

# FAMILIES AND HEALTH

## EDITORIAL

Families and Health is a vast subject. This newsletter contains articles on a wide variety of associated themes. The in-depth survey from Nigeria sets out many of the problems damaging the health of women and children. It also points out what can be done to meet the challenges and the importance of men sharing with women in this task. The significance of poverty as a major cause of ill health is underlined by several contributors. The importance of the environment is another recurring theme, whether it is picking up rubbish round the home, or combating malaria by dealing with mosquitoes' breeding grounds. The article from Bangladesh tells of the tragedy of arsenic-poisoned wells, whereby measures thought to bring health with the provision of safe drinking water have brought illness and death. Here too, the Church is working to help. Good health is a matter of spirit and mind as well as body and the article from Canada makes clear the prevalence of mental illness and the damaging stigma attached to it. And then there is HIV/AIDS, where in Africa, Hong Kong

and USA, efforts are being made to increase understanding as to how it is transmitted and to help those already affected. Christians worldwide are trying to follow their Saviour who broke through taboos and brought healing to body and mind.

This is a priority for us all.

## NIGERIA

One of the major roles of women is the promotion of healthy life in the family. The happiness of a nation, to a larger extent, depends on the health of the children who are the leaders of tomorrow. Unfortunately, in most developing countries, child health has not been given the attention it deserves and Nigeria has particular health problems militating against the well-being of children. These may be a result of negligence, ignorance, traditional practices, poverty, poor environmental sanitation.

### **Women's Role in the Family's Health Needs**

Women and children are the most vulnerable to diseases in Nigeria. The top-heavy health structure means normal

medical services are outside the reach of the majority of the population (Okonjo 1991). This inadequacy, as well as the preventable nature of most of the diseases, has led to the institution of a primary health care programme. The basic aim is to achieve 80% coverage of the population in health-care, effectively attacking the disease problems that contribute up to 80% of the unnecessary deaths and disabilities affecting Nigerians. The strategy for achieving this target is the introduction of immunisation campaigns against the six major killer-diseases of children. While there are no specific moves related to women, the various components of the primary health-care system are directly related to them (Okonjo 1991). These include nutrition, provision of adequate water supply, environmental sanitation, immunisation, maternal and child health, family planning and treatment of communicable diseases. Women are the implementers of the child-survival revolution. For example, the success of the expanded immunisation programmes, launched in 1985, has very much depended on the ability to persuade mothers of the importance of immunisation.

The major causes of child mortality – malaria and diarrhoea – are related to poor environmental sanitation. Furthermore, several of the communicable diseases affecting both adults and children are water-borne. The numerous and time-consuming tasks of women often mean that they neglect to boil drinking water. Even though they know the advantages of doing so, they do not have the time and the extra fuel cost can impose extra financial burdens. So the mere provision of safe drinking water supplies may not be enough to ensure their use. One of the many factors associated with childhood health problems is poverty.

#### **Poverty**

The harsh economic climate, as well as the high inflation rate, undoubtedly hinders parents from giving their children adequate health care. Most families, whose income-generating capacity is too low, often find it difficult to give their children medical attention. When a child is sick, parents who cannot afford to pay medical bills may resort to traditional medical doctors and 'quack' medical personnel. These usually aggravate the child's condition. If the family is poor and has little or no land for cultivation, they may not be able to buy nutritious foods. This predisposes the children to nutritional disorders, such as kwashiorkor, pellagra, beri-beri, blindness and sometimes untimely death.

A UNICEF – sponsored study observed that all the demonstration about the nutritional properties of milk, meat and eggs in health centres and women's clubs throughout the developing world offer nothing to a mother unless she has the wherewithal either to buy or to grow such foods. Hunger and malnutrition cannot be divorced from the context of people's lives. Whether people have

enough to eat and enough of the right kind of food depends on their income. The only lasting solution to the problem is, therefore, the eradication of poverty. But this process, in many developing countries like Nigeria, is excruciatingly slow. For some communities the process is stagnant or sliding backwards. As has been shown in the previous IAFN newsletter, which told of "the feminine face of poverty", women are often the most afflicted by poverty.

In Nigeria, only 10% of the people who are at the echelon of power in all private and public institutions are women (Amali, 1990; UNICEF, 1991). The poor with low and irregular incomes live in shanty towns, slums, one-room apartments. Very poor families fall below this level and are generally destitute. In developing capitalistic economies like Nigeria, many of this section of the population are women, either as individuals, family members or unacknowledged heads of households. A good number of women have become sole providers within their families, with little or no resources.

In order to augment family income, mothers put up their little girls as servants or domestic child-labour. At times these girls are subjected to physical and sexual abuse. From an early age, girls are trained to fetch water and firewood, grind corn, or do road-side selling alongside their mothers. In most cases, boys have the responsibility of doing less arduous errands. Any crisis that alters the balance of power in the family is first felt by women. Where the crisis is finance-related, the task of adjustment is left to the ingenuity of the mother and the sacrifice of the female children. Although poverty may be caused by low wages, unemployment and sickness, given the patriarchal dominance of the Nigerian society, the resulting circumstances

remain outside the control of women (Suara, 1998).

There is no doubt that education is important to understand and solve the problem of poverty. Poverty is genderised in Nigeria because women who are a disadvantaged group are mostly illiterate, unemployed or underemployed. They have little access to credit and have minimal power over their environment. Illiteracy among women must be seriously addressed if poverty is to be de-genderised.

Large families are, no doubt, a strain on the available resources in Nigeria. A child in a polygamous marriage, particularly where resources are lean, stands a slim chance of benefiting from formal education. A child so disadvantaged could resort to unlawful means for survival. Similarly, children whose parents are violent to each other seem to exhibit similar characteristics as they grow up. The use of 'double standards' by parents in training a child becomes another dehumanising factor. If a father tells his son "do not steal" but steals government funds the next day, and is declared a wanted person, the child looks confused at this paradox. Confusion over norms sets in; and this affects healthy growth.

When the social environment is permissive to drunkenness, smoking cigarettes, taking hard drugs and indiscriminate sex, many young children may take to these vices. Many children then become victims of drug addiction, leading to mental disorder, while others can become victims of HIV/AIDS, either through sexual intercourse or as a result of direct contact with infected material or through infected pregnant mothers passing it to their child/foetus. In redressing these ills, a desirable environment can help a child overcome acquired tendencies towards unfavourable traits. Undesirable environments may cause children's growth to become stunted, as they become victims of diseases or disturbed emotions.

#### **Healthy Environment**

Closely related to home is the environment. The need for a healthy environment is crucial to all human beings. Dalumo (1988) noted that the foundation of environmental health rests on man's need for fresh air, potable water, healthy food and good shelter. It is important to ensure sustainable and adequate environmental sanitation inside and outside the home, and the Federal Government has introduced compulsory monthly environment sanitation. Some states also introduced bi-weekly sanitation. Regrettably, an average Nigerian has acquired the habit of

have not brought positive results. If there is one issue in the development litany which seems clear-cut, it is the issue of hunger. The hungry child is the image etched into the consciousness of everyone who responds to the challenge of poverty and deprivation in the developing world.

### Crucial role of women

Women produce 60-80% of all food grown in Sub-Saharan Africa (FAO 1996). They suffer disproportionately from hunger and malnutrition, but they also contribute disproportionately to reducing it. Women grow a large share of the world's food for domestic consumption. When they have income, they tend to spend more of it on food for the household than men do. So a woman's direct access to cash or production – or lack of it – has a direct bearing on how much the family has to eat. Yet conditions often conspire against women. When women work long hours, they have less time to produce food for the household, provide child and health care and collect clean water and fuel. Women are rarely permitted to decide how much of their food crops is sold and how much is to be kept for the household. While the numbers of female-headed rural households rise, women are still denied the land, credit, technology and training they need to feed their families. Women must be a larger part of the solution. Due to the poor economic situations in the country, their work is now doubled. They cannot sit at home and watch the children yell for hunger. There is an observable shifting of roles from feminine to masculine with women paying fees, engaging in agriculture, bricklaying and concreting. These were the supposed roles of the men, which the women are taking over in their struggles to provide health for their families.

### Strategies for attaining healthy family life

Some of the workable strategies that could be adopted by women to promote healthy family life are:-

- self-help groups: Women collectives or cooperatives should be encouraged to integrate health education and other activities. These could form the media through which the Nigerian women could disseminate information on health issues
- women should be encouraged and given access to bank loans and credit facilities
- women should ensure that their children receive immunisation early to protect them from communicable diseases

- women should ensure that the living environment is healthy by keeping it clean
- women should create a supportive environment for health through increased vegetable production and other fruits for sale and home consumption during the dry season. This will go a long way towards improving the nutritional status of the family.
- literacy in itself is a contribution to ill-health and this may relate to lack of knowledge about possibilities and choice or lack of healthy food. This calls for involvement by literate women to help educate the illiterate ones.
- Families should limit their size to what they can afford.

### Conclusion

Being a parent is an awesome responsibility. To educate a woman means to educate a family, and indeed a nation. Therefore, women must ensure that they are not marginalised, but become instruments of conscious and directed positive change. The goal is the immediate development of themselves and their children's quality of life. Women must be provided with every support which they, acting in concert, can use to shape and improve their lives through the awareness and the practice of healthy living. This should not be done in isolation or exclusion of the men. Both should be equal partners in the developmental process to ensure maximum benefits to all.

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Suara, JSO (1988) Genderisation of poverty: some shocking realities about women in Nigeria. *Journal of Women in Colleges of Education* Vol. 2 pp 1-3.

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polluting and littering the environment by indiscriminate throwing away of empty cans, kitchen refuse, and all sorts of rubbish carelessly around his dwelling. People urinate and defecate along the streets. Poor drainage systems, lack of potable water, and enough water for performing domestic duties, also contribute to poor environmental sanitation. In most cities and public places, conveniences are not provided. Human beings, especially the women, have close links to the environment. If healthy social development is to be maintained, not just promised during electoral campaigns, the environment must be targeted for change. The various governments in Nigeria have great tasks to provide the basic environmental infrastructure. At the same time, the process of cultivating a healthy mind for establishing priorities and for cultivating the right attitudes is essential.

### Malnutrition

Malnutrition constitutes a significant threat to the life and well-being of children. Consistently hungry and malnourished children tend to be apathetic and hostile. The result of a recent study conducted in 53 countries, including Nigeria (1997) revealed that 6.5 million children die of malnutrition yearly. UNICEF reported in 1998 that in Nigeria, malnutrition is a public health problem with an estimated 28% of children below five years of age being underweight, 11% wasted and 52.2% stunted. After few decades of strenuous wrestling with the problem of malnutrition, the agony of the hungry child is still very much with us. Notwithstanding efforts by governments to improve agricultural production and nutrition education programmes, these

being most affected. It is very unfortunate that one of the preventable diseases becomes the number one cause of morbidity and mortality in a country with the necessary resources to eradicate the disease.

### The Policy:

Tanzania's policy on malaria is articulated through the National Malaria Medium Term Strategic Plan (2002-2007). The plan aims to:

- increase the proportion of children with febrile episodes that receive appropriate treatment within 24 hours of onset from 19% to 60%
- increase to 80% the proportion of clinical malaria cases that are treated appropriately
- increase to 60% the proportion of pregnant women and children sleeping under a properly treated mosquito net
- increase to 60% the proportion of pregnant women and children who are effectively protected against malaria with Intermittent Preventive Therapy
- improve the capacity of epidemic-prone districts to recognise malaria epidemics early and respond appropriately
- ensure that communities understand the dangers of malaria and what to do about it.

### The Control:

The parasite Plasmodium Falciparum is responsible for over 95% of malaria infections. Over the years, chloroquine treatment responded well. However, in 2001, the policy of using this as the first line drug ceased due to high resistance and a 52% total treatment failure. The drug regime was then changed. Other preventive measures include use of insecticide-treated nets introduced in a national scale social marketing programme.

### The Neglected Therapy:

According to the National Malaria Control Programme officials, malaria mosquitoes bite at midnight when it is quiet and cool. This encouraged the use of drugs for treatment and nets for preventing people from being bitten. Environmental management was neglected.

During pre-independence and the early years of independence, control of mosquito breeding sites, i.e. clearing of water ponds, cutting grass around homes, removal of cans and other water-holding devices, was a role of every household.

The system of 'dry day' where every home emptied water containers at a special day of the week and cleared its home surroundings, killed many mosquitoes. This is the malaria therapy which needs to be revisited. There is no single strategy, but why breed enemies and start to manufacture weapons to fight them? How effective the weapons are is questionable and that is what is facing Tanzania.

### Conclusion:

Effective malaria prevention and control is useless without eradicating the vector. Residual sprays in the homes, killing the mosquito larvae and eliminating the breeding sites are necessary strategies. The fewer mosquitoes there are, the fewer cases of malaria there will be, with lower morbidity and mortality.

Those entrusted with malaria prevention need to:

- raise the profile of malaria among politicians, potential partners and community leaders
- improve the flow of information on malaria to key target audiences at national, community and household levels
- influence positive behaviour change among target audiences with great emphasis on environmental management, treatment-seeking and other critical malaria-related behaviour.

"It can be done, let every one of us join hands and play our part."



### Editorial Note

As the above article points out, in Africa malaria kills more people than HIV/AIDS. The Roll Back Malaria programme initiated by 90 organisations including WHO, the UN Children's Fund, the UN Development Programme and the World Bank, aims to halve malaria deaths in Africa by 2010. It is seeking to bring together civil society, religious groups, traditional leaders, banks and other groups in the fight against malaria. In other countries, as in Tanzania, Church leaders are involved. Bishop Dinis Singulane is chairing the Roll Back Malaria campaign in Mozambique and says the Church must get involved in basic health education to combat this preventable and curable disease which kills a child in Mozambique every 30 seconds.

### Malaria

Tanzania is a tropical country whose ecology and weather favour the existence of various transmittable diseases. One, malaria, remains the number one cause of morbidity and mortality. Several strategies have been employed to try to prevent and control malaria, but still the disease is rampant in all parts of the country.

Tanzania has an estimated population of 34 million (2002 census). 3.4% of GDP is used in malaria control interventions annually. A Tanzanian spends \$11.37 per year on health and \$2.14 is spent on malaria services only. About 75% of malaria expenditures are met by the household, with the Government contributing 20% and partners 5%. Of the household malaria expenditure, about one-third is spent on anti-malarial drugs, one-half on bed nets, insecticides and other preventive measures. This disease and economic burden is greatest on the poorest households and contributes to the continued poverty-disease cycle.

There are an estimated 16 million cases of malaria per year, resulting in about 100,000 deaths of which 39,000 occur in children under five years old. Malaria accounts for 43% of hospital admissions and 32% of in-patient deaths for children under five. It is estimated that nearly the entire population of Tanzania is at risk of malaria; children and pregnant women

## CENTRAL AFRICA

Women have unequal access to the use of basic health resources and this has had a negative impact on their lives. In order to address this, there should be intervention by the Government, the NGOs and all relevant stake holders. Such interventions should be:

1. Ensuring the establishment of high health standards and the review of laws and policies relating to women's health.
2. Implementation of the following health programmes:
  - gender sensitivity
  - decentralisation of health services
  - special needs for women with disabilities
  - planning of health services with women.
3. Providing more accessible primary health care services of good quality.
4. Making reproductive health care accessible to all girls and women of all ages.
5. Strengthening preventative programmes that promote women's health through:
  - removing harmful attitudes and practices (e.g. female circumcision)
  - social and development education and employment programmes
  - programmes that aim at equal sharing of child care and household tasks.
6. Strengthening laws and giving out necessary information on women's health through:
  - public health campaigns
  - the media
  - counselling.

7. Supporting and strengthening the national capacity to improve gender-sensitive policies and programmes.

## DEMOCRATIC REPUBLIC OF CONGO

In the DR Congo, where insecurity and war prevail as well as political instabilities, the population live in very hard conditions which make them poor. There are many problems

concerning health – here are some of the serious ones.

- Child malnutrition is a highway for all diseases – it is thanks to malnutrition that children become fragile and vulnerable and, as a consequence, their death rate is increasing every year.
- Poor families have no way to get access to health care of high quality.
- Poverty being the consequence of the wars, political instability and low purchasing power, means many families are unable to get access to health consultation – even those who are raped for a clinic check up – and they can't afford medicine. Because of this, many use traditional practices such as witchcraft; they even use medicine without consulting a doctor. This practice is harmful for many.

## NORTH INDIA

Health is the state of mind, body and soul. Health and Family are the most precious gifts. About 50 years ago, the joint family where all members of the family stayed together was a tradition that was followed but today the concept is quite unknown.

Health enables and strengthens a person's ability to take and implement decisions; ill-health depreciates this ability. A person is then dependent on others to implement his/her decisions which usually do not ascertain same satisfaction or results. Historically, we Easterners have been careful of our hygiene because of our climactic conditions. Now, the health consciousness of a person is greatly dependent on the health etiquette of the family: the manner in which a family serves water or food, Do they dip fingers in a glass of water or share drinking vessels between ill and healthy members of the family? The cleanliness of the living area and the locality also affects health.

### Death of mothers and new babies

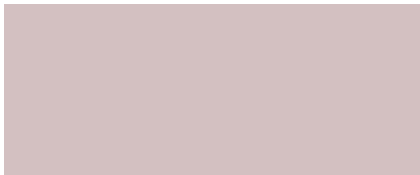
Illiteracy is one of the facts that pushes parents to accept early age marriage for their daughters when they are as young as 14. As a consequence, the death rate for both mothers and babies is increasing. Many unwanted pregnancies add to the problem. Parents fail to take care of their children and sometimes they have an abortion which leads to serious gynaecological consequences. There are also sexually transmitted infections such as HIV/AIDS thanks to prostitution which results from the failure of child-care in poor families.

Methods of disposing of kitchen waste to the simple issue of taking care of laundry became important factors in keeping the family healthy.

With the quantum advances made by the medical fraternity, the benefits of health care are being reaped by many. However, there are a lot of instances where the saying "prevention is better than cure" is applicable, especially to the lower-income families. A huge number of casualties are accredited to common diseases like malaria, diphtheria, polio (all, in part at least water-born diseases) and tuberculosis and whooping cough (air-born diseases). These are some diseases which can be prevented easily if the family improves its living environment, drinks boiled water, quarantines the diseased family member and ensures adequate medical assistance for them.

In this materialistic and competitive world, there are so many responsibilities bestowed on an individual from his first

breath to his last that he is left with no time anymore to love and take care of himself or his family members. The race for being successful is so fast that man has become nothing more than a robot, fighting to go ahead and in turn getting the worst incentives like stress and depression. The number of young people from the age group of 15-20 committing suicide and undergoing depression, the increase of breaking families and divorces, are clear evidence of the imbalance of the human mind and environment. Family is the biggest support of a man, but if a man is not healthy then the same support becomes a burden. It's the family that provides a clean and stress-free environment for an individual to grow and develop. Health is not just a family concern; it is very much a state concern too because it is only healthy families that make a healthy nation and in turn a developed and peaceful nation.



## MYANMAR/BURMA

Most families live together as extended families to save expenses. A plot of land and renting a house is not affordable for the middle classes. So how are we living? – Either in Church compounds, or living with parents or with friends or relations and looking after their land. What about a family's income? Without mentioning income we cannot talk about health. The head of the family is the man. Middle class people or government employees will not earn enough to buy a 50 kilo rice bag, the very basic principal food. What about oil, vegetables, salt, firewood or electricity? The majority of the family have to work extra hours just for daily living. Most of them fall into debt. Once you are in debt, you will never escape from it.

So what will happen next? Health becomes the problem. Even for daily living everyone has to struggle really hard. If you become ill, most of us use traditional medicine which is cheap and get advice from friends and medical personnel. If you get well, there is no problem. If the illness becomes serious,

then you may meet the local GP once or twice. Medical care in Myanmar is not free: cotton wool, spirit swabs, bandages and tablets all cost, as do the consultation fees. By the grace of God most people are near to God because they are frightened to become ill. God's blessing is asked each day to overcome. There is no future as Christians among the majority Buddhist community.

This is about urban areas. What about rural areas? Life ends at 40. There are fewer resources, less educated and more extended families. Malaria, tuberculosis, gastro-enteritis, worm infestations are common.

So among families health is a major issue. What can we do about it? We must do something for our fellow Christians in Myanmar to help provide clean water, mosquito nets, nets for fishermen, farming equipment for farmers, shelter and medicine.



## EGYPT

### A holistic approach

For us (The Episcopal diocese of Egypt) Jesus is considered the first pioneer in using the holistic approach in reaching out for the community and developing it. He touched people's needs in every way and as we are His servants we are called to do the same. For this purpose, the diocese has committed itself to invest in human resources and use a holistic approach in community development.

For any country in the world that aims at developing its community, human resources is the key word for money investment. To ensure a better future,

both health and education sectors have to occupy the first priority in planning and improvement.

One of the important aspects of real development is health, and for that reason, we have taken initiatives in many poor areas to start health-awareness programmes especially for women and young girls. We serve in areas like Ain Shams, Medinet el Salam, El Nahdah and Sadaat city.

The most common feature in the areas we reach out to is poverty. The population is characterised with bio-

diversity where some emigrated from Upper Egypt in an attempt to find better jobs and places to improve their livelihood. Others suffered from living in old buildings that were demolished or collapsed and the Government resettled them in cities like Medinet el Salam or El Nahdah. People are poor in terms of minds and hearts as well as in relation to money.

Therefore, in designing awareness programmes for these areas, health-related issues are raised to rectify the wrong inherited beliefs in addition to providing new information about feminine topics (issues related to circumcision of girls, family planning, personal hygiene, and menstrual cycle etc). The information is usually presented in a form of brainstorming discussion, in addition to illustrative materials. The social workers' role is to get the wrong information out from their group; exchange opinions, then present the rectified information to them.

In some areas, there is a gynaecological clinic along with the awareness programme, where the doctor acts as a social worker as well in providing the right information to his patients.

We believe that we care, but Jesus heals and transforms lives.



## Wells of 'killing' not 'living' water

Wells have a mythic status in many cultures; from European folklore in which throwing a coin into a 'wishing well' makes a wish come true, to blessed wells associated with a Saint with reputed healing powers. In the Bible, with most of the narrative taking place in semi-arid or desert areas, wells are naturally key to many of the accounts. God opens the eyes of Hagar, cast out due to Sarah's jealousy and about to die of thirst, to a nearby well (Genesis 21:19). Then Isaac (Genesis 24) and Moses (Exodus 2:15) both meet their wives at wells and many more accounts follow right through the Bible with Jesus Christ having one of his most significant conversations with the Samaritan woman at Jacob's Well, whom Jesus offers 'living water' (John 4). Wells are so important within the Bible and in folklore because a good clean source of water is essential for the life of all societies.

Every year three million children under five years of age die of diarrhoea and this is also a major contributor to malnutrition for both children and adults in the developing world. In Bangladesh the percentage of infant deaths caused by diarrhoea was probably one of the highest, but has recently been much reduced. The solution has been a well: a simple, strong, hand-operated pump that draws water, through a pipe from the shallow groundwater beneath. During the 1970s and 1980s the Government, UNICEF, international agencies and many of the poor, with low-interest loans from NGOs, installed wells by their homes, amounting to over four million

countrywide. I recently spoke to Hassan who spoke of his happiness and pride when he installed a tubewell in his courtyard. He had to save for some time to afford it, but it made life so much easier for his family, especially the women, who no longer had to trek long distances and the children weren't sick so often. Wells again had become a powerful symbol of a new and more promising life.

Now try and imagine how Hassan felt when Rebecca, a local woman testing his well for arsenic, discovered dangerous levels – 40 times higher than the safe limit in the water. This explained why his friendly neighbour who shared his well had developed a deadly cancer, why his previously attractive young wife's skin had become rough with dark blotches, why he frequently felt too weak to farm his land and had the early signs of gangrene of his foot, why his elderly aunt had got very sick and died and his youngest child had been born badly deformed. His prized well that he had spent his precious savings on had brought death and sickness to his loved ones. 'Utter devastation' could not come close to describing how he must have felt.

Hassan is a character I have created, but the details and scenario are real enough. In over 100 communities where the Church of Bangladesh Social Development Programme (CBSDP) works, this nightmare situation is repeated many times over; there are in effect many Hassans each with a heartbreaking tale. In one small village, Bholadanga, over 35 people have already died from the slow painful effects of 'the

king of poison' while in another village, Alumpur, over 400 people are already showing symptoms as over 90% of their wells are arsenic-affected.

The arsenic is naturally found in Bangladesh's groundwater, deposited with the water that flows from the Himalayas, along with rich soils, over millennia in this 'land of rivers'. It wasn't until the wells were sunk into ground layers that had accumulated the arsenic that it became a problem. As arsenic has no colour, smell, or taste, it was not until the first symptoms and death that the poisoning became apparent. The CBSDP has been identifying contamination through testing wells, giving vitamin treatment that, along with safe water, aids recovery and providing alternative sources of water, such as very shallow dug wells that go above the arsenic-contaminated water levels. Other options for arsenic-safe water include deeper tube wells that go below the contaminated water, filters and rainwater harvesting. But the need is immense as over 40 million people in Bangladesh are currently drinking arsenic-contaminated water and the resources committed to tackle the problem are vastly insufficient. Please pray for us that God will help us to make a difference and that the Church of Bangladesh will be able to offer 'living water' in more than one sense, so that the families now drinking 'killing water' will live and their suffering will cease.

### The impact of mental illness on one family

According to a professor of psychology, those who have experienced trauma describe their lives as 'before' and 'after' the event. I can appreciate this statement since our son's return home after two years of independent living and his being hospitalised within 24 hours with a problem later diagnosed as 'mental illness'. It was traumatic for all members of the family as the journey of learning how to manage the illness began. The next two years were a terrible roller-coaster ride.

Schizophrenia has been described as a roller-coaster ride without a switch. Family members watch helplessly as a loved one goes from one crisis to another. The clinical term 'episodic' does little to relieve the trauma that follows the diagnosis. The onset of this disorder usually occurs between 15 and 30 years of age and most commonly in the teen years. As is to be expected, it is very difficult for the young person to accept the label of illness and the necessity of taking medication.

There were people who told us to walk away but it was not an option for us. We searched for help and found an organisation that offered support and education to families struggling with mental illness. We learned many things about the illness and were able to share our experiences with others who truly understood our pain. We found strength in knowing we were not alone. The knowledge that 'insight' (when the ill individual begins to understand that the illness can be managed) could come with time gave us hope. Progress was slow with many ups and downs but hope prevailed and with medication and support our son's life stabilised and he returned to school, earned his diploma in welding and became employed. Yes, life was divided into 'before' and 'after', with rejoicing for the return of the son we love.

In our story and in the stories of others suffering from mental illness, the key word is 'manage'. If someone suffers from diabetes, medication and lifestyle are keys to the management of the

imbalance in the body. Research has shown that an imbalance of chemicals in the brain are a key factor in mental illnesses and with new medications, as with diabetes, one can learn to manage the imbalance and lead a productive life.

It has been said that creativity often comes out of suffering. The founding of Mental Health Estrie (see below) to support other families as they journey with a loved one is proof that creative goodness can come from the suffering individuals encounter in life.

May our story help to erase the stigma associated with mental illness and create a new depth of understanding.

### Facts about mental illness

Mental illness are words which frighten people. The greatest fear comes not from what people know about mental illness, but from what they do not know.

Fear of mental illness needs to be confronted and openly discussed. Some people are afraid that they might become sick themselves. Others believe that the individual who is sick has a weakness in their character – they made themselves sick and consequently can make themselves well. Many believe that a person diagnosed with a mental disorder will always be sick and will probably get worse. These are myths; nothing could be further from the truth. Mental illnesses, like many physical illnesses, are treatable.

Mental disorders are prevalent in all societies. No country is exempt as the percentage of the population with mental illness is constant around the world. One in five people will experience a mental illness at some point in their lives. If someone states that they do not know of this problem in their community, they need to look around with new eyes.

In Canada, until recently, the number one consumer of medical budgets was mental illness – and no one talked about it. Presently it is the number two use of hospital beds after accidents – and no one talks about it. But progress is being made and much of this is occurring at the 'grass-roots' of our society.

AMI-Quebec Alliance for the Mentally Ill, a volunteer community organisation located in Montreal, is an example of what a few concerned people can accomplish. This organisation began some 28 years ago when four families, all with loved ones who were mentally ill, came together to talk and to share. Simple, yet radical.

It has been the inspiration for the development of Mental Health Estrie in a rural area some 100 miles from Montreal. Its mission is to help the minority population of English-speaking families, totalling some 20,000 persons, living in pockets of relative isolation over a fifty-mile radius. In only four years, a volunteer Board of Directors of seven committed individuals has formed and established an office with part-time staff. Support groups are held on a regular basis. There now is a comprehensive resource centre including a lending library of books and videos and free pamphlets. Special educational events and public awareness are a priority and there are many plans for the future.

The power of people sharing, caring and learning together is strong and it challenges the stigma. With the diminishing of stigma comes openness, a willingness to seek treatment and the recovery of hope. The motto of AMI-Quebec and Mental Health Estrie is "the recovery of hope and the hope of recovery."

You may think all this was possible because of the prosperity of Canada. But prosperity does not necessarily mean that social problems are a priority for the decision-makers. Many social problems are being solved by wonderful dedicated volunteers. Is this model of 'grass-roots' action possible in other countries? The answer is a resounding 'yes'. An important note needs to be added here: community volunteers can do much to help families in the turmoil of mental illness but the medical diagnosis and treatments are the domain of the medical professionals, not volunteers.

It is helpful to remind ourselves that only a few years ago, HIV/AIDS everywhere carried a huge stigma. Now, in many places, people suffering from HIV/AIDS are seen as victims of a dreadful disease with efforts being made worldwide to deal with the impact. This disease has been with us only a few decades – a nanosecond of time compared to mental illnesses. The same evolutionary process of openness, a willingness to learn and discussion is needed to remove the stigma of mental illness. It is time to stop turning a blind eye to the impact of mental illness and to stop pretending there is no problem. Concerned individuals and community support groups can and will make the difference.



## ENGLAND

### Editorial Note

*Currently, there is considerable concern in UK about children's unhealthy eating habits which are resulting in obesity and other health problems. Efforts are being made to ban advertising for 'junk foods', lessen sugar and salt intake and promote the eating of fruit and vegetables in school and the home.*

### Healthy eating sessions

The Pendle Family Support Project in Blackburn Diocese works with families

who are struggling to cope, and the Parent Support Group grew through a few mums who wanted to meet and receive teaching on issues which would help them and their families. All agreed that they had problems getting their children to eat 'healthy' foods and there was also much discussion about what 'healthy' food actually was.

One session concentrated on healthy lunch boxes for children. Dried fruit,

different sorts of bread and low-fat snacks were all brought in for parents to try. Other combinations of food were also suggested. When they realised the cost of these was not particularly higher than the products they were already buying, they were surprised but realised that their children would benefit from this.

Other sessions were more hands-on, giving the parents a chance to make and taste various dishes, using vegetable protein instead of meat and using healthier ingredients for dishes such as pizza, which most parents agreed was part of the staple diet in their homes. They were encouraged to make their own pizza bases and to use low-fat cheeses, fresh tomatoes and tuna; all ingredients the parents admitted they would not have thought to buy.

As bad diet is a major concern to health workers in many parts of England, 'Grassroots' Family Support in Pendle Parent Support group will hopefully be the forerunners of changing eating habits in the area.

## HIV/AIDS

### BOTSWANA

Much has been written about HIV and AIDS in the African continent, particularly the Saharan region where Botswana lies. The continent is reported to be home to 10% of the world's population yet constituting two-thirds of all people living with HIV. Families in this region are thus placed in a specially vulnerable situation.

HIV first surfaced in this country 20 years ago. It has since been ravaging like a fire, taking a large toll of life; with the relevant impact on the structure and health of the family and the population. Estimates of the prevalence have been made over the years, the most recent being a national prevalence of 17.1% (19.8% for females and 13.0% for males).

### Effect on the family

The effect of HIV on the family is multi-faceted: prolonged illness, loss of earnings, loss of educational opportunities and loss of life. The last has been the most devastating. Death has been in the age group that is child-bearing and economically family-supporting. This has left older members of the family with the burden of orphans to be cared for by members of the

family who are largely economically unproductive. Presently it has been estimated that orphans constitute 16.7% of all children aged 0 – 18 years. Such children are left in the care of members of the family, mostly grandparents. Incidents of grandmothers taking care of up to six grandchildren, orphaned through the loss of two daughters who were heads of female-headed households, are not

uncommon. These same grandmothers will have spent many months caring for terminally-ill daughters. This paints a gloomy picture and depicts a lot of suffering at individual family level. Interventions at various levels are, however, in place and bring some relief.

### Prevention of infection

National programmes have been instituted for limiting the spread of the disease

### Emphasis is laid on:-

- behavioural interventions highlighting abstinence, faithfulness to partners and use of barrier methods during sex
- monitoring of blood donors to ensure virus-free blood in the blood banks
- education of health workers on safe practice in the use of needles and care of patients
- education of relatives in precautions to be taken when nursing relatives at home
- prevention of mother-to-child infection through testing of mothers at antenatal clinics, relevant treatment of the mother and administration of suitable intervention to the baby at birth
- encouragement of youth, particularly those aged 12 to 19, to delay age of first sexual activity.

### Commitment from Government

On recognition of the situation, the Government has shown commitment to programmes against HIV/AIDS.

- Voluntary testing after suitable counselling is available for all at no cost. Early detection makes treatment possible before the disease takes a firm hold. Willingness to use the voluntary testing centres is increasing and the benefits of early intervention are being realised by the population.
- Antiretroviral treatment has been made available to all nationals since the year 2002. An estimated 40,000 citizens are enrolled in this programme. Parents are able to live a healthier life, carry on in employment and bring up their children.

### Supporting structures

- Assistance is forthcoming from various non-governmental and international organisations. Locally, community groups – youth groups, religious organisations, women's groups and more recently men's groups – all join hands in education and motivation towards prevention and, if necessary, support of families confronted by the scourge of HIV/AIDS.
- Orphan care. At Local Government level, orphans are registered and provisions and money are provided at monthly intervals to the families caring for them.
- Although there are yet no government orphanages, homes have been established by organisations such as the SOS Village Association.
- Home-Based Care. This is available for families in several centres, both rural and urban. Because rural families do not move as often as urban families, this programme is well established and stable in the rural areas because home-

based carers always find their clients. The staff of home-based care are mostly retired nurses with their characteristics of empathy, patience and a caring attitude. They enjoy trust and respect from the people they care for. A couple of 'day care' hospices have been established including one run by the Anglican Community in Gaborone.

### Looking ahead

Elimination of the stigma of HIV has been given high priority. This is slow. Blame can partly be apportioned to the way the diagnosis and management was first handled by health administrators and workers. If such a phrase can be used for such a devastating disease, a 'glimmer of hope' can be provided by:-

- education and information about how HIV/AIDS is contracted, laying emphasis on dispelling the several myths which abound and misinform, leaving people vulnerable to infection
- strengthening the programmes of voluntary testing and treatment which have been proved to be of benefit, ensuring that they reach as many of the population as possible.

Despite Botswana being such a large country – (582,000 square kilometres; with a scattered small population over 1.5 million) – access to health care is such that every person in the country is within 15 km of a health facility and in every village there is a rural health motivator trained in the basics of family health.



## WOMEN AND AIDS

HIV/AIDS is not just a health issue, but also a development, gender, social and economic one, and should be regarded as such. To be able to conquer this social illness we require comprehensive and contextualised programmes and new language, which avoid stigmatisation and marginalisation and accept HIV/AIDS as a problem which affects everybody.

Recent data reveals that the proportion of women among those newly infected with HIV is growing everywhere in the world. Two-thirds of those newly infected people aged between 15 and 24 are young women and, according to The World Health Organisation in 2000, 14 million women worldwide had the virus.

Given the central role played by women in the reproduction, care and sustenance of human beings, a threat to their well-being as posed by the AIDS pandemic is a threat to the human race as a whole.

### Women's vulnerability to HIV/AIDS

Women's vulnerability to HIV/AIDS can be seen to be a product of a combination of factors: for example, their biological make-up and social, cultural and economic factors which combine to make women more vulnerable than men to sexually transmitted infections, including HIV.

#### 1. Physiological/Biological factors

- Women's biological make-up makes them more vulnerable to HIV infection. It is believed that women are three times more likely to get infected from a single sexual encounter than men.
- This is due to the fact that women have an extensive surface area in their sexual and reproductive organs which are easily damaged, thus allowing easy entry of the virus from an infected partner. This is further compounded by the fact that semen remains in the vaginal canal for a long time after sexual encounter.
- Vulnerability is made worse in young girls, by the false belief that the younger the woman the less the likelihood for her to be infected, leading to some men – some of who may already be infected – targeting young girls for sex. There is another false belief that sex with a virgin cures HIV/AIDS.

#### 2. Economic factors

Poverty and marginalisation, disempowerment and traditional gender roles all combine to put women at a higher risk for HIV infection.

### 3. Socio-cultural factors

Some of the cultural practices which lead to increased risk to HIV infection are:

- Use of herbal and other agents to dry the vagina during intercourse. Use of such substances may cause erosion and inflammation of the vaginal wall leading to easy entry for the virus.
- The practice of female genital mutilation also exposes the young girls to added risk of contracting HIV/AIDS.
- Widow inheritance, as well as certain widowhood rites, are practices that pose an increased risk to women.

- Polygamy has also continuously been cited an added risk.

Violence against women, which is often overlooked, is also a contributory factor to women's vulnerability. Domestic violence robs women of their self-esteem and confidence and may lead some to leave the family home, throwing them into poverty and destitution which are factors that enhance vulnerability.

HIV/AIDS impacts differently on women relative to men due to their dual role as bearers and nurturers of life. It falls upon women mostly to care for those within their families and other relatives who get infected. The death of a partner through HIV/AIDS more often than not exposes the woman to being ostracised by family and friends. Widowhood is also the

beginning of destitution for a majority of women whose dependency for a livelihood is on their spouses.

The daily care of people living with the virus as well as that of AIDS orphans also falls on female relatives, often an older sister. This brings further vulnerability to the female orphan who may have to drop out of school to take care of her siblings. Without proper information on how to prevent themselves from getting infected while taking care of the infected relatives, women are also at risk of infection.

## SOUTH AFRICA

The challenge of health and family is nowadays very high, especially in the rural areas. This is caused by the pandemic of HIV/AIDS and the refusal (in other areas) to accept the brutality of this disease to the people. In many rural areas, the stigma of being HIV-positive in the community is so high that people find it difficult to disclose their status. As a result, the virus easily infects old people who are usually home caregivers. The myth of being bewitched or poisoned is still a scapegoat.

In one area, an old woman (who worked lands and collected firewood in order to get money) cared for her granddaughter who was very sick. She washed her with charred hands without knowing her health status. Worse, she did not tell other people of the nature of the sickness (because of ignorance). She bathed her sores. It was very late when she disclosed her suspicions to the Sister of the Community of the Holy Name in Zululand. The Sister advised her to use gloves and provided her with some. The woman was later diagnosed with HIV/AIDS and died. She is not the only victim. The denial of the existence of this

disease is causing people to visit traditional doctors who claim they can cure them by providing vomiting herbs.

Unemployment and retrenchment have caused a lot of havoc on health issues among families. They are no longer able to attain healthy and nutritious foods. Young mothers are too busy with their own lives to plant vegetables for their children. To make a difference in the people's lives, the Sisters of the Community started a drop-in centre for orphans at Isandlwana. The Committee, which includes the local nursing sister, priest and the local chief together with the Sisters, does the selection of the needy children.

Teenagers' and young adults' pregnancy and divorce have caused many families to separate. The Christian Education Department and Sunday school have programmes such as parenting. These programmes help the young mothers and the grannies (who are hurt and angry because they find themselves playing the role of foster parents to their orphaned grandchildren).

While cases of incest and rape among

families are so many and escalating, the Teaching Sisters are doing tremendous work in counselling children and parents. Some cases are referred to the Psychology and Guidance Services in Education. The pathetic part is that some parents prefer to deny everything, accuse their children of lying and rather side with the rapist. The Sisters also identify needy orphans in schools, to help provide basic needs as some are also HIV-positive.

## USA

**The HIV/AIDS epidemic is far from over** HIV/AIDS is more than a public health issue. It is also a social justice issue... an economic issue... a human rights issue.

The National Episcopal AIDS Coalition (NEAC) was founded in the US in 1988 as a community of faith, hope and action, offering understanding and spiritual comfort not only to those infected but to their families and to those who minister to them. Today, as HIV continues to spread in spite of treatment breakthroughs, NEAC must battle complacency as well as prejudice. It is fighting to reduce the stigma of HIV/AIDS that affects not only those infected but everyone who associates with and ministers to them. The epidemic is far from over in the U.S. and other developed countries. In the U.S. death rates are going up among vulnerable and forgotten populations. Rates of infection among African-American men in places like Newark and Chicago are as high as in some of the hardest-hit areas of sub-Saharan Africa. At the same time, infection rates are going up among

affluent older people as well, though poor, rural, and minority communities continue to be hit hardest.

As one commentator noted, "When someone finds out you're HIV positive or have AIDS... you can lose your wife, your kids, your job, your business partners, and the support of your church." It is not unheard of for a pastor to refuse to officiate at the funeral of a person who has died of AIDS-related problems. Nor is it unheard of for families, and communities, to ostracise those infected.

Fortunately, it is also not unheard of for people like the individuals and organisations that are members of NEAC to offer support and information. In addition to advocating for a compassionate and ethical ministry, a major NEAC concern is to educate the public, especially Episcopalians, about the disease. To that end, NEAC is revising its popular Teen AIDS Prevention curricular, which is designed to teach teens to be peer educators and provides scriptural resources to support the public health information it offers. Last year NEAC issued the second edition of Youth Ministry in an Age of AIDS, which provides information for adults about the risks that adolescents face and offers easy-to-use lessons for opening a dialogue with young people about HIV. This free resource is guided by General Convention resolutions to promote abstinence and monogamy as well as offer instruction on disease prevention. The NEAC AGAPE (All Generations AIDS Prevention Education) project is working to create similar resources for people over 50.

A recent study found that the proportion of adults who believed that a person infected with HIV through sex or drug use deserves to have AIDS has increased in the 1990s. NEAC is working to reduce that kind of ignorance and to recommit the church in the US to the mandate in the Episcopal Church's baptismal covenant to "seek and serve Christ in all persons" and to "respect the dignity of every human being."



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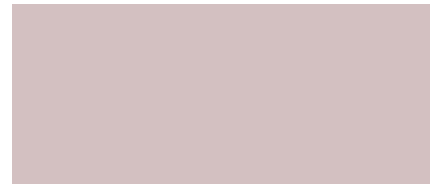
## HONG KONG

### St John's Centre

A Filipino woman, Helen, came in the Centre early in one morning. She was totally lost. She kept on talking about her story. At first we were puzzled. As she continued, we began to put the pieces together. Helen was dismissed after serving her employer for only two weeks. She came here in late August this year. In a recent health check-up, she was notified that she was HIV-positive. Helen was a single mother with two kids. She had no idea how she got the HIV virus. When she arrived in the Centre, Helen was in a confused condition. Her story is just the tip of the iceberg. Hong Kong has a total population of 6.7 million, and 5% of them are non-Chinese. The majority of them are females serving the local families as domestic helpers. In 2003, the Centre conducted a questionnaire survey to identify AIDS knowledge, attitudes and practice amongst the foreign domestic helpers. The findings revealed that the majority of them had minimal knowledge of reproductive health. To serve the needs of these workers, the Centre organises a series of activities including health talks and outreaching activities in areas where migrant workers meet, such as Wanchai, Victoria Park and Central. Additionally, a large-scale cultural performance is organised annually to raise their AIDS awareness. The Project has been going on for some time, and it gradually gets the support of the foreign workers.

The HIV Education Centre of the St. John's Anglican Cathedral was the first (and is so far the only) faith-based institution to undertake the AIDS ministry in Hong Kong. The Centre is 10 years old this year. Its goals are to raise AIDS awareness amongst the general public and help create an AIDS-free society for our generation. All the

services are available to anyone regardless of religion, sexual orientation or nationality.



### PRAYER

ALMIGHTY GOD, giver of life and health, help families in every country to enjoy, use and protect your gift, with thankfulness of heart;

SON OF GOD, SAVIOUR, healer of children, women and men, strengthen us in providing medical care and loving support to those afflicted in body, mind or spirit, and to their affected families;

HOLY SPIRIT OF GOD, giver of wisdom and power, guide us in caring for the environment in which families live, in addressing the need for nutrition and safe water, and in deepening awareness about health.

**Amen**

*Rev'd John Bradford*

**THE NEXT FAMILY  
NETWORK NEWSLETTER**  
The next IAFN newsletter,  
to be published in the  
**Easter 2006 Anglican World**,  
is to be on the theme of  
**Acts of Terror and the Family.**

Visit the Family Network website: [www.iafn.net](http://www.iafn.net)

The views of individual contributors do not necessarily reflect those of the International Anglican Family Network.