Sr. Dr. M. Agnesita A C

Author Bio

I recently read the book "**Across the Seas**", a concrete yet powerful narration of the real life experiences of Sr. Dr. Agnesita during her service as a medical doctor in a remote village in Kenya, Africa.

S.Agnesita Mary, my elder sister, is a member of the Apostolic Carmel Congregation of Sisters. A qualified medical doctor, she is now in her eighties. She completed her medical graduation at St John's Medical College, Bangalore, India, and later obtained her MD from the All India Institute of Public Health, Calcutta. She worked briefly at St Martha's Hospital, Bangalore, and Holy Family Hospital, Patna. However, she soon realized soon that her calling was not to serve in cities, but among the poor and the marginalized.

In 1977, as she had aspired, Sr. Agnesita was assigned to a remote village called Palliagaram, in Chengalpattu District, Tamil Nadu, India. Although her primary responsibility was to serve as a doctor in the local clinic, she never confined herself to the four walls of the hospital. She reached out extensively to surrounding villages and communities afflicted by poverty, illiteracy, ill health and bonded labour. She showed particular concern for persons with disabilities and established a special school for the intellectually challenged, as well as integrated education facilities for children with hearing and visually impairments.

At the time of her transfer from Palliagaram, there was visible and significant improvement in the villages – especially in health, education, confidence, self-sufficiency, and the overall economic condition of families. This transformation was largely achieved by empowering women in every sphere of life. The journey, however, was not easy. It involved tireless dedication, struggles, resistance to change and countless challenges. *'HEALTH FOR ALL, A RIGHT AND A POSSIBILITY, My JOURNEY WITH PEOPLE AT THE PERIPHERY'* is her first book, documenting her more than twenty years of mission in Palliagaram.

In the year 2014, Sr. Agnesita received another assignment in Kenya, Africa, in a remote and little-known village called Kimwanga, situated close to the Uganda border and far from Nairobi. While the context was different- a new continent, culture, language, food habits and belief systems-the core mission and approach she adopted remained the same. She soon discovered that the sufferings and challenges faced by the people there, were strikingly familiar to those she had encountered in Palliagaram. ACROSS THE SEAS narrates her mission and experiences in Kenya. My wife

Caroline, and I have personally witnessed Sr. Agnesita's work and mission during our visits to both India and Kenya. I now leave it to the readers to hear directly from Sr. Agnesita as she shares her journey and reflections on her mission in Kenya.

I pray that Sr. Agnesita may continue to be showered with God's abundant blessings – especially with good health – so that she may carry on her service to the less fortunate as an instrument of the Almighty. I wish her every success in her mission.

(Alphonse Vazhappilly)

Acknowledgement

I am filled with joy and deep gratitude for having had the good fortune to live in Kenya for ten years. I can never sufficiently express my sentiments of thanksgiving to God for His loving plans for my life. Sr. Susheela A.C, the first Regional Superior of East Africa Region and later the Superior General of the Apostolic Carmel Congregation, was the instrument and inspiration for my coming to Kenya. She also encouraged me to pen down my experiences of those years for which I remain ever grateful. Sr.Nirmalini, the present Superior General of the Congregation was very supportive of my initiatives in the Health Ministry for the poorer sections of Kenyan society. I pray God's blessings on her.

I will always remember with joy and gratitude Sr. Winifreda A.C and Sr. Maria Deepthi A.C, the Regional Superiors of the East Africa Region of the Apostolic Carmel Congregation. They enabled me to initiate and implement the projects that I had envisioned for the health and welfare of the rural population of Kenya. Their wholehearted support and encouragement allowed these initiatives to proceed as planned. Sisters Ancilla A.C, Karuna A.C and Maria Jessina A.C, the Provincial Superiors of the Southern Province of the Apostolic Carmel Congregation, consistently showed great interest in my mission for the people of Kenya. I am ever grateful to each one of you dear Sisters. My special thanks to Sr.Jessina for writing the foreword for this book.

My elder brother Jose Vazhapilly and my younger brothers, Johnny, Kurian, Alphonse and Sebastian stood by me as strong pillars, boosting my spirit as I ventured into unfamiliar paths in my ministry among the poor and downtrodden. They also extended generous financial support for my projects, ensuring their smooth execution. Alphonse designed the cover page of this book .By writing Author Bio, he provided the connecting link between my two books. He was interested in reading this book and in this process, he identified gaps from a reader's perspective, enabling me to address them effectively. May God bless them and their families with good health and lasting happiness.

Many are the Apostolic Carmel sisters who encouraged me in penning down my experiences. I mention a few of them who read through this little book and offered their appreciation as well as suggestions for improvement. I name a few of them here: Srs. Lira Morais, Liceria, Jessie, Violita , Margaret Mary and Sudeera. My heartfelt thanks to every one of you dear sisters.

Dr.Geetha, despite your demanding schedule as a Professor and Head of the Department of Psychiatry at John Hopkins University, Baltimore, USA, you generously reached out to different countries, offering your expertise and making psychiatric services accessible to rural populations in distant regions. The villages of Kimwanga and seventy-eight other villages in Bungoma County, Kenya, were privileged to benefit from your services. On behalf of all of them, I extend my heartfelt gratitude to you.

Drs. Ravi Narayan and Thelma, if it were not for both of you, I would not have attempted to write this book. Thanks for your interest in my health ministry both in India and in Kenya. A special word of thanks to Dr. Ravi for generously volunteering to write an appreciative summary of this book and for helping with its publication. May God bless you abundantly.

Sr. M. Agnesita AC

Foreword

Kimwanga – a tapestry of rolling fields, sun-kissed huts, mud-plastered homes capped with tin roofs, emerald maize swaying against amber hills, and children's laughter spilling over dust-kissed lanes. It was here that Sr.Agnesita, a medical doctor, first greeted the village from a modest balcony overlooking its heartbeat. It was a beginning-perhaps the spark of a noble mission, a journey Across the Seas, a luminous tide that rides the wind, forever echoing the promise of a sea-born destiny.

Across the Seas, written by Sr. Dr. Agnesita, chronicles the luminous journey of a medical doctor who answered a divine call to serve in the farthest reaches of humanity. In the annals of humanitarian endeavor, the real-life experiences of Sr. Agnesita- first at Palliagaram in Tamil Nadu, India and later in Kimwanga, Kenya -stand as a testament to the transformative power of compassion and selfless service to people on the periphery. Her mission in Africa remains a living witness to hope made tangible.

Step by step, she developed programmes that touched every facet of community life. Beginning in a classroom hospital, her mission evolved to establish the Carmel Dispensary-a beacon of hope in the periphery. In this remarkable journey chronicled in the book, we encounter a narrative of profound impact. From the dust-kissed lanes of Palliagaram to the grass-carpeted Kimwanga, her story is one of luminous service: treating illness, educating communities on health, combating addiction, nurturing mental well-being, and empowering women. Each effort became a stitch in the tapestry of a transformed community- an unknown village connected to the global village not by wires or roads alone, but through the universal language of compassion and care.

As you glide through these pages, you will be dazzled to witness school dropout girls blossoming into certified health workers; women's circles evolving into nimble teams that share home-care skills, facilitate open dialogue, and guide families in forming pocket –sized saving groups. The narrative also captures the steadfast presence of Bishop Norman Wambua and Fr. Marcellus Auma, the God-sent shepherds, along with Mr.Maurice Wanjala, Nicholas and Mary – the compass points that oriented her mission. Their whispered assurance, "God comes to the aid of His Servant," echoed through time and season, reminding us that humanity's desire to do good never wanes.

This book stands as a testament to how one dedicated physician, armed with faith, science and relentless compassion, can stitch together a tapestry of dignity, health and hope. In every page, readers will feel the pulse of a community healed, empowered, and finally seen- a living proof that when love meets skill, even the most remote periphery can become the centre of the world.

Dear Sr.Agnesita, our heartfelt thanks, deepest gratitude, and sincere appreciation for infusing your words with life and transforming them into vibrant, breathing images that touch the soul. May blessings flow like a river along your path as you continue to extend God's healing touch each day, working tirelessly, for the less fortunate with the outstretched hands of the Almighty.

Sr. Maria Jessina, A.C

Provincial Superior, Southern Province

A.C.Provincial House, Kozhikode- 673 009

From Chengalpattu, Tamil Nadu to Kimwanga, Kenya:

An Inspiring Johnite Tale in Community Health

A Short Introduction

Dr. Ravi Narayan (Batch of 1965)
SOCHARA, Bengaluru

This is an introduction by a fellow Johnite (Batch of 1965) to a most inspiring Johnite colleague, Sister Dr. Agnesita AC (Batch of 1968), the first Sister Doctor who took Community Medicine as her vocation. Professionally trained in M.D at AIIIPH, Kolkata she spent her career in the villages of Chengalpattu District in Tamilnadu. Later at an age when most of us contemplate retirement, she made the courageous decision to go overseas and work in the village of Kimwanga and its surrounding communities, in Bungoma County, Kenya.

I had the unique opportunity to read and review, her most inspiring earlier story of building community health as both vocation and mission in the villages of Chengalpattu District. That work titled "**Health for All - A Right and Possibility: My Journey with People at the Periphery"** remains a powerful narrative**.** I have now completed a review of her second book; a collection of reflective chapters titled **Across the Seas**. This latest compilation is an inspiring, touching and deeply insightful story of Sister Dr. Agnesita's second innings in Community Health-undertaken at an age when many others choose retirement. True to her courageous faith and professional commitment to the values of her Congregation and the motto of our Alma Mater, Sister Agnesita embarked on a transcontinental adventure to work in community health in the interior regions of Kenya, in the small village of Kimwanga and the surrounding cluster of villages.

This Story of Kimwanga covers a wide range of unusual experiences and challenges. The chapter titles are evocative and offer readers a sense of the multi-dimensional and multisectoral challenges of grassroots community health. That Sister Dr. Agnesita, undertook this mission for the second time, so late in her career, stands as a testament to the missionary spirit she embodies. The Chapters include: Incubation Period; Market Women; Birth of a Clinic; People are out there; Ready to Grasp and Grow; The Clinic comes of Age; Everything is Possible for God; No half Measures;

A Global Village; Go out and Spread the Good News. To ensure that this small yet deeply inspiring book reaches a wider audience, we at SOCHARA have offered to Sister Dr. Agnesita –an esteemed Johnite colleague and Community Health visionary- our support through the SOCHARA network and website.

Another very important dimension of this remarkable work, and one that serves as an example to all of us, is her ability to establish a meaningful and productive working relationship with her classmate Dr. Geetha Jayaram. A socially sensitive and highly innovative Mental Health professional from John Hopkins, Dr.Geetha not only provided support and solidarity but actually facilitated an overseas mental health project supported by the International Rotary funds. The funds were routed through the Rotary Club of Bungoma Magharabi. Dr.Geetha and her team from John Hopkins University actively participated in the training of Community Health Workers (CHWs) through regular visits, sharing their expertise and experience. However, due to the travel restrictions imposed during the Covid –19 pandemic in 2019, the training continued online. Once travel restrictions were lifted in 2022, the Staff from John Hopkins resumed their visits to Kimwanga. They visited the area three times between August 2022 - June 2023.

Geetha's and Sister Agnesita partnership, I hope will be a lovely story that will excite and inspire the Johnites to further strengthen the excellent Rural Initiative of the NA Chapters. We hope other regions also may follow suit promoting true Global partnership- not merely solidarity through funding and equipment, but through professional involvement and local training support. Sister Agnesita aptly titled this chapter in her book, A **Global Village**. Thelma, I and others were fortunate to have Sr. Agnesita as one among the few Johnites who were part of the first faculty team in the newly established Department of Community Medicine, which began in 1973 under the leadership of Dr. Marie Mascarenhas.

It was not merely a renaming of erstwhile department of Preventive and Social Medicine (1964-1973) but a complete shift in emphasis towards Community action, outreach, and social relevance. This change was inspired by the first evaluations of St. John's in 1972-73 and was further strengthened by the Cor Unum document and the Alma Ata Declaration. We all worked together in Mallur, Silvepura and four other villages with outreach included in the Dommandra PHC.

We also worked closely with the Action group for Community Welfare – a network of outreach centres in urban areas around the new St. John's Hospital. Sr.Agnesita later went to AIHPH, Kolkata to pursue her MD (PSM). Not many Johnites know that Sister Agnesita was one of the earliest, and perhaps the only, Sister Johnite in the first decade to select Public Health and Community Medicine as her preferred path.

I cannot help but quote the last paragraph of her epilogue which beautifully summarizes this unusual journey in such a humble way -so typical of the Sister Agnesita, whom we have known all these years.

> "*Fortunately, I had this opportunity to live in a different continent with people of a different race and culture. I had hardly time to master the language of the people. But our communication was at heart level. This communication is much deeper than mere words. People of the area, where I worked, instantaneously understood that I cared for them, loved them, and understood their difficulties and problems. The tears the people shed, when they heard that I was leaving Kenya, was a proof of their love for me and of course mine for them. They wanted to baptize me with a Bukusu name. They said that it looked as though I was a 'Bukusu' at heart and that I always lived there with them. They were simple people and did not hide their emotions. Men on the village roads would stop me and express their sorrow and disappointment because I was leaving the place. I assured them that the sisters would continue to take care for them. Whatever be their reactions the fact is that I enjoyed working with and working for the people there."*

I strongly recommend this book to every Johnite. Wherever you may be,

may it inspire you all to live the motto of St. John's.

These books will now be available online on our SOCHARA Website:
Please visit and be inspired.

Book one: Health for All – A right and Possibility. My journey with people

at the Periphery by Sr .Dr. Agnesita A C year 2013

https://archive.org/details/sochara.healthforallrigh0000agne

Books two: Across the Seas

https://www.sochara.org/wp-content/uploads/2026/03/Across-the-Seas-Agnesita.pdf

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Epilogue

Prologue

This book is a sequel to my first book***, 'HEALTH FOR ALL, A RIGHT AND A POSSIBILITY, My Journey with People at the Periphery'***. Both books are based on my real life experience of working with rural populations- the first in India, the present one in Kenya. Even though these two countries are located on different continents and their people belong to different races, there are many similarities in the life situation of the people, along with some obvious differences.

It was the year 2012, I was still in Bangalore. One morning, I received an e-mail from Sister Susheela, the Regional Superior of the East Africa Region of the Apostolic Carmel Congregation. "Two years from now," she wrote, "you will be free of your term of office as the General Councilor in Bangalore. Please plan to come to Kenya." I felt annoyed and apprehensive and did not respond to that mail. At my age of seventy-two years, was I expected to start life all over again in a different continent, among unknown people of a different race and culture? Months passed by, but Sister Susheela was not one to give up easily. She wrote again, "You need to come only for two years."

Strange as it may seem, in 2014, Sister Susheela was elected as the Superior General of our Congregation. I found myself in a predicament. I was now bound to obey her. She smiled at me and repeated her earlier words, "You need to be in Kenya only for two years." My apprehension and anxiety did not subside easily. "Sister, I do not have any blue print of what I would do there in Kenya, "I said. But she was firm and reassuring: "Oh that is not a problem. Just go there and everything will be alright,"

Well before my preparations to leave for Kenya were completed, she spoke to me again. "I am not sending you to Nairobi, the capital city of Kenya, but to a faraway place- Kimwanga, a village in Bungoma County. It is the last foundation that I started while there I was in Kenya. I would like the people of a low income group to benefit from our services there."

That was a welcome news to me. Any place, far away from the hustle and bustle of cities, a remote area on the periphery where people live in difficult conditions, would be a place where I would prefer to live and work. Bungoma was closer to Uganda than to Nairobi. Kimwanga, the village where I was expected to work, was just about twelve kilometers from the Ugandan border but nearly four hundred and fifty kilometers away from Nairobi.

Incubation Period

At last I was in Kimwanga, Kenya; to be with our sisters in the recently started convent in Kimwanga. It is a small village situated in Bumula Sub County of Bungoma County. Fortunately by 2014 – the year that I arrived in Kenya- the process of devolution, which involved transferring the powers of administration and governance from the National Government in Nairobi to the newly formed Counties (a form of partial decentralization), was almost complete.

The process of devolution was something like this: Each County had its own administrative system. There was a Governor, a Legislative Assembly, and Ministers responsible for various sectors, among others. Still, the Counties were not entirely independent of the National Government. They depended on it for finances, and policies related to education and health were framed at the National level. The Counties were responsible for implementing these national policies and ensuring that services reached the people. Citizens could present their grievances at County offices, making redressal easier and more accessible. In many ways, this system of administration was far superior to the earlier centralized system.

Otherwise who would have known this tiny village- Kimwanga- at corridors of power in Nairobi? Kimwanga would have been little more than a tiny dot on the political and geographical map of the National Government. Fortunately, County administration was closer to the people, and governance was further divided into Sub-counties, sub-counties into locations and locations into villages.

The sisters had already settled in the newly opened school building in Kimwanga. Some of the classrooms had been temporarily modified to serve as residential quarters for the sisters. There was a balcony overlooking the village, and beyond it lay the high way connecting Nairobi to Uganda. This balcony became my refuge during those initial months. I would stand there dreaming and absorbing the calm atmosphere of the village dotted with mud plastered, tin-roofed huts.

The front yards of these huts were covered with green grass where children played, women went about their daily chores, men chatted, and visitors were welcomed and food was served. Majestic silver oak trees and artistically trimmed green fencing demarcated homes and farms of different families. People seemed almost merged with nature. Surrounded by maize fields, their only hope was that their cooking pots would not be empty. Their prayer was that the weather gods would be favourable, that their children would not go hungry, and that adults would not starve, fall sick or die. They were marginal farmers depending solely on their tiny plots of land.

Incubation period is not an idle period. The body suffers violence and fights against the disease germs that have entered it. The temperature of the body rises indicating the struggle within. However, in the process, the body builds up its immune system, and if the body remains strong, the enemy is defeated and health is restored. It is an active, but slow and painful process. So I was there on that balcony watching the captivating landscape, with Mount Elgon lining the horizon during the day. The clear blue sky at night was equally enchanting, with glittering stars and a brightly shining moon that almost transported the mind to another realm of existence. There I stood remembering, recalling the past and dreaming, scheming and planning for the future. At times all seemed futile and hopeless, and dreams vanished as quickly as the passing clouds in the sky above me. "After all I am not going to be here for long. I am a stranger to the people, their culture and language. Will my ideas and plans be accepted? What can I accomplish alone here, when all the other sisters are engaged in the school?" I continued to dream and days passed into weeks….

"Are you dreaming?" asked Sister. Irene D'Souza. "You have some visitors", she continued. Three villagers - two men and a woman – were at the door. "Are you the new sister who has come to this convent? We also heard that you are a doctor. Surely, you will be of great help to us." I responded: "I do not know anything about the people of this area, the language, your problems and the village situation. So, how will I be able to help you?"

Nonetheless they were insistent. “Oh that is not a problem. We are ready to accompany you to our villages so that you can get acquainted with our people, our problems and our needs. We have many problems and no one to help us”. Perhaps these three villagers- Maurice, Nicholas and Mary- were right in their insistence that the people needed my help. I was ready to set out with them and explore the neighbouring villages. I trusted them implicitly.

Then onwards, it became a routine to walk with these two men and a woman for more than two hours a day, visiting the sick, and people with disabilities. There were many children suffering from epilepsy, sickle cell anemia and several other health problems. Hearing impairment and intellectual disabilities were also very common. We also met a few people with mental illnesses. Of course, people believed that the mentally ill and epileptic persons were possessed by the devil.

I was also keen to know the available resources in the villages. Every village had a Government Primary school. Fortunately, Kimwanga Government Primary School also had a school for the Hearing impaired. This was a great blessing for all the neighbouring villages. Secondary schools were within walking distance for the students. Government dispensaries were also not too far away. However, drugs for epilepsy and mental illnesses- and at times even the drugs for ordinary ailments- were not available at these dispensaries. There was no question of a doctor being present in them.

Conversation with these volunteers gave me deep insights into their culture, life style and living conditions. They cooked meals only once a day. For most villagers, breakfast consisted of only a cup of tea, and for many even that was not always assured. About eighty percent and more of the villagers in our area went without lunch. In the season of cassava harvesting, they may have boiled cassava or sweet potato.

During these long walks from one village to another, the conversation often turned into discussions of what we could do for the people which other NGOs were not doing. Some of the NGOs had trained Village Health Volunteers to give health education to the people. These three friends were some of those who were trained by one of the NGOs. So they told me “We can only talk to villagers. We are helpless when people need some practical help. If you start some useful programme that would be of great benefit to the people”. I told them that imparting health knowledge was a very important part of any health work. “However, we shall also plan some practical programmes for the benefit of the people.” The warmth of my three companions-their friendly and cordial approach- and the welcoming

smiles on the face of the villagers had a magic effect on me. My anxiety and fears about working with a new race of people, on a continent different from my own, completely evaporated in no time.

My incubation period was coming to an end. It lasted almost four months and was an enriching period of my life. Now, I was perfectly healthy in mind and body.

During these walks in the villages, families came out with their sick children

2

Market Women ....Birth of a Clinic

‘Are you the new Sister who has come to the convent there? Are you also the doctor about whom some of our people speak?’’ queried some women in the market. Yes, I had gone to Kimwanga market. The sisters’ residence and the Carmelview Primary School, Kimwanga are situated just a kilometer away from the Kimwanga Catholic Church and the market. The Market was off the high way, with small shops lining on either side of a muddy road. People sold some of their farm produce in the open. The fact of my walking around the villages had already become the market news. One of those small shops was a ‘cyber’ if I can call it by that name. The shop also offered many other services which villagers need.

Being a new foundation, the Convent in Kimwanga did not have wi-fi connection. Whenever I needed it, I had to come to this ‘Cyber’. One morning, I was there at that shop and some of the women, who were selling their products in the open, saw me. They repeated their question. Women wanted to make sure that I was a real doctor and that it was not a joke. The moment I said, “Yes,” they started pouring out their health problems. Everyone wanted to speak. Perhaps they thought that I was a “mobile doctor” and that I would provide instant cure. Fortunately, I was able to convince them that they needed to come to our campus and then I could examine them and find out what their sicknesses were.

A Classroom Hospital

Gradually a trickle of patients started coming to the campus. The head teacher, Sister. Irene D’Souza provided a vacant classroom that was not occupied yet at that early stage of opening of the school. The classroom was modified into a clinic, with minimum requirements of an examination table, and drugs. One of the volunteers, who introduced me to the villages, Mr. Maurice Wanjala was my assistant; he was the translator, pharmacist, cleaner, public relations officer, all jobs rolled into one. He was very intelligent and soon mastered the skills that were required of him. Initially, patients came one by one, hesitating, not sure of what to expect in a school campus for their medical problems. However, once they entered, they saw that the simple medical facility was homely, humane, professional and affordable. Maurice prophesied that this clinic would continue to grow and so, from day one, we maintained the records of patients and their

treatment. A follow- up system was introduced. People nicknamed the clinic as a ‘Classroom Hospital’.

People from the neighbouring villages came with all sorts of ailments. They had the confidence that we will not turn them away for want of cash. For more than one year, the fee for the treatment was only fifty Kenyan shillings. Even later, it did not go up beyond Kshs. 100- 150/= for five days of treatment with antibiotics and other accompanying drugs. Going to Bungoma Referral Hospital means incurring transport charges and charges in the County hospital too; they had to pay for investigations and medicines, even though the cost was much less than that of the private hospitals. They could get the same treatment in our clinic at a cheaper cost. Patients with high blood pressure, heart diseases, diabetes, epilepsy, and other chronic illness did not need to come every week. A fortnightly or monthly visit would be sufficient for them, depending on the severity of the cases. In these cases, the cost of the treatment would be around Kshs 200-400/.We did not advertise the clinic; neither had we a billboard. Yet people started coming from distant villages. It was not only the low cost of treatment that brought the patients from faraway places, but the personal care, proper diagnosis without costly investigations, affordable medicines and timely and appropriate referral. People knew that if a sickness could not be treated here, we would tell them what the probable diagnosis was and where they could find the needed treatment. They were sure that we would not waste their money on unnecessary drugs and investigations.

The Kenyan Medical License

I was an Indian doctor. I knew that I needed a Kenyan medical license if I wanted to practice medicine in Kenya. Being a senior by age, travelling to Nairobi and getting through all the formalities of Kenyan Medical and Dental Board seemed a big hurdle, and so I was apprehensive and uncertain of what I should do about this problem.

One evening as I was just closing the clinic, Bishop Norman Wambua, the Bishop of Bungoma Catholic Diocese, came to the convent on an informal visit. I invited him to visit the newly opened clinic. He looked around and seemed satisfied with the clinical set- up. His only question was, “Do you have a Kenyan Medical license?” I was happy to share with him my problem in getting the medical license. I told him that if getting a license involved a complicated process, I would have to think about leaving Kenya. He smiled and assured me that he would be responsible for getting my Kenyan license. I only had to submit all my documents to the Diocesan Office and Bishop would entrust the task to the Priest, Rev.Fr. Marcellus Auma who

was in charge of Medical Programmes of the Diocese, he said. He started the process without delay. After about three months, he appeared again, with my Kenyan medical license in hand.

Annual renewal of the license was not a problem either. Rev.Fr. Marcellus Ouma would go every year to Kenya Medical and Dental Board in Nairobi and do the renewal and would deliver the license to me. Covid-19 in 2020 made this process even easier. Now I could renew the license online, paying the fees through M-pesa. From then onwards, the clinic progressed smoothly. Patients appreciated the thoroughness of our services and the dedication and commitment with which we worked. Almost all the diseases were treated in the clinic except major surgical problems, malignancies, those who needed specialized investigations and admission in the hospital, were managed successfully.

Patients waiting in school verandah

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People Are Out There

How could I ever forget the families and people whom I had seen during my visits to the villages, people struggling to survive, living a hand-to-mouth existence? They could not afford one hundred or even fifty shillings for buying medicines. The words of a poor woman in India flashed across my mind. When questioned why she waited till the child was so sick and serious, her answer was, "How can I buy medicine for the sick child? If I did so, I would have to deprive food for my other children, and all of them would have to starve." Here too the situation was similar.

The poor seek treatment only when they cannot endure the pain or discomfort of the sickness any more. So we see the patients with severe infections and complications because they come in the late stages of the disease. I needed to reach out to them in the initial phase of their diseases and make drugs and preventive treatment available in the villages. I said to myself, "I am needed in the clinic and I cannot leave the clinic unattended. However, I can reach out to many more people who are sick in the villages through the Community Health Workers (**CHWs**)."

The process of identifying women who could be trained as health workers started immediately. Since the medium of education in Kenya is English, getting women with knowledge of English was not difficult. We chose married women who were school drop- outs at the Secondary school level. The only other qualification required was that they were ready to work with the families and the people. In other words they should be community - oriented people. They were all from different villages and they were supposed to be Health Workers of their own villages.

Training of Local Women

Training of local women as CHWs started on January 21, 2015. During one of my last sessions with them in 2024, they recalled their first session in that 'classroom clinic'. "Do you remember Sister, we sat on the floor for your classes? We were so much interested in the classes you conducted that we forgot all about lack of furniture and other discomforts…" No, I did not remember those difficulties of the initial years. What was uppermost in my mind was the positive outcome of these efforts. Kenyans even in the villages usually did not sit on the floor. Even the very poor will make a type of 'sitting device' a sort of contraption of three wooden pieces nailed

together. They would carry this contraption with them whenever they went for any village meetings. No wonder, the fact of sitting on the floor was still very vivid in their mind. They recalled that classroom too. It was a multipurpose room which served as a clinic, pharmacy, wound dressing room as well as a room for CHWs.

The training lasted for a month and was followed up by input sessions every fortnight. The emphasis was on promotion of health and prevention of diseases. Various modes of transmission of diseases were dealt in detail. Malaria and water borne diseases were common in the area. They received sufficient knowledge of Prevention of diseases and nutrition and nutritional deficiencies. Their training also enabled them to treat minor ailments and diseases, cuts and wounds. They visited every family of their village and assessed their health needs and other problems.

The Health Workers were given a medical kit with drugs for treating ordinary and simple diseases. They also knew their limits and referred the patients on time to hospitals. People were very happy that they did not need to go to the chemists and hospitals and spend their modest earnings they received on medicines. Instead, they could now buy maize flour and even some vegetables needed for the evening meal. They no longer had to endure unnecessary aches and pains, infected wounds, or other illnesses. They obtained these medicines at no personal expense.

Tackling the Problem of Malaria

Bungoma County is well-known for its extensive malaria burden. Severe Cerebral malaria was frequent because timely treatment was unavailable when the infection remained in its uncomplicated phase. As a result, community members began asking Community Health Workers (CHW) to provide anti-malarial medications to them.

During their next bi-weekly meeting, the Health Workers brought the villagers' request to my attention for evaluation. Some villagers also came to the clinic to emphasize the urgent need for antimalarial drugs. I was reluctant to entrust antimalarial drugs to the Health Worker's hands. At the same time, I knew from the patients arriving at the clinic that they were purchasing from the shops a few antimalarial tablets according to the money they had in their hands. They did not buy full dose of medicine.

People would go to the Chemist with as little as ten or twenty shilling and they would receive one or two tablets based on the calculated price.

This habit of buying medicines including antimalarial and antibiotics, was widespread among village residents. Clearly, they were using under- dose medications, leading to repeated infections and drug resistance which became a serious threat in rural settings. For these reasons, I finally decided, in the villagers' interest, to add antimalarial drugs to the list of medicines supplied to them. Both the CHWs and the community were extremely pleased that antimalarial drugs would be made accessible through CHWs.

I provided the Health Workers with comprehensive education about malaria, covering prevention and therapy. The government distributed mosquito nets during in the early years of my presence. Each family received nets proportionate to its size, and the nets were renewed every three years. From 2022, if I recall correctly, the nets were supplied only to pregnant mothers. Other preventive measures were also managed effectively by the Government. The lacuna was regarding the treatment for Malaria. They did not receive free drugs for Malaria. So my emphasis in the class was on the proper and regular treatment of malaria patients.

The standard medication for uncomplicated malaria is Artemether 20 mg+ Lumefantrine 120mg, commonly referred to as AL. This is the first- line drug for uncomplicated malaria and is available in all public dispensaries, as well as in County hospital. However, patients had to pay for these drugs. Our clinic also used the same medication. I instructed the CHWs on the dosage of AL, specifying age- wise and weight -wise guidelines for both children and adults until they memorized it thoroughly. Once I was satisfied with their skill and memory, I added AL along with other medicines to their medical kit. At their fortnightly meetings, CHWs had to present the reports of their work.

The CHWs had to maintain a record of each patient they treated, including the presenting symptoms of their diseases and the drug dosage administered. Their visit diaries to the patients and families and the records of medications given were checked. If any errors were found, they were pointed out so that the mistakes would not be repeated. Fortunately, the Community Health Workers rarely made errors when treating people with malaria symptoms. The villagers were very grateful that AL became available in their villages, enabling them to receive timely treatment. After this intervention, we heard of no further complications or deaths from malaria. The Health workers charged a small fee for antimalarial drugs,

which was considerably less than the price in private shops or government hospitals. Other medications were provided free of charge.

The Health Workers contacted the families of children, adolescents and adults suffering from epilepsy. They encouraged parents and family members to bring these individuals to the clinic for assessment and necessary treatment. Very poor epilepsy patients received free treatment and continue to receive regular medication.

The Health Workers understood clearly that they were not doctors or nurses: they functioned as Community Health Workers who visited families and provided timely assistance with medical and other needs. They advised women on proper child care and nutrition, followed up with the pregnant women for antenatal check-ups and immunizations, and encouraged mothers to take their children for immunization to Primary Health Centres at the right time. When patients needed referral to County Referral Hospital, the Health Workers accompanied them either because the patients were afraid of hospital formalities or because there were no family members to accompany them.

Thus as I sat in the clinic treating a limited number of patients, I experienced the satisfaction of knowing that the Health Workers are extending their outreach to many more sick individuals in their villages.

CHWs with their medical kit -Ready for action

Irene Sangura (CHW) treating patients at home

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Ready to grasp and grow

I was struck by the Health Workers' enthusiasm and responsiveness to any constructive idea I shared during our interactions. They were receptive and eager to absorb the ideas discussed in our fortnightly meetings. It was clear that they were committed to implementing initiatives that would enhance their own lives and the lives of families in their villages.

Typically, when an NGO or Church representative visits a village, the community expects some form of assistance whether financial or material. This was the case when the Apostolic Carmel sisters arrived in Kimwanga. Some women from the villages would be there in the clinic almost every day asking to see me, not for treatment but for 'assistance'. This request for '**assistance**' went on for a few weeks. At the beginning of a school term, you can expect a long line seeking financial assistance. I had to clarify that I wasn't an NGO with funds, and I couldn't help them with cash.

I decided to address this issue with the Health Workers. Their circumstances were similar to those of the women seeking 'assistance'. As small- scale farmers, they had limited cash reserves. I emphasized the importance of savings, even if it was just a few shillings per week. Over time these small savings would accumulate, and by year's end, they could have a substantial amount. This habit would help them avoid begging or borrowing in emergencies.

Forming Women's Groups

The Community Health Workers (CHWs) trusted my advice and were eager to take action. They were keen to educate and organize women in their villages. I highlighted the benefits of forming women's groups, and they had many questions about the safety and advantages of saving their earnings. To address these concerns, we organized a training session on 'Leadership and Women's groups.' which included information on the 'Small Saving Scheme'. The CHWs participated in group discussions, raised questions, and received clarifications from resource persons. By the end of the day, they were enthusiastic about forming groups and starting their savings initiatives.

Sr.Agnesita animates Women's group at Masielo and Nakhwana villages)

Pass Books for every member and Registers for Secretaries were supplied. Secretaries of women's groups brought the weekly collection of their savings to the office at our Centre. We entered the amount in their Group Register and made sure the accounts in all the books were tallied. Women and their families were happy that, at time of sickness or any other need, they could withdraw their own money with self-respect and dignity.

Some of the groups innovated their own methods of supplementing their income such as cultivating vegetables or starting some small business which helped them to enhance their income and savings. Coming for weekly meetings in their own neighbourhood, fostered friendship among the members and they readily helped one another in time of sickness or any other crisis. Occasionally, seminars were organized for them on various topics such as Home Care and Herbal Medicine, nutritional and emotional needs of children, prevention of teenage pregnancy and ill effects of Alcoholism etc. Women's Day celebration was an annual feature.

The evaluation of women's groups and their saving scheme is recorded here in their own words: "Now we know that we can better our lives and that of our families with our own resources, however small they may be. We have learned to save and think of the future. We are happy that we have come a long way from our dependent and helpless mentality to a self-reliant and self-respecting attitude which enables us also to reach out to others".

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Do Something for My Son

A distressed woman entered the clinic. I sensed her anxiety and desperation. "Help my son", she begged. II inquired about the issue. "He abuses his wife, and his children and even me, his mother. He is disposing of family assets, and we, a middle class family, are being pushed to the brink of poverty. He drinks alcohol from dawn till dusk and continues through the night," she explained.

The situation was severe chronic alcoholism with all its repercussions on health and family life. I clarified to her that medicines alone cannot cure alcoholism; a comprehensive, multi-faceted approach is required. I recorded her address and phone number and promised to contact her once I arranged a programme for her son.

I recognized that alcoholism was not an isolated incident. During those earlier days of my 'walking around' the villages, I visited a family in the vicinity of the convent. While speaking to them in the front yard, I asked whether I could see the rooms in their house. I needed to get some fair idea of the actual economic situation of the families of the villages around. So, they took me inside and in one of the rooms, there stood a huge mud barrel. The head of the family, poured fresh homemade alcohol taken from that barrel in a big cup and offered me with a wide smile. "It is good. Would you like a drink?" I thanked him and refused the offer. "Many people come to drink and we earn good money. This is our livelihood". He explained.

Alcoholism is a pervasive problem in the villages. During the days of my 'walking around the villages', I came to know that for many families, brewing alcohol was a business for earning their livelihood. Most of men and women drank, and children from their early age got into the habit of consuming alcohol. I said to myself that if this were the state of alcoholism in the villages, then I would not be able to do anything about it and so I turned a blind eye to this problem as an impossible case. However, the urgent plea of the woman to do something for her alcoholic son disturbed my conscience, making me aware that numerous families suffered from alcoholism's effects and required assistance.

This challenge was beyond my individual capacity. I was already occupied with running the clinic full-time. Moreover, health workers and women's groups needed my attention. I began searching for someone interested in

engaging with this type of work. I sought Alcoholics Anonymous (AA) groups that could support us, but was unsuccessful. Eventually, I found an individual knowledgeable about the subject who also wished to deliver talks on the adverse effects of alcoholism on health, families, and society.

Seminar on Alcoholism

Health Workers reached out to village families and invited them to attend an Alcoholism seminar. A series of presentations with visual aids were organized. Interactive sessions and group discussions enabled participants to understand the seriousness of the problem. Many attendees had personally experienced these difficulties in their lives and families.

Our goal in arranging these sessions was not merely to provide theoretical information and then abandon the participants, but to aid those wishing to quit drinking entirely. Initially, we requested individuals and families interested in abandoning drinking and 'alcohol trade' to gather weekly in their villages to discuss and share with one another their plans and experiences. Some of them decided to stop brewing alcohol and initiated a different way of life. Some women, who had attended talks on Alcoholism, convinced their friends –men and women-for the need to give up drinking and selling alcohol.

Formation of AA Groups

Even though forty to fifty alcoholics attended the seminar, only a small number-about ten to twelve individuals- initially decided to quit alcohol.
I invited this small group to visit to our Centre in Kimwanga, once a month. They were asked to share their experiences before and after giving up drinking. These meetings were organized according to the twelve – step principles of Alcoholics Anonymous (AA) meetings. Participants shared their success and failures of their effort to abstain from alcoholism.

During the monthly meetings, the twelve steps of AA were explained to them. Members shared their life experiences based on one of these twelve points. After a few months, the number of people attending the meetings increased. It was interesting to listen to the reasons that brought them to the AA group. Most members of the initial group were chronic addicts and binge drinkers whose habits had disrupted and destroyed their family and social life. A few of them even lost their jobs.

When these addicts finally joined our AA group, a remarkable change was noticed in them. Their family and social relationships improved, their work culture became healthier, and even their physical health showed signs of

recovery. This visible transformation of lives motivated other former alcoholics in the villages to join the AA group. The members themselves named the group as '**Carmel AA Group'**.

Seminar on "Ill-effects of Alcoholism" -2017

AA Group formed and meeting in progress

Progress of AA Group

At present there are about twenty five members in the group, though not all of them attend every meeting. Most members have managed to abstain from alcohol despite social customs and pressure from peer groups. Fortunately, not only lies and gossip go around the villages but also the good that is happening to individuals and families in the villages. People as far as 20 -25 Kms away started hearing about what was happening at our Centre in Kimwanga. They wanted to attend the meetings. So a few individuals from the neighbouring Sub County, Sirisa, began attending these meetings. However, the distance was a limiting factor, and I lacked resources to reach out to these distant places. Nevertheless, we do not focus on numbers; helping even a few families to improve the quality of their lives is considered a blessing.

We were delighted to receive reports from Community Health Workers (CHWs) that, although not all reccovering addicts attended Alcoholics Anonymous (AA) meeting , many families had stopped brewing alcohol. Some patients who visited the clinic for treatment also informed me that they aspired to lead a healthy, dignified life and sought alternative livelihood options. A representative case is **Scholastica, a resident of Machwele village.** She was severely addicted to alcohol,which had nearly ruined her lfe. In her moment of desperation, she chose to participate in the seminar that we had organized, "The Ill-effects of Alcohol". She undeerstood her situation and resolved to quit drinking. She joined the AA Group. Like most individuaaals, she did not achieve immediate success,

but she persevered.Within three months, she made substatial progress and worked diligently. Her health recovered and her family celebrated her improvement.

The transformation in Scholatica's behaviour was remarkable. She became courteous and polite, a stark contrast to her previous rude and disruptive conduct. I highlight Scholatica's story because her changed life inspired numerous men and women to abandon alcohol.

We were hoping to be able to connect with existing AA groups in Kenya (if any) so that this small group could become part of a broader network and effect societal change.

Scholastica from Machewele village gives testimony

of her transformed life after joining the AA group

6

A Much Needed Change Made Possible

"I warned my husband that I would abandon him and leave if he brought another wife into the home. He heeded my words and did not remarry." This was one of the daring declarations made by a woman striving to halt polygamy. Not every woman enjoyed such luck. Polygamy is a customary practice among certain Kenyan tribes. Bungoma County is one such region whose population includes the 'Bukusu' as the principal tribe and numerous sub- tribes, all of which uphold polygamous traditions. Bukusu custom not only permits but expects men to marry at least two to four wives during their life time. Maurice Wanjala, the clinical helper and Cornelius Masinde, the gate keeper, once informed me that people even regarded men who were married only once as abnormal.

During my ten-year residence in Kenya, I observed a revolutionary shift in women's attitudes. The establishment of women's groups and leadership training programmes broadened their perspectives. "Formerly, education was not considered necessary. Men, women and children labored in fields or forests to earn their livelihood. In those days, expenses were minimal. Now, we must educate our children for a better future. With multiple wives and many children, how can a family afford to educate all the children?" they asked. "Times have changed. We must also adapt. Are we not justified?" they added.

Indeed, their concerns were valid. Unfortunately, many men resisted change, which led to conflicts and family separations. Every transition brings its own challenges. I was optimistic that these disputes would gradually ease and result in a harmonious future. I was told repeatedly that Bukusu culture is deeply traditional, and the clan elders would not permit any alteration. This was largely true. Yet I sensed that a transformation of their entrenched customs was imminent. A quiet, progressive protest against polygamy began spreading among women. They empowered themselves, and their families benefited from this subtle revolution. As a result, an increasing number of children started attending schools. They were highly intelligent and eager to pursue secondary and university education.

Women's Day Celebrations

Observing the self-assurance and creativity of these women, I recognized that a promising future lay ahead for them. We began celebrating Women's Day in 2015. The gatherings attracted large crowds, sometime up to four hundred participants. The event provided an opportunity for the members to interact with women of more than twenty five villages. They were happy to share their ideas as well as their accomplishments. On stage, women showcased their skills and talents, presenting self-composed songs, skits, and poems that expressed their aspirations and visions. I was thrilled to witness their enthusiasm and vibrant cultural performances, which sprang directly from their own desires and were not borrowed concepts.

The theme of one year was 'Say No to Alcohol'. The next year's theme was 'Brave and Honest Women'. Each year we selected themes that were practical for their lives. They illustrated the positive impacts of these themes in their families and villages through songs, dances and skits. We were fortunate to secure influential women speakers as resource persons for the celebrations. The focus always remained on enabling women to claim their rightful place in family and society.

Progress of Women's Groups

Women's day celebrations catapulted the Women's groups into action, casting a bright light on their initiatives. There were many persistent requests to start similar programmes in villages where womens' groups did not exist. We already had twenty five Women's groups comprising of seven hundred and more women as members of these groups. One day, a few men came to the clinic wanting to see me. They were not sick; they simply wanted to understand what improvements the clinic had brought to the women's lives. The villagers said, "Our neighbouring villages have improved from what they were earlier. The clinic is the reason. That is what the women told us. So we have come. We also need your help." Perhaps, they thought it was some medicine that I gave them transformed the villages. I smiled and told them that I would send our Health Workers to their village. I assured them that if their people would listen to the Health Workers and act according to their directions, their villages would also be transformed. I promised to visit them at some time or other.

The ripple effect of this programme continued to spread, though not always in the same mode of thinking. When the women learnt that they did not need to adhere strictly to the traditional way, they began to improve their own skills and talents in their own unique manner. This shift in thought

enabled them to devise innovative ways of enhancing their resources. It became a source of great joy for me to witness their progress and positive transformation in their communities.

Women's' Day Celebrations-2017 - Women from Mwienga village on the stage

Women enjoying the Women's Day celebrations

Women's meeting in Lwanja village

7

THE CLINIC COMES OF AGE

A market rumour was announced by Sr. Irene to the sisters in the Convent. Everyone was intrigued. She chuckled and added, "Dr. Agnesita administers American medicines. The patients she treats are recovering smoothly without any complications." This was the circulating rumour. Regardless of the story's details, the patient influx was rising. The rest of the tale was irrelevant.

Choosing the right medicines demanded expertise and insight. The drugs were purchased from Bungoma, a town situated fifteen Kilometers away. At that time, I lacked both nursing staff and laboratory facilities. Nevertheless, about thirty- five to forty patients visited daily to receive our services, especially those with epilepsy from the outset, because government Primary Health Centres could not supply epilepsy or psychiatry medicines. In my early experience working with villages, I observed numerous epilepsy sufferers confined at homes - both youngsters and adults. They were denied essential medication, leading to repeated seizures, which hindered their education and employment prospects.

Old is gold

I fondly recall my medical college years at the St Johns Medical College and St. Martha's Hospital, Bangalore. This is the right moment to acknowledge the comprehensive training provided by Professors of Medicine, Surgery, Obstetrics, and Gynaecology, as well as all departmental Professors of that era. I am especially thankful to Dr.Balasubramaniam, Professor of Medicine, under whose guidance I served as an Intern and Senior House Officer (SHO) in Medicine Department. He taught us that even medical students and junior doctors must diagnose diseases through meticulous history -taking and thorough clinical examination of the patient. "If the clinician does not know the diagnosis, investigations are useless and only waste the patients 'money", he would advise. It was this rigorous clinical instruction and the Professors' personal dedication to us that enabled me to treat the patients affordably now.

Modest yet Impactful

Patients presented with various ailments, from common cold to cardiac disorders and cancers. Most conditions were managed in our clinic. Cases of malignancy or those requiring major surgery were referred to the County

Referral hospital after diagnosis. Unfortunately, that hospital could not accommodate many of the referred cases, which were then sent to larger city or Medical College hospitals in Nairobi. Ninety- nine percent of these families could not afford treatment beyond Bungoma, so they endured suffering silently and received only palliative care. For instance, a sixty-five-year-old with recent abnormal behavior, was brought to our clinic, believed to be mentally ill- a diagnosis shared by previous facilities. After l taking an exhaustive history and performing a detailed physical assessment at our centre, I determined that the condition was probably due to the brain tumour that was causing this problem.

I documented my findings, provided a provisional diagnosis, and referred the patient to the County Referral Hospital. The Referral hospital then sent the patient to a private facility for Magnetic Resonance Imaging (MRI), which confirmed the brain tumour. Whether the tumour was malignant could not be verified by me or by Bungoma hospitals; They referred the patient to a larger city hospital. The family lacked the financial means to seek treatment elsewhere, and the patient passed away within a month. This exemplified the outcome for rural patients with malignancies or conditions requiring major surgical interventions.

The clinic operated daily from 9 am to 5 pm from Monday to Saturday. An average of 30-35 patients received our services each day. Despite the availability of antenatal and post natal care in Government Health Centres, postnatal women presented with large breast abscesses and other postpartum complications. Women were pleased that they could avoid travelling to Bungoma for treatment these complications; they could visit our clinic and we would provide necessary care without excessive formalities. Follow- up visits and daily dressing were straightforward in our clinic, owing not only to lower costs but also to thorough and professional service. Patients previously treated by private physicians or district hospitals began attending our clinic because they were not improving despite being prescribed expensive medications. The underlying reason was simple: their illnesses had been misdiagnosed and treated for unrelated conditions. Upon accurate diagnosis and appropriate treatment in our clinic, their health improved. The staff were delighted to witness patients recovering well and remarked, "We have evolved into a Referral hospital. Observe the positive outcome here."

Despite these accomplishments, the clinic remained unregistered with the government because it lacked a suitable building. We were still situated in

a school corner. Everything occurs in its own time. God recognizes every need and prompts suitable action in His time.

A Memorial

The Apostolic Carmel Congregation celebrated its 150th in 2018. The then Superior General of the Congregation, Sr.Susheela (formerly Regional Superior of East Africa Region) proposed to the Regional Superior of East Africa , Sr.Winifreda, that a Memorial be erected in Kenya to commemorate the 150-year milestone. The memorial was intended for the activities benefitting the poor. Sr.Susheela's brother, Mr. Kochouseph Chittilappilly- a prominent businessman and philanthropist) agreed to finance the construction and Sr.Susheela confirmed the commitment.

The leadership and their councils examined various initiatives to assist the poor. After extensive deliberation, they decided to construct a dispensary in Kimwanga and a Day Care Centre for children of low- income families. I was overjoyed because, although I had not expressed a need for a separate building, the requirement was now being met. God understands every need and fulfills it, especially when it serves the poor.

The Contractors were instructed to accelerate the construction, because the school required the space we were occupying, as the student enrolment was steadily increasing. Fortunately the dispensary building was completed by August 2018. I intended to relocate the available furniture, boxes of medicines, and some medical equipment to the new building. I then observed a truck delivering construction materials to our campus and requested the driver to assist me in transferring the items from the existing clinic to the new dispensary building. He complied willingly.

Eventually, we operated independently. A sign displaying the name 'CARMEL DISPENSARY' was erected. From then on, we referred to it as a dispensary because the clinic was expected to be managed by a doctor, though the dispensary could be run by a nurse. We were uncertain about who would eventually replace me. All that time, the existence of the building itself was all that mattered to me; the specifics did not.

"Oh! We need not get confused in the school now.
We feel freer and our children and sometimes even we, adults can cry when in pain as loud as we want. More facilities will be added very soon, we hear".

There were many more such comments and expressions of joy, just in seeing this small building. It was indeed small in size compared to other hospitals. But it served our purpose. We were satisfied.

Patients came from near as well as distant villages. They came from neighbouring Counties too, such as Busia, Kakamega, Kitale, and Eldoret.

8

EVERYTHING IS POSSIBLE FOR GOD

"Sister, please come out immediately," the Receptionist called.
I too could hear loud shouting and commotion outside the clinic. I feared that a group of thugs had entered the campus and were assaulting the patients. I rushed out of the consultation room to see what was happening. "Oh, it is only a mentally ill patient" I told the staff. His family members were struggling to restrain his violent behavior. I administered strong sedatives which made the patient calm to some extent. I then advised the relatives to take him to the District hospital.

Many people believed I could treat not only physical illnesses and alcohol dependence but also mental disorders. Despite their superstitions, they placed great trust in the Carmel Dispensary. Among the rural population, it was commonly believed that individuals with mental illness or abnormal behavior were possessed by evil spirits or victims of witch craft. At times, I wondered whether some of them thought that I was performing an exorcism rather than providing medical care.

It is true that only a small number of people were aware of the psychiatric treatment available at the County Referral Hospital. However, the long duration of treatment and the associated financial burden made it impossible for most families to continue the treatment.

An Obvious but Neglected Need

I explained repeatedly that I was not qualified to treat patients with mental illness. Nevertheless, the villagers refused to give up. Seeking treatment at the County Hospital was expensive, and regular follow- up was impractical. As a result, families continued bringing their mentally ill relatives to our clinic.

I was not trained in psychiatry, nor did I have access to psychiatric medications. Still I assured them that I would try to arrange proper treatment in the near future. I began exploring the possibility of engaging a part time Psychiatrist for the clinic. Soon, I became deeply disheartened. I discovered that, at that time there were only about one hundred psychiatrists in the entire country, most of whom were based in Nairobi or other major cities. My search for a Psychiatrist at Bungoma County Referral

Hospital also ended in disappointment. “We have only one psychiatric Nurse here”, I was told. This was in 2017. I found myself in a painful dilemma. What was I to do? Abandon my plans altogether and leave these suffering patients and their families without any support?

It looked as though God was waiting for willing hearts and helping hands to serve these people. When I first arrived in Kenya, my Convent had no wifi and I had lost contact with my medical college classmates. Re-establishing communication took time. Then, quite unexpectedly, I received an email from one of my classmates, Dr. Florence from Sri Lanka. In her message, she also shared the phone number of another classmate, Dr.Geetha Jayram. Dr. Florence had managed to obtain my contact details through our sisters in Sri Lanka. Dr.Geetha was the Professor of Psychiatry in John Hopkins University, Baltimore, USA. At first, this accidental information sent by Florence did not seem to be of any relevance to me.

I was living in a remote village of Kenya, nearly five hundred kilometers from Nairobi. Geetha was in Baltimore, close to Washington D.C. What connection could there possibly be between my search for a Psychiatric support for patients in rural Kenya and a psychiatrist working in the United States? It seemed almost foolish to imagine that she could help me in any meaningful way.

However, as the number of Psychiatric patients seeking treatment steadily increased, I felt a growing inner compulsion to help them and their families. Often, the suffering of family members was more intense than that of the patients themselves, and I felt their pain deeply. Without further hesitation, I decided to call Dr.Geetha.

She answered the phone on the very first ring. This was in July 2017. To both our surprise, we were able to connect instantly and effortlessly. I was not aware of the time difference between our two countries. At that moment, my only desire was to speak with her. There we were, chatting warmly like long- lost friends. She told me she was travelling to attend an appointment in another part of the country and had time to talk.

Knowing she was on the move, I did not waste much time .I explained my situation plainly: “Geetha, psychiatric patients are coming to me, and I feel helpless. I can manage other patients, but not those with psychiatric illnesses. I have heard that you have organized a Community Psychiatry programme in Bangalore. Could you help me as well?”

There was a long pause. I waited anxiously. Finally, I heard the words I had been hoping for: "I am interested in extending my services to Kenya". I felt an immediate sense of relief. Dr. Geetha was clearly a visionary, someone with a deep commitment to service. She expressed her willingness to expand her work to Kenya but explained that she would need time to plan and coordinate with her departmental team to develop appropriate strategies and action plans for this new venture.

Eagerly Looking Forward

Several months passed. Those of us who knew Geetha were not surprised by the delay. She was a woman of great generosity and creativity. Her work extended far beyond her department at John Hopkins University. She was constantly exploring innovative ways of reach to the poor and underprivileged communities across different countries.

She had been involved in Community-based mental health Projects in India and Lithuania, in addition to working with Community Colleges and other educational Programmes in parts of the United States and India. Universities frequently invited her to speak on topics such as integrated health care and cost-effective service models. She was highly sought after, not only for her professional expertise but also for her strong commitment to community- based mental health care.

The **Book of Proverbs** in the Bible reminds that there is a time for everything. We are called to wait patiently and trust in God's timing.I believed that the moment was now approaching. We had secured a separate building for the clinic, providing space for Dr.Geetha, her team and their activities.

I waited patiently for a word from her. Six months passed and then more, with no word. Despite my faith and confidence in God, doubt began to creep in. I found myself thinking, "How foolish I am. I am in a remote village in Kenya and Dr.Geetha is an important figure in John Hopkins University. Was it not foolish of me to contact her and ask her to help these villagers?"

"Yes, you were wrong," God said-not because you contacted Dr. Geetha, but because your faith wavered and you failed to place your trust in me. Three more months passed. Then, at last Dr Geetha brought encouraging news: she was making plans to visit us. She mentioned, however, that it would take another three months before everything could be finalized. Soon

after, she began sharing the details. ″There will be five of us”, she informed me.

Once again, anxiety crept in-, this time over financial matters. I believe Geetha, sensed my concern, as she soon reassured me through amessage: "There is no need not worry about the finances. I am a Rotarian and I will try to obtain support from the Rotary Club.″ In addition, she was assembling a team of Psychiatric nurses to travel with her and they were willing to pay their own expenses.

From that point on, progress was swift. Flight tickets were booked and dates confirmed. The team was scheduled to arrive at Nairobi and then take a domestic flight to Eldoret, the airport closest to our location, on August 15. Geetha later called to say they expected me to arrange accommodation and meals for the group. I told her that I had only two rooms which are available, both designed for single occupancy. She suggested, "perhaps two of us could share one room." I responded that if she and her team were comfortable with basic accommodation and simple meal, it would be manageable. It became evident that they were truly committed to coming to Kenya to assist us, regardless of the conditions they might encounter. I eagerly awaited their arrival as they finalized their programme schedule. The team planned to stay with us for approximately one week. Each morning would be dedicated to treating patients with mental illness, which would also serve as hands-on clinical training for all clinical staff, including our community health workers. The afternoons would focus on training these Health Workers- encouraging them to incorporate mental health into their regular responsibilities and equipping them with the skills needed to identify symptoms of mental illness and to support patients and their families effectively.

A Dream Fulfilled

During this period, I trained the Health Workers to recognize individuals with mental illness and to differentiate these conditions from intellectual disability. They conducted village surveys and compiled a list of people in need of mental health support. Although this initial list surely was not entirely accurate, it contained a sufficient number of cases to begin the work. This preparation allowed the visiting team to start immediately upon arrival without wasting valuable time. Finally, the long awaited day arrived. I travelled to Eldoret airport to welcome the team from the United States. The date was August 16, 2018. For me, this was the realization of a long-

held dream. It was truly inspiring to see how gracefully the team adapted to the limited facilities available at our centre.

Sr.Agnesita welcoming Dr.Geetha and team at Eldoret National airport

Families who had been waiting for four years or longer to obtain treatment for their relatives were successfully contacted. They arrived with their patients, and this time their expectations were met. Community Health Workers also brought along patients they had identified, and several family members accompanied them. The families expressed satisfaction with the care provided and were especially pleased that they were actively involved in the in the treatment process. All necessary medications were made available, and patient records were carefully organized to allow effective follow- up during future clinic visits. The medical mteam worked tirelessly from Monday through Friday, attending to patients daily from 9 a.m. to 5p.m., with one- hour break for lunch.

During the evenings, Dr.Geetha and I travelled into the town to assess about the availability of psychiatric medications. Unfortunately, the medicines prescribed by the USA team could not be found. At that time, only drugs supplied by the Government Referral Hospital were available in Bungoma town, and these were known to cause serious side effects. Subsequently, I discovered that the medications recommended by Dr.Geetha and her team were available in Nairobi. Despite their high cost, I ensured that these medicines were purchased for the benefit of our patients.

Dr.Geetha became increasingly aware of the importance of establishing an ongoing follow-up programme as many such patients in rural communities had no access to mental health care. Over the course of five five days, the team treated more than forty patients; however, this small number represented only a small fraction of the actual need. After Dr. Geetha and her team returned to their home country, patients continued to arrive, and treatment for those suffering from mental illness did not cease. As word of the services offered at the clinic spread, patients were brought in from both nearby locations and distant villages. So faith in God, Sr. Agnesita continued to receive mentally ill patients, providing treatment and medications at minimal cost. Patients from the poorest families were given medicines free of charge.

We are hoping Dr.Geetha would succeed in getting some funds for us through Rotary Foundation.

Geetha and team training CHWs

Sr.Agnesita and team getting hands –on-expereince.

USA and Kimwanga teams

9

No Half Measures

The clinic operated from a simple building, furnished plainly and without any sense of modern style. The staff, though fully qualified, were neither elitist nor condescending. While the physical infrastructure may have lacked sophistication, the quality of care and professional expertise was outstanding. In time, additional specialty services, including Psychiatry and Epilepsy care were introduced.

Staff members were free to approach the consultation room any time to notify Sister Agnesita of patients who required immediate attention. They took care to ensure that the patients felt comfortable, reassured, and at ease during their visit. The clinic functioned without excessive protocol or rigid formalities. Staff members openly shared information with Sister Agnesita regarding a patient's financial circumstances, medical condition, or relevant family background whenever necessary.

However, everyone clearly understood that Sister Agnesita demanded complete dedication and accountability. She had zero tolerance for negligence, indifference, or half-hearted effort. Mediocrity was unacceptable. Any lapse in duty was addressed promptly, and the individual concerned was required to correct or complete the task without delay.

One major issue, however, remained unresolved. The clinic had not yet been officially registered with the Ministry of Health in Nairobi. Now that the clinic had moved into its own building, with expanded space and improved facilities, there was no valid reason to postpone the registration any longer. The process required an inspection by the Public Health Officer, followed by approval from County authorities, after which the documentation would be forwarded to the Ministry of Health in Nairobi. Unfortunately, Registration procedures were often slow and could stretch over several months, and in some cases, up to a year.

Fortunately, Sister Agnesita was a member of the Rotary Club of Bungoma Magharibi, a relatively new club that received its official charter in 2019. During her visit to Kimwanga in 2018, Dr.Geetha had interacted with several prospective members of this Rotary club while it was still in the process of formation. She encouraged them to increase their membership so the Club could be formally chartered. Dr. Geetha, her husband and

several colleagues from her department were members of the Howard West Rotary Club in the United States.

Dr. Geetha recognized that continued psychiatric services at the Kimwanga clinic would require external financial support. She therefore planned to seek a Global Grant from the International Rotary Foundation. If approved, the funds could only be disbursed to Sister Agnesita through a chartered local Rotary Club.

From the outset, this Rotary Club had established a strong and respectable reputation. Its membership included doctors and nurses serving in County and Sub-County Hospitals, which further enhanced its standing and credibility.

Sr.Agnesita and Moses Karogi pose for a photo
after the Rotary Club weekly meeting in Bungoma

Sister Agnesita shared with some of her Rotary friends who were doctors in the Sub-County hospital, challenges she was facing with the registration of the clinic. They were glad to assist her. One of them coordinated with the Public Health Officer to arrange an inspection of the Carmel clinic and to help Sister Agnesita to obtain the required report. This intervention resolved all the issues.

The Public Health Officer visited the clinic within a few days. His first visit was friendly and informal. A few weeks later, in the year 2020, he returned with his staff for the formal inspection. I presented all the necessary registers and required documents. Fortunately, at that time, one of our Apostolic Carmel sisters, Sister Franciscah, who is a registered Nurse, was

working as a staff member in the clinic. She had all her certificates and Registration documents in order.

Community health Workers (CHWs) were also present at the clinic that day. The officer questioned them individually about their roles and responsibilities. He then called all the staff members including me, and asked what made our clinic different from other Government and private clinics in the area. One of the CHWs spontaneously replied, "Our dispensary treats epilepsy and mentally ill patients, which other dispensaries or clinics do not do." The Officer smiled, acknowledging the truth of this statement.

Not only the Sub - County officials but also the County health authorities were pleased with our clinic. Regarding Registration, it was required that the name of the health facility be permanently displayed on a board. Accordingly, the name was fixed as "CARMEL DISPENSARY, KIMWANGA". A dispensary could be registered easily and could be managed by a nurse. The Public Health Officer was happy to note that the available infrastructure, as well as the standards of cleanliness and sanitation were excellent.

A few days later, we received the inspection report, which was one hundred percent positive. The officer had deliberately overlooked the deficiencies in our laboratory and the limitations of our infrastructure –such as the limited number of tests conducted at that time and the lack of equipment like a refrigerator and autoclave- knowing that these gaps would be addressed sooner or later. It truly seemed as though this Dispensary was God's special project. He guided the mind and hands of the Public health Officer to grant us an A+ Report, though in reality, we probably deserved no more than a C+.

The Report had to be submitted to the Kenyan Medical and Dental Board together with our application for the Registration of the Dispensary. I could not imagine travelling to Nairobi, a journey of nearly five hundred kilometers by Matatu (a 14- seater public transport vehicle). Once again, Fr. Marcellus Auma who was instrumental in getting my Kenyan Medical License, obliged to do the needful. He undertook all the necessary steps and travelled to Nairobi to submit the documents required for registering the clinic with the Kenya Medical and Dental Board. We were delighted to receive the Certificate of Registration for the Carmel Dispensary, Kimwanga, within a fortnight. The Annual renewal of the license is completed online and it does not pose any difficulty.

The Carmel Dispenary was widely appreciated not only in Bungoma County but also attracted patients from neighbouring Counties such as Busia, Kakamega, and Kitale. On occasion, patients were even brought from Eldoret and other distant places. Consequently, many people shared our joy when we received formal Registration from the Ministry. Every small achievement of this modest dispensary became a source of happiness for the community around us.

A spontaneous expression of joy on hearing the news:
“The dispensary is registered with the Health Ministry”

10

A GLOBAL VILLAGE

How can one describe this insignificant, a remote village- where ninety percent of people live in mud huts- a global village? By the end of this chapter, I am sure you will find the answer. Sister Agnesita was neither presumptuous nor overconfident about her ability to treat psychiatric patients. Therefore she requested Dr. Geetha to send one of her staff members to evaluate the psychiatry programme she had initiated in Kimwanga. Sister Agnesita wanted to be certain that her diagnosis of mental illnesses and the treatments prescribed were accurate. She needed guidance, as she told Dr. Geetha. Fortunately, Dr.Geetha had been thinking along the same lines. She, too, felt the need for an evaluation and follow up before proceeding further.

Follow -up of the Psychiatry Programme

Dr. Geetha sent one of her staff members, Moses Karogi who was working with her at the time. He had also been part of the team that had earlier visited with Dr. Geetha. Moses is originally from Kenya but is now settled in the USA. He speaks Kiswahili, the national language of Kenya. I was pleased because he could communicate with the patients in their own language and teach Community Health Workers (CHWs) in a language that they not only understood but could also use to clarify their doubts and discuss their problems comfortably.

Moses visited us exactly one year after their first visit to our Centre. He arrived in Kimwanga in August 2019. The CHWs had informed the villages, as well as the patients who required follow-up and treatment, about the arrival of doctors from the USA. I especially wanted all the patients whom I had diagnosed and treated for mental illnesses to be followed up by Moses Karogi. He followed the same pattern as in 2018- working for a week, seeing the patients in the mornings and teaching CHWs in the afternoons.

Even though he was working alone, Moses worked diligently and saw every patients in detail, giving each one his full attention. We maintained a separate file for every patient, documenting each visit from the first consultation, along with detailed history, diagnosis, treatment and progress

.Any setbacks were also recorded. This systematic follow- up made it easy for Moses to evaluate the patients and provide guidance to Sister Agnesita.

Sister Agnesita was truly happy when Moses informed her that the diagnosis made and the treatment given to all the mentally ill patients, were absolutely correct. "Now you can confidently continue their treatment in this clinic without any hesitation. I will inform about Dr. Geetha about this. You need not have any apprehension regarding this project." he said.

Moses Karogi treating patients

CHWs attend follow up classes by Moses

The year 2020 was marked by the COVID-19 Pandemic. Everything came to a standstill. There were no meetings, or travel, yet the dispensary continued to function. Fortunately, Bungoma County was spared worst effects of COVID-19, as it is located at the western border of Kenya. The county strictly followed all the precautionary measures prescribed by the Ministry Health. By 2021, the spread of COVID-19 had subsided, and Community Health Workers (CHWs) were once again able to resume their meetings, follow -ups with families and other activites.

In His goodness, God seemed to make up for the lost time. 'The project for Mental Health in Kimwanga,' submitted by Dr.Geetha had been pending with the International Rotary Foundation for two years. In May, we were informed that the project had been sanctioned and that the funds would be sent to the Rotary Club of Bungoma Magharibi in due course. However, there were still several hurdles to overcome before the funds could reach us.

God's gifts are always overflowing and are far beyond measure or comparison. In 2020, we lacked funds and were extremely anxious. "People cannot afford to pay for these costly psychiatric drugs. However, this is a genuine need, and I cannot refuse these medications to the patients," remarked Sister Agnesita. Yet, it seemed as though God asked her, "Why

did you doubt?" The waves of my anxiety appeared to reach Sister Susheela, who once again recommended our project –without any promptings from us - to her brother, Mr.Kochouseph Chittilappilly,who readily agreed to support it. A detailed project proposal, outlining our activities and requirements, including the budget, was prepared and submitted. Within ten days we received the joyful news that the project had been sanctioned.

Sister Agnesita was overjoyed and immediately set to work. She equipped the laboratory with all the essential equipment and test kits and reagents. She appointed a fully qualified laboratory technician and a registered nurse. We purchased a refrigerator and an autoclave. In short, all the requirements for a Registered Dispensary – previously lacking- were fulfilled. Essential drugs for different categories of patients were stocked in sufficient quantities to last more than six months. It was true that the funds from Mr. Kochouseph Chittilappilly were intended to support us for only one year, but this did not trouble us. Sister Agnesita was confident that funds from the International Rotary foundation would be available before the end of the year. Moreover, her life experiences had taught her that God would never fail her whenever she felt an urge to help people who were needy, disabled, or helpless, God walked with her and paved the way forward. So, she went forward with confidence. She knew that she needed only to take one step at a time. God is a God of abundance. He supplies our every need especially when it is in favour of the poor and downtrodden.

In 2022, the eagerly anticipated grant from the International Rotary Foundation was obtained by Bungoma Magharibi Rotary Club. The club planned to release the funds in installments in accordance with the approved budget. I was unable to abandon the patients during working hours to attend Rotary meetings in Bungoma. Consequently, Rotary Club officials visited the dispensary several times to prepare the budget as stipulated in the Project. Eventually the green light was given, bringing a sense of relief and joy to our team.

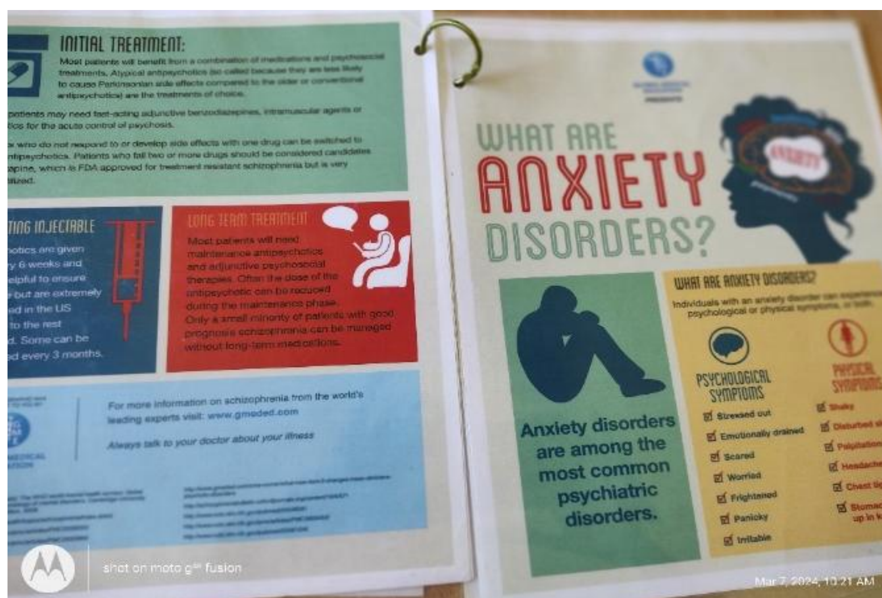
We were fully geared to extend the Community Health Programme to the entire Bumula Sub County, which encompasses roughly about one hundred villages. The number of Community Health Workers (CHWs) was raised from nine to twelve. Until then, CHWs, had managed health issues in their own villages. Now, each CHW is assigned responsibility for 7-8 villages.

Mental Health Training Initiative

Dr. Geetha and her team imparted foundational knowledge and skills to CHWs, enabling them to identify mental illnesses among villagers with greater precision. Common practices include confining mentally ill patients at home or letting them to wander, which makes them a subject of ridicule.

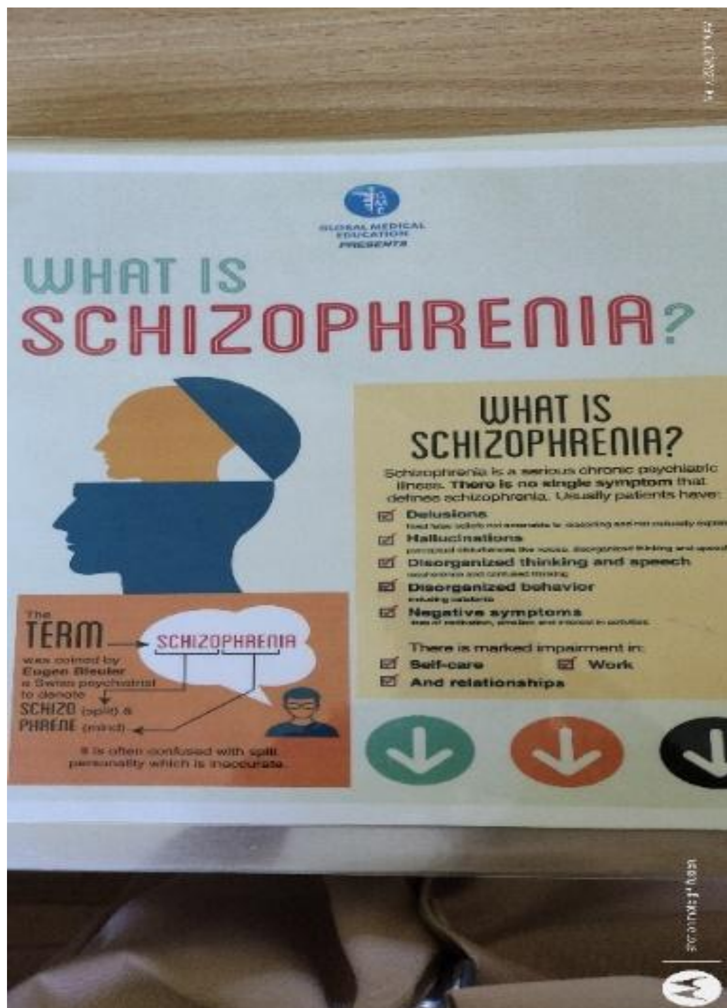
At this juncture, CHWs required additional instruction on mental illness and epilepsy. After training, they were expected to run awareness session in each village so that communities understand the true nature of these conditions. Patients need encouragement to seek medical treatment instead of resorting to superstition or witchcraft.

Therefore, a three -week training programme on mental health and epilepsy was launched for CHWs. The instructional materials supplied by the by John Hopkins Team, USA, proved extremely useful for the training sessions. Moses Karogi from John Hopkins furnished enough copies of the handouts so every health Worker received her own set. By the end of three weeks, CHWs were acquainted with various mental illnesses like disorders such as depression, bipolar disorder, anxiety- related problems, etc. Dr.Geetha also provided Power point slides on these subjects including Epilepsy.



And many more such Hand outs

The Community health Workers (CHWs) were very interested in the classes we conducted for them. Their belief systems were exactly the same as those of the villagers. The traditions and beliefs passed on from one generation to the other, were not easy to shake off. But with repeated



classes and explanations as well as their implicit faith in those who taught them, (also CHWs were educated to some extent), old beliefs slowly were replaced by the more factual knowledge presented to them. Besides, they were seeing the patients getting better with the psychiatry and epileptic drugs with which we treated the patients.

With this new knowledge gained, CHWs wanted to know whether prayers would also help healing. We can and should pray to God in faith, I told them. With God-given-intelligence, humans have discovered medicines for various diseases including mental illnesses and epilepsy. He is the author of life. Medicines are God's instruments and we use them to be healers. They posed numerous pertinent questions and resolved many of their uncertainties. This preparation enabled them to address the myriad questions that villagers would raise during the awareness campaigns they were scheduled to conduct later.

Online instruction for Community Health Workers

At that time John Hopkins University was deeply engaged in the CHW Training Programme. The cost of their initial visits were funded from their own resources. With the project now approved, they anticipated that it would cover their and other expenses. Due to post- Covid -19 travel bans, the United States did not allow trips to Kenya. As expected of Dr. Geetha,

she refused to let any obstacles to compromise the quality of her work. She directed her team to deliver online classes for CHWs in Kimwanga. On our side, we equipped computers and prepared for the sessions. The CHWs participated in three virtual classes in 2022 conducted by John Hopkins University team. The Team was extremely happy with the interest and enthusiasm shown by our CHWs during these online sessions. They raised insightful questions, cleared their doubts and expressed eagerness for deeper details of the material being taught.

Can you envision these rural women, once simple housewives, now joining online courses broadcast from USA? I advised the CHWs not to underestimate themselves as ordinary village women. They have now gained international recognition and appreciation! It became a reality. Moses Karogi informed us that the Kimwanga Dispensary and its CHWs were highly regarded among the staff of the Psychiatry Department at John Hopkins University.

The training initiative and follow- up of the Kimwanga Psychiatry programme remained an ongoing endeavour. Between August 2022 and June 2023, the US Team visited Kimwanga three times. The John Hopkins team's commitment to assisting psychiatric patients in rural regions greatly aided the advancement of the programme in an effective and efficient way. Sister Agnesita could elucidate and discuss the patient issues with them. They would also examine patients personally and confirm the diagnosis and treatments. If any modification in the treatment process required, they would notify Sister Agnesita and she would act promptly.

Team from USA treating the mentally ill patients – 2018

Welcoming USA Team -2023

Rotary Club members were regular visitors to our dispensary. Rotary members interested in Mental Health in Nairobi, whom Dr.Geetha had met in international meetings, would come regularly to plan and evaluate the project. They knew about our work and would drop in whenever they could find some time. Bungoma County officials would call Sister Agnesita and ask her for details of the programme; they were happy about the services we were rendering to the people

On the occasion of inauguration of Global Mental Health Project

I suppose that the reader would have no objection now about the title of this Chapter. Moreover, I think we become global first in our attitude, in our thinking, and above all in possessing an "Enlarged Heart" which can embrace the whole world without borders and barriers.

11.

Go Out and Spread the Good News

"You have given us the knowledge and we have the interest. You are right in telling us to go out to the villages and share this knowledge, not in one village but each of us in 7-8 villages. It was alright for us to walk within our own villages even if it is about two Kilometers or more. But how will we manage going to 7-8 villages?" asked the CHWs. I did not expect them to walk 8-10 Kilometers per day. Bicycles were budgeted for in the project. CHWs did not know about this.

"Can you ride cycles?" Oh, yes, they unanimously shouted with joy. I had a bicycle in the clinic. A riding test followed. One by one, they had to ride the bicycle for some distance. They proved to be good cyclists. There is an exception to everything. One of the CHWs was a handicapped person. She could not use her right hand as well as left leg. That was Doris Wabwile. She stood aside, sad and despondent. She was almost sure that she would be dropped from the list of CHWs and as a consequence, be deprived of her monthly allowance that she was receiving. "No, problem Doris," I called out to her. "I will give you a travel allowance; it is to be used only for going to the villages allotted to you." Oh! She beamed with joy.

Sr.Agnesita and the sisters inaugurating the project

CHWS ready for their ride

Preparation to Go to the New Villages

For the past few years, CHWs were working in their own village and in their neighborhood. They were familiar with these villages and with individual families. But now they were going to people whom they did not know. At times people could be hostile and even reject them. I explained to them that when they go to a new village, they must be in their uniforms and should introduce themselves to the people as Community Health Workers from Carmel Dispensary, Kimwanga. They had also to inform of their presence in the area to the village officers and later on meet the Sub-Chief and Chief of the area.

They were given the Format prepared for Data collection. Sister Agnesita told CHWs that their data collection was not to be like data collection for Census or any other data collection used for the mere gathering of information. Instead, the data collection by CHWs was intended to provide services to families and villages. It was also an opportunity for CHWs to understand the families, their problems and their needs in detail. Therefore, they should spend sufficient time with every family, introduce themselves, and explain the purpose of their visit and of their continued visits to their families and their villages. Gradually they had to prove themselves to be friends of the families. Only then should the CHWs start the data collection.

Why was all this preparation and precautions needed? You may ask: It would not be easy for families to disclose illnesses such as mental illnesses and epileptic problems of their family members. Families are afraid that if these diseases become known to others, it would adversely affect their family status and relationships. We wanted to change such beliefs and fears and convince them that these diseases were like any other physical illnesses and could be treated. However, it takes time to build up confidence and trust in the people and for the disclosure of their problems.

Data Collection

CHWs were given a format for data collection which made it easier for them to conduct the survey of the families in a village. They were given exercise books in which, according to the Format given, they would enter the statistics of each family. The information collected from the families included, the name of the villages, and number of family members, their name, ages and sexes, and whether there was any one with mental illness, epilepsy or any other chronic problems. CHWs had to preserve the exercise books; they would need these particulars of the families for their follow up

visits. Once the survey of a village was completed, they would collate the data of that village and would bring the data to our Centre and the Computer operator would enter it into the system.

A Sample of Data from the villages.

Date	No.	Name of the village	No. of house hold	Population	Mentally ill	Epilepsy	Awareness Program No of Participants
May	1	Namwini	67	369	8	3	38
2022	2	Sifuniame	60	571	8	5	34
	3	Bumula Centre	104	681	11	12	20
	4	Mwiyenga	415	6,254	17	7	100
	5	Sang'o	215	1,800	6	8	34
	6	Myanga	565	6,100	15	16	34
	7	Lwanja	583	2,167	3	6	150
	8	Nangeni	616	2,610	3	7	96
	9	Mwomo	533	1,064	1	5	83
	10	Nalutiri	480	994	2	8	110
Oct.2023	...104	Muhanda	121	920	4	6	21
		Total	**18,015**	**1,42,967**	**365**	**542**	4577

Persevering Effort

While gathering information in the villages, the Community Health Workers (CHWs) became intimate with local families and acted as trusted advisors to the residents. At this phase, the CHWs focused on households with members affected by mental illness, epilepsy or health issues needing attention. The families were informed that medical treatment was accessible at Kimwanga Carmel dispensary or Bungoma County hospital. Nevertheless, due to entrenched prejudices and superstitions, persuading these patients to seek health care, proved challenging, which was an anticipated obstacle.

Over time, as CHWs kept visiting the families, the villagers understood that the programme was not a short-term or fleeting intervention. Word had spread throughout Bumula Sub County that the CHWs of Carmel dispensary, Kimwanga were conducting comparable outreach. Furthermore, some villagers had already visited the Carmel dispensary for various ailments and experienced health recovery. Consequently, a segment of the population was prepared to heed the CHWs advice and visit the Carmel dispensary, though they still had numerous inquiries

At that point, CHWs announced that they would arrange a village meeting so that all the families could assemble for the meeting. At that meeting, they would be given more information and they would be able to clear all their doubts and get answers to their questions. People agreed. So, CHWs met and enlisted the cooperation of the village officers, as well as of Sub-Chiefs and the Chiefs of the villages and started organizing village meetings.

This process of data collection in the villages went on from May 2022 to October 2023. During this period, one hundred and four villages were covered: data collected, collated and compiled and entered in the system in the Dispensary. This process of data collection and documentation provided a comprehensive view of the mental health problems of Bumula Sub County. Once the data collection of a village was over, the next step was to conduct the Awareness Programme in that particular village. This process went on beyond October 2023. At their fortnightly meetings, the exercise books with the details of every family were checked and the collated data tallied with what was in their exercise books. Sr. Agnesita saw to it that CHWs conducted awareness programme in every one of the villages allotted to them. This meant people of one hundred and four villages had the opportunity to participate in the awareness programme conducted in their villages.

Awareness Programme

For the purpose of conducting the awareness programme in the villages, CHWs were divided into four groups consisting of three CHWs in each group. Initially only CHWs went to the villages to conduct the Awareness programmes. Very soon, CHWs realized that the villagers asked very many questions and they could not provide satisfactory answers to all their questions. So, our Nurse Emily Masinde accompanied them to the villages whenever there was a meeting with the people. When CHWs found it difficult to answer a question, the nurse addressed them and gave them a

scientific and satisfactory answer. Nevertheless, it was not easy to erase from their minds the deep rooted traditional beliefs of witchcraft and evil spirits as the cause of mental illness and epilepsy

Since CHWs and the Nurse too, spoke to them in their local mother tongue, even the illiterate could understand what was being said by CHWs. It would be more of a participatory programme. CHWs explained in detail the causes of these diseases. Just like the physical illnesses, mental illnesses are to be treated with medicines. Fortunately, people, at least some of them, from their long experiences, had realized that witchcraft was not an answer to their problems.

The villagers had strong faith in God and so they went to Prayer Centres on their own for healing of their dear ones. CHWs told them that they can pray by all means and ask God in whom they believed, to heal their family members. But God expected them to use medicines for healing of diseases because medicines were produced using God-given intelligence. We will not give them any wrong or harmful medicines, we assured them. There were still some people who were sceptical and not easily moved to accept the good news presented to them. Our words did not produce one hundred percent effect, but still, as time went on, the number of mentally ill patients seeking treatment increased. They could see the improvement in the mental condition of the patients which enabled them to live more or less normal family life.

A Beacon of Hope

The Village Officers and occasionally, Sub-chiefs participated in the meetings. We were pleased to notice the enthusiasm of these officials and many remained until the conclusion of the village gatherings. The subject was completely new to them. Fortunately, as this medically and scientifically grounded knowledge spread throughout the villages and became a common discussion topic at wells and market places. A noticeable, positive influence swept through the community's mindset. Approximately 70-80 % of the villagers were satisfied and persuaded to seek proper medical treatment for their family members instead of spending money on witchcraft and other superstitious practices.

Awareness programme in progress in different villages

As an outcome of these initiatives, roughly two hundred individuals with mentally illness and about three hundred epilepsy sufferers enrolled for medical care. Between seventy and eighty percent of the mentally -ill patients and nearly ninety percent of epilepsy patients returned and follow-up visits and continued treatment. The parents of children with epilepsy noticed daily that their children experienced fewer seizures.

Many children were able to continue their education, and adults could start earning a living. The lives of patients and their families were transformed, bringing joy and hope. People who had nowhere to turn, often due to ignorance or superstition, and those who couldn't afford treatment, found help at the Carmel dispensary in Kimwanga. They could come for treatment, sometimes paying what little money they had, and others received it for free.

The mental health programme was designed for these vulnerable families. Some patients would say,"Sister, I am hungry and there's no food at home-

how can I take these medicines?" Community Health workers (CHWs)confirmed this was a common issue. To address this, a supportive programe was started, providing maize flour for making 'Ugali', a staple food . The neediest patients could collect 4 Kg of maize flour every fortnight, or even weekly if needed. Destitute widows and widowers were also benefitted from this programme.

Agnes, a CHW provides home services to an epileptic boy

Many marriages were saved as patients became less violent or depressed. Some men reported, "My wife has come back-she's caring for me again." While not every case was successful, we were happy with a 60-70% improvement rate. Regular follow-ups, showed tangible progress, and, it was rewarding to see patients' lives improve. I gained valuable insight into the lives of the people in rural Kenya, sharing in their struggles and joys.

Follow up of a psychiatry

patient at home

Epilogue

Seas do not separate; continents and mountains are not obstacles. Human spirit soars high above mountains, crosses the seas and continents and finally it discovers that human beings are essentially of the same make. After all, God created human beings in His image and likeness. Race, colour, language and religion do not matter. It is the heart that communicates. Pope Francis stresses the idea of 'Synodality': journeying together whatever be our culture, language, race or colour.

Fortunately, I had this opportunity to live in a different continent with people of a different race and culture. I had hardly time to master the language of the people. But our communication was at heart level. This communication is much deeper than mere words. People of the area, where I worked, instantaneously understood that I cared for them, loved them, and understood their difficulties and problems. The tears the people shed, when they heard that I was leaving Kenya, was a proof of their love for me and of course mine for them. They wanted to 'baptize, me with a Bukusu name. They said that it looked as though I was a 'Bukusu' at heart and that I always lived there with them. They were simple people and did not hide their emotions. Men on the village roads would stop me and express their sorrow and disappointment because I was leaving the place. I assured them that the sisters would continue to take care for them. Whatever be their reactions, the fact is that I enjoyed working with and working for the people there.