saudi Arabia. The majority are suffering from Post Traumatic Stress Disorder (PTSD).

"Many recount images of torture or death of their siblings, children, spouses, cousins or parents. It takes some time for them to feel safe again. They usually experience anxiety, depression, isolation and sometimes suicidal thoughts. The presence of a supportive, consistent community (including Arabic-speaking families, churches and mosques), counselling and sometimes medication are what works. English as a Second Language (ESL) programmes have been a great help for adults; finding a job helps mostly men feel they are still able to provide for their families."

Thuy is a Vietnamese immigrant to Canada. Her sensitivity to the needs of the traumatised Vietnamese community has

involved consulting for child welfare authorities and probation services, and speaking at ecumenical conferences on the challenges faced by immigrant cultures.

"I came from the war zone country of Viet Nam 25 years ago. As most Vietnamese in my generation and that of my parents, I had been living in constant fear. I can still remember how the country dealt with the problems of bombs raining around us, or how we managed to protect ourselves to find a safe place to hide from the shootings and bombardments.

"The clients I work with are Vietnamese-speaking people from war zone countries including Viet Nam, Laos, Cambodia and from southern China, who have experienced war, escape, relocation and transition and who with incredible courage and resourcefulness continue their journey toward integration and adaptation in the Canadian culture. Role reversal among the family members, change of social status, legal problems and lack of a support system compound their difficulties.

"Seeking professional counselling from a non-family member may be a new concept to many Vietnamese. Fear of breaking confidentiality or losing face, the mindset that 'I don't need help because I can resolve my problem on my own' and the stigmatization of mental illness can be hindrances to seeking help from outside sources."

Samia works with refugees from Central and South America, in particular Colombia, Honduras and Mexico, often with families whose experience of the drug cartels, kidnapping, murder and other atrocities has caused them to flee through the 'underground network' via the United States to Canada.

"Immigrants and refugees usually go through what is called migration stress. They experience many losses in leaving their homeland, their families, friends and the world they know. Precarious immigration status leads to insecurity navigating a complex immigration system.

"I practise a holistic therapy using an approach that focuses on the culture of the person, the social context that brings them to Canada, trauma they might have experienced, migration stress and family dynamics. It offers a variety of social services that answer to how people find stability and wellbeing, fostering good family dynamics, conflict resolution and engagement with their communities."

Both Thuy and Samia work for The Lighthouse, an agency run by the Christian Reformed Church in Toronto, see www.lighthousecentre.ca.

Romero House was established as an emergency response to people fleeing El Salvador in the wake of the assassination of Archbishop Oscar Romero and the civil war which erupted in that region of Latin America. Romero House continues to welcome refugees and persecuted minorities from Europe, the Middle East, Africa, Sri Lanka and South America.

Diane's role of therapist supervision includes professional development and therapist self-care:

"The challenge of these remarkable therapists and workers, and the communities to which they belong and serve - and my

challenge as their clinical supervisor - is to understand the healing process from multi-generational complex trauma, and for each of them to keep their own balance emotionally and spiritually. All of these therapists are Christians working in inter faith and ecumenical circles, faithfully grounded in the love of Christ."

CONTACT: Diane Marshall, email dmarshallmft@sympatico.ca. More information about Romero House is at <https://romerohouse.org>.

Learning, unlearning and relearning as a hospital chaplain

The Revd Helen Grace Siromony has served in healthcare chaplaincies in India and at the Dumfries and Galloway Royal Infirmary in Scotland. She reflects on her experiences accompanying patients and their families on the journey towards healing.

Working in Scotland as a Healthcare Chaplain was in many ways different from my previous experience as a Palliative Care Chaplain in India, where I come from. Because India is multi-religious and there is mutual respect for varying beliefs, I could visit any patient in hospital irrespective of their faith tradition. In Scotland a referral from a doctor, nurse or patient themselves is required.

Initially it felt strange to lose the opportunity to engage with patients freely and it was challenging to accept that some patients did not want to see the chaplain even after being identified and referred by a doctor. Nonetheless, I found my work very meaningful and fulfilling and was able to work with the health care team and the local church to serve patients and families when health was affected.

Agnes was found collapsed at home by her carer making her morning routine visit. Living alone and with no relatives she was brought to the hospital by the ambulance team. She was suffering tormenting pain due to a tumour in her ovary, and had mental health difficulties. She was agitated throughout entire nights for weeks continuously and always demanded attention of the staff. She was lonely and in utter despair. In one of my visits, she said, "Could you please stay with me a bit longer today?" It was obvious my visit made her calm down.

Unlike India, I have seen loneliness as a common problem here, and living alone could be one reason for it. Agnes remembered her childhood life when she regularly attended church and asked me for a Bible.

She was happy to read the Bible and during my visit would share with me the chapter that she had read that day. Psalm 23 was her all-time favourite. I contacted a local priest who visited regularly. Agnes spent her last few months with caring and nurturing people around her and her spiritual needs were met. In one of my visits she said, "Your visit gives me peace".

Beryl came to hospital to be treated for an infection that was not clearing even after taking antibiotics. Her family asked if I could go and pray. She was eventually diagnosed with cancer at an advanced stage. When details of her condition were

explained to her all she wanted was to go home and spend the rest of the time with her husband, children and grandchildren.

She told me, "I want to go home up in the sky". She was very aware of what was happening to her and she was well prepared to face it. She could also think clearly and make decisions about what she wanted to do. As the Health Care Chaplain I communicated this to the doctors and her wishes and desires were respected. Beryl was sent home where, in due course, she died. I learned from her family that, as she wanted, she had met all the family members and spent time with them, shared love and said goodbyes. I had the privilege to contribute a small part at her funeral.

In my experience in India, it was very rare to see a patient who didn't live with their family. No patients ever discussed details of their funeral, the hymns of their choice, etc, with me. These decisions are always made by the family.

Being hospital chaplain has been a very rewarding experience. There was much to learn, unlearn and relearn using the strengths of the experiences of both contexts in order to reflect on and explore appropriate and effective ways of supporting patients' spirituality. I have come to realise that besides offering spiritual care for patients and families, it is critically important to facilitate networks between families, health care teams, local clergy and support systems, who together can bring spiritual fulfilment for all involved.

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An authentic ministry

"Healing sits at the heart of Jesus' engagement with people and scripture reveals him restoring hope and transforming relationships. Those marginalised because of their illness are restored to community and limitations to their flourishing are lifted.

"To be caught up in healing and healthcare is to be drawn into God's passion for human flourishing and the family offers a primary context where such flourishing is founded - an agency for restoring hope and recovering community. Christians have been at the forefront of healthcare from the time of the apostles and our continued involvement is a sign that our faith is rooted in scripture and continues the apostles' witness to faith in action."

Bishop David Rossdale, IAFN Chair

Dismantling the stigma of HIV/AIDS in Zimbabwe

Stigma means different things to different people. One dictionary defines it as "the shame or disgrace attached to something regarded as socially unacceptable". There may be a feeling of 'us' and 'them'. People who are stigmatised are marked out as being different and blamed for that difference. Some people see a person who is HIV positive as someone who is dying or as someone who is not supposed to touch anyone. Yet this is not so.

HIV is a virus about which many people have fears, prejudices or negative attitudes. Being stigmatised can result in isolation, rejection, gossip and exclusion from social activities. Fear of being stigmatised can mean people end up suffering in silence instead of getting the help they need.

Church and community leaders can be exemplars and ambassadors for ending the stigma associated with HIV/AIDS and restoring those affected to good health and to their communities.

The following is taken from reports by Maud Marengereke, the Pastoral Care/HIV/AIDS Desk Coordinator for the Diocese of Harare in Zimbabwe.

The Anglican Diocese of Harare has joined forces with other progressive organisations in the fight against HIV/AIDS-related stigma and discrimination, saying that people should know and understand that HIV/AIDS can be managed through prescribed treatment and lifestyle choices. One way of promoting this message is through the bi-annual Embrace Magazine produced by the Diocese's HIV/AIDS Desk. The desk is coordinated by Mrs Maud Marengereke in collaboration with Revd Tambaoga Manjengwa.



Maud Marengereke, Pastoral Care/HIV/AIDS desk coordinator for the Diocese of Harare addressing high school students

Furthermore, the Anglican Diocese of Harare in partnership with United Society Partners in the Gospel (USPG) has embarked on a programme aimed at eradicating HIV related stigma and discrimination in local communities. The three-phase intervention programme being rolled out from 2016 to 2019 will have 20 new Centres each year.

As a starting point, the programme trains two Focal Persons from each of the 20 Centres on basic concepts of HIV stigma and discrimination. The Focal Persons educate and raise awareness among parishioners and communities and are also responsible for carrying out parish activities in liaison with the Pastoral Care Coordinators. Additionally, clergy, church wardens and members of school leadership teams receive training.

Initial support from local leaders, kraal heads and church members has been very encouraging and most Centres are

working harmoniously through the Focal Persons in a collaborative and non-partisan manner. Community Awareness Meetings have been held at Centres, with high participation by local people. The Programme is creatively presented with drama, music and poetry, and men and women living with HIV speak about their experiences in ways that give hope to and elicit empathy in many. Banners, t-shirts, key holders and posters are used in the campaign to raise public awareness.

There is an ongoing need for more education programmes to increase understanding of HIV/AIDS amongst local communities, and the hope is that each Centre will have its own support group helping to share information about stigma and discrimination related to HIV/AIDS.

World AIDS Day commemorations took place in December 2016 at St Michael Mission in Mbare, with a higher attendance by clergy and parishioners than in previous years.

The Bishop of Harare, Rt Revd Chad Gandiya, gave an address and said that church and community leaders should lead by example by treating people living with HIV/AIDS equally in their communities as this reduced stigma and discrimination.

Bishop Gandiya said that it was important that the church should realise that HIV/AIDS is a reality and people should be prepared to accept the challenges brought by this pandemic especially to families from poor backgrounds.

Mr Saruchera, Education Secretary for the Diocese of Harare, reminded listeners that many families have been affected by this pandemic which has resulted in children being forced to head families after their parents succumbed to HIV/AIDS. "Several homes no longer have parents but children who are compelled by circumstances to look after themselves." He urged people to be good ambassadors and help spread the news that stigma and discrimination have no room in our lives.

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Niassa Diocese: 'Life Teams' in the community

The Diocese of Niassa in Mozambique shows how healthcare in the community can be strengthened by voluntary 'Equipas de Vida'. Rebecca Vander Meulen explains.

Antonio Julio is two years old and lives with his mother in Mapudje. He was refusing to eat and would only breastfeed. His mother regularly offered him the standard baby porridge made from maize, water and salt, which he refused to eat. She had even taken him to the hospital but received no help. The day we practised making enriched porridge with vitamin A-rich, orange-fleshed sweet potatoes and peanuts, his mother tried to give him some. He not only kept eating, but he grabbed the spoon from his mother to eat by himself. Now she makes enriched porridge for him every day—and the rest of the family enjoys it, too.

The church is strategically placed for effective community development and since 2004, the Diocese of Niassa in rural Mozambique has been encouraging congregations to create their own 'Equipas de Vida' or 'Life Teams'. There are now 340 active community development teams, with over 10,000 volunteers of many different ages, women and men, addressing both HIV/AIDS and other health-related opportunities.

Volunteers are expected to spend no more than about four hours per week on their community development work, so that their own income-generation work is not adversely affected. Some volunteers serve as counsellors, receiving a monthly lesson on a specific health topic to bring back to ten other households. Some serve as nutrition monitors, weighing babies and helping parents think through better ways of feeding their children. Some focus on hygiene, encouraging every household in the community to build or improve its own latrine. Some, as farmers, take the risk of experimenting with new seeds or new farming methods, and share the outcomes with fellow farmers.

These community facilitator staff members are known as 'adeptos'—a Portuguese word that describes a fan at a sporting event, affirming the role of the local community team—not the staff members—as the primary agent of change. The adeptos serve the volunteer as change agents by helping them build their capacity to work more effectively towards their vision. Adeptos teach with clear explanations in the local languages, which is critical for deep comprehension, as many rural families speak no or little Portuguese.

Cobue is a small village in a remote corner of Mozambique offering better health services than most communities of its size because of the Anglican Diocese of Niassa's comprehensive community project. One evening last October, a woman was admitted to Cobue's health centre. Infected ulcers and raw bed sores covered large areas of her body leaving her unable to sit up or walk.

Cobue's experienced doctor began removing dead tissue while a traditional midwife and the patient's mother waved cloths to keep the flies away. A team of dedicated people worked for hours each day to clean Esperança's sores. Her immune system had been decimated by HIV, despite years of faithfully taking ARV medication. Her prognosis was poor but her name, Esperança means 'hope' in Portuguese and hope proved to be stronger than the bacteria that fought to take her life.

Three days into her wound care, with thousands of milligrams of antibiotics circulating through her body, Esperança managed to leave her bed to go to the bathroom outside. This was something she hadn't done in weeks. Her joy at having been able to get out of bed overwhelmed her thoughts of death. A team of efficient and dedicated people obtained authorization from the national Ministry of Health for Esperança to begin a new regime of ARVs—a significantly more expensive set of 'second line' medications that are only available to a small proportion of Mozambicans living with HIV.

Within days, Esperança's increasing mobility, healing sores and weight gain proved that these new ARVs were effectively halting HIV's reproduction within her body. She arrived home



Esperança with her medication

to surprised celebration: friends and neighbours didn't think she would ever step foot in Mala again. The Mothers' Union group surrounded her with prayers of thanksgiving. Esperança had the courage to live beyond the facts, fully aware of the possibility of being humiliated in that hope.

Properly managed, HIV is no longer a death sentence. We are still far from that reality here in Mozambique, where tens of thousands of people still die annually from AIDS-related causes. Esperança's life gives flesh to the vision of zero deaths.

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'Wabvuwi': the extraordinary story of a clinic for local communities

Edward Ndaima describes how a tragedy led to the building of a clinic at St Clare's Mission, Mrewa, in the Diocese of Harare, Zimbabwe.

The story of the Anglican Wabvuwi (Fishers of Men) Guild building a clinic in Zimbabwe is not an ordinary story, but one of sacrifice and commitment. It is a story of not just sitting and complaining about government failures, but one of standing up and complementing government efforts in providing health facilities and services to the nation.

Inspired by their Mission from Mathew 28.19-20 "Go ye therefore, and teach all nations, baptizing them in the name of

the Father, and of the Son, and of the Holy Ghost: Teaching them to observe all things whatsoever I have commanded you: and, lo, I am with you always, even unto the end of the world”, the Guild decided to go beyond the ordinary call of duty of evangelism by embarking on a project of constructing a clinic at St Clare’s Mission in Mrewa. The clinic is equally not ordinary, its size and architectural design is well above that of most clinics found in rural parts of Zimbabwe.

The story of the clinic began on 9 November 1997, a day that brings sad memories to the Guild when five members died in an accident at the turn-off to St Clare’s Mission. As part of evangelism through works, the Guild had contributed various items of clothes, food and cash for donation to Mutemwa Leprosy Centre in Mutoko, about 150km from the capital city Harare. Twelve members of the Guild including the leadership of Harare Diocese were selected to deliver the donated items. They spent the day with the sick, socialising with them through music and sharing the word. It was a day well spent.

On their way back and continuing in the spirit of visiting the sick, they decided to see a member of the Anglican Church who was not feeling well in Mrewa. As they turned from the main road they were hit by a big truck from behind and four members of the Guild died on the spot and a fifth one was pronounced dead upon arrival at the hospital. It was a sad ending to a day that had begun well.

Following this tragedy, members of the Wabvuwi Guild felt that something needed to be done in memory of these members who had died on duty. Discussions were held with the local community of Mrewa and its leadership and the Anglican church. Consensus was reached on the idea of the clinic in view of the inadequacies of health facilities within the area which were characterised by people travelling long distances to access health facilities, and failure by some community members to access health facilities including expectant mothers. Whilst it was members of the Harare Diocese who died in the accident and who had organised the visit to Mutemwa, the clinic project was adopted as a national project covering all dioceses. In addition, a National Conference of Wabvuwi Guild is held annually in August at St Claire’s Mission where the clinic is being built.

Funding for the project has come from members of the Guild and the Anglican community in general. Donations have also been received from some organisations. The superstructure has now been completed and the walls have been plastered both inside and outside. A staff house has also been fully completed and is ready for occupation. The remaining stages are flooring and ceiling, electrics, plumbing and glazing as well as equipping the whole clinic. The targeted completion date is June 2017 with the official opening scheduled for August when the Guild holds the annual national conference.

The Bishop of Harare Diocese, Chad Gandiya has played a major role in ensuring that the project gets to where it is now, saying, “Some of those who perished in this accident could have survived had they been attended to sooner but unfortunately they had to travel to Harare for medical



The clinic in Mrewa built by members of the Wabvuwi Guild

attention and lost valuable time and in the end could not be saved.

The Wabvuwi have provided labour for the construction of the Clinic and have fund-raised locally to cover other building costs such as materials. The Diocese of Harare is proud of the commitment and sacrificial service given by this men's Guild. The Fishers of Men in Zimbabwe are doing great work through contributing towards health facilities of the country and indeed it is a story of spiritual healing to physical healing!

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Loving and compassionate God

who desires fullness of life for all your children,
we pray for families everywhere
especially those parenting in poverty and in difficult contexts.

Be with them, and those working alongside them in their communities,
as they seek to improve health, resilience and well-being.

May they be further encouraged and emboldened by these stories of local initiatives which have the capacity to transform, so that all may flourish.

Sheenagh Burrell, Coordinator of ALMA: linking the dioceses of Angola, London and Mozambique



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