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CHRISTIAN MEDICAL COLLEGE AND HOSPITAL, VELLORE, S.INDIA

MISSION HOSPITALS – WHO NEEDS THEM?

See full story on page 2

MISSION HOSPITALS – WHO NEEDS THEM?

CMC's new initiative

CMC has a long heritage of supporting India's Mission Hospitals primarily through medical training but also by helping with equipment, technical support, staff placements and a shared approach in promoting the Healing Ministry.

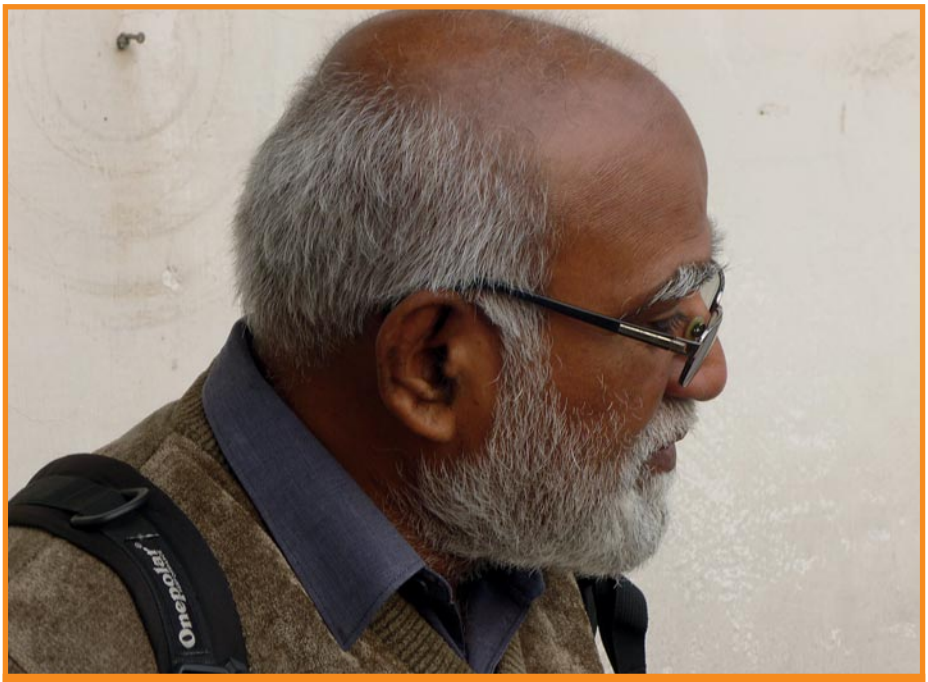
Despite this, Mission Hospitals are in decline. There are probably about 200 left which may be 20% of the original number. Is this important? New hospitals are being created, new doctors are being trained and some states are bringing in arrangements to assist the needy.

The answer lies in the figures. 72% of the rural population has access to 30% of the hospital beds while the 28% of urban dwellers have access to the 70%. Not only that but those living in the more remote areas may have to travel miles to access healthcare. Put simply Indian cities have four times the numbers of doctors and three times the number of nurses found in rural areas.

This problem is further compounded by the fact that long waiting times, poor provision of facilities and moderate medical staff skills have forced people to either forgo treatment or rely on what local ("quack") medical support is available or seek commercial private care which poses an affordability challenge to the majority of Indians.

The Mission Hospitals can be a lifeline as many of them were established to meet the requirements of particular disadvantaged groups or communities and the needs have not diminished. Several of the Mission Hospitals were established over 100 years ago (at the time Ida Scudder was launching what would become CMC) with the same objectives including the provision of healthcare to women who were excluded. Some are sited to help with specific groups - as with the Prem Jyoti Hospital in Jharkhand which helps a particularly poor tribal group, the Maltos, who were described in the Times of India as the most disadvantaged community in India.

They offer sound and affordable but often basic healthcare to large numbers who would fall outside any other provisions. Often they seek to address wider issues including social, educational and even economic



Dr. Sam David: Started as Mission Hospital Co-ordinator in the Mission Office in December 2013.

Prem Jyoti Mission Hospital near the Bangladesh Border in Jharkhand working with Malto tribals.

Neo-natal ward at the Duncan Mission Hospital, Rauxall near the Nepal Border.

Khariar Mission Hospital in Nuapada District, Odisha: One of the most backward districts in India.

matters as part of their healthcare delivery.

In a few years' time, these hospitals may have all but disappeared and they are under pressure from the fast expanding spread of commercial medicine. CMC has sought to upgrade and extend its support for Mission Hospitals to address this decline and we have pledged support for this. As our regular readers will know, our agenda is very much to help vulnerable communities and we believe that supporting the Mission Hospitals will reach out to a very large population needing the help and support of their local Mission Hospital.

We have committed to pay for the salary and expenses of a senior member of staff in the Mission Office to act as Mission Hospital Co-ordinator who will take active steps to assess the priority needs of Mission Hospitals and will through CMC and other agencies start to implement real improvements in the standing and function of Mission Hospitals.

We were delighted to welcome Dr.Sam David to this post in December and our Chairman, Dr. Gareth Tuckwell, and I were able to meet him in February and visit several Mission Hospitals. This tour has thrown up a number of early opportunities which Dr.Sam David will take forward. He has a lifelong experience working in Mission Hospitals and with disadvantaged communities and was working with the Emmanuel Hospital Association before taking on this role.

Friends of Vellore sees the improvement of the status and function of Mission Hospitals as a major opportunity to work through CMC and other agencies to deliver healthcare on a wider scale to underprivileged communities and any help, gifts and support are welcome. We have started a Mission Hospital Fund to help aid the initiative which has absorbed the Thompson Fund, which many of you were kind enough to support, after discussion with the Trustees and Thompson family.

Front cover image:
Maltos - India's most disadvantaged community: Times of India

Medical Missions in India

Past, Present & the future

CELEBRATE THE PAST:

The role of the church in establishing hospitals in India dates to the early part of the 16th century, yet, it is only in the latter part of 19th to early 20th century, with the intervention of "social theologians" that medical work became part of church's missionary activities. By then there were substantial advances in scientific knowledge of the human body and ailments associated with it.

The church pioneered in taking these scientific advances to many regions in India by establishing hospitals. Over the last 30 to 40 years we have seen others actively participating in health care ventures. In the past, medical care was a luxury for men but for women, it was almost impossible. Hence many Christian hospitals started out for women. Sir Kedarnath Das stated that "*medical missions were largely responsible for introducing Western obstetric methods in India*".

Three generations. The majority of births are at home and problems are unreported and the death rate for mother and babies is high especially with girls as young as 11 or 12 being married in these poorer communities served by Mission Hospitals.

COMMITTED TO THE PRESENT:

The Missions' Office here in Vellore is committed to the present. Sadly, many of the hospitals that flourished till the middle of last century have closed down and we are left with about 200 hospitals.

In India, every 14 minutes a pregnant woman dies due to complications

Many are struggling. Almost all students going through the portals of CMC have an opportunity to serve through some of these hospitals, in some of the neediest and marginalised areas in India. The condition of women and children in rural India still continues to be pathetic. It is encouraging that some of the hospitals within the network of CMC are passionately involved with communities that are excluded and impoverished, living below the poverty line. There are staff that have gone well beyond the walls of the Mission Hospital and are involved in the community to help alleviate burdens and extend care and compassion. They felt the need of the community has become their concern. Community based development and rehabilitation, education, agricultural initiatives and insurance schemes for specific target groups are amongst the many forms of involvement.

We thank God for those who have moved out into areas of need and are there on behalf of us all, helping the poor who would never have any access to health for themselves. Stories from the field are heart breaking. Many a times the sick are brought to these hospitals in very critical condition. Even today our colleagues in smaller mission hospitals see many pregnant women with impending ruptured uterus, eclampsia and all kinds of complications. It is our joy to partner with many doctors, thousands of nurses and others of the health care teams that are active in many areas of need. It is important to motivate younger ones and support those who have responded with a sense of calling. We cannot afford to be laid back now and allow these hospitals to deteriorate or close down. In many poor areas these are the only source of quality health care. It involves sacrifice and compassion as modeled by our Lord Jesus Himself.

CONFIDENT OF THE FUTURE:

We are working out schemes to stand by those who have made a commitment to serve among the needy. Each one in the team is important. They all play different roles and are subject to considerable and sustained pressure. We must identify the priority areas

and encourage groups to pioneer. The immediate requirement is to improve and modify the mission website of CMC, make regular visits to the hospitals in our network, support with equipment and relieve some of them from time to time from the sustained pressure on staff. We should identify urgent demands, passing on information and concerns to the faculty here and the alumni globally. The most important area is to help with reviewing

governance and to pass on good practices to those who ask it of us from within our network. We must encourage and support students and graduates within CMC to carry on the vision of Aunt Ida and the motto of CMC.

"Not to be ministered unto but to minister"

Dr Sam David: Missions Office CMC leading on CMC's Mission Hospital Initiative.

REFLECTIONS ON HEALTHCARE AND OUR FUTURE STRATEGY

My recent trip with Friends of Vellore (FOV) Director, Richard Smith, to visit the amazing work being done by Mission Hospitals led me to reflect on healthcare in India and the challenge of comparing that to what we receive in the UK.

The NHS here is doing a great job in delivering core evidence-based target-driven healthcare, primarily disease-care, but we have a dream, perhaps, of something more...of building communities where health is found through an environment that offers relationship, compassion and care; communities that embrace the totality of our need. The Francis report emphasised some of the potential gaps in UK healthcare. Here, so many of our illnesses arise from stress, poor relationships and self-harm of one kind or another. On our trip, we saw wonderful healthcare being delivered with the minimum of resources, care that was often centred on every aspect of each person's wellbeing.

Health is a concept like truth which cannot easily be defined. To define it is to kill it. Nor can it be possessed. It can only be shared. There is no health for me without my brother or sister. There is no health for Britain without India. Health is a value word. The language of science alone is insufficient to describe health. Giving people the medical treatment they require does not necessarily bring health.

Friends of Vellore is passionate to work with CMC, Vellore to bring wellbeing to poor, deprived and disadvantaged people. CMCH is one of the finest hospitals in India and yet it holds to a bigger vision of health than we do for the UK as it seeks to be a living witness to the healing ministry of Christ, working in partnership with the church and committed to the promotion of health and wholeness in individuals and communities, with a special concern for disabled, disadvantaged,

Access to any healthcare – even basic – is a blessing.

marginalised and vulnerable people.

Health is something we crave but we often look in the wrong places to achieve it! Perhaps it is often found in relationship to God, to ourselves (in accepting responsibility for who we are, rather than looking in the mirror and longing to be different), to community (our neighbours both locally and further afield) and lastly in relationship to our environment as stewards of our God-given resources. Health brings wellbeing and a sense of coherence. It embraces a restoration of the possibility of fulfilling the purpose for which we were created.

I believe it was A.C.Oman who suggested that health and wellbeing speak of a depth of relationships such that to be me, I have to be me in such a way that I help you to be the 'you' you are meant to be'.

As we travelled from hospital to hospital, we began to see a picture of 'being healed communities' where care and love are the backdrop which enable each person, individually and jointly, to become more fully human. We could see how in sharing their loaf with another they may meet, not only their hunger for food, but also their hunger for community. It became clear that in sharing, we make health possible for one another.

Whilst the longing for health has always been with us, in the UK our expectations today are rather different to those in India. There, I watched a woman of 37 being told she was dying of cancer. She was serene, accepting, strong in faith and just concerned for her family.

When we look at definitions and expectations around health, we are also called to reflect on responsibilities; those of professional care-givers and those of the wider community. These responsibilities are inextricably linked to the social, economic, cultural, spiritual and political realities of our day.

In much of India, expectations around health are very low. The acceptance of dying, at what we would call a young age, is amazing. The wider community so often recognises that health is a community responsibility. I remember my amazement when I visited the home of a man who was dying of cancer. I turned round whilst examining him and saw about a dozen members of the village standing there watching. They were his community; they were committed to his wellbeing and his care. We would be quite upset if our neighbours wandered into our home whilst the doctor was examining us in bed! In India there is a strong bond, often forged through adversity, which minimises any sense of self-pity and brings a skin of hope and a shared sense of belonging.

So health is situational; it is related to what a people group believes to be fullness of life for them. It is an expression of the qualities to which they give value, including their capacity for enriching community relationships.

Here in the UK I often hear an individual response that cries "this should not happen to me". At some level, we are all seeking health. And yet so many of the people we saw in India could seemingly tolerate stress; that is, they were prepared to suffer. Health does not exclude suffering. Perhaps a whole-hearted acceptance of our mortality is essential for health, both personal and social. And of course in India death is still common at all ages and not hidden away as it so often is here.

The amazing advances in medical treatment, with which we in the UK try to keep death at bay, may result in us keeping so called 'well', for which our appetite is ravenous though perverted. But in the struggle for health, for meaning, for community and for fuller humanity, the tools are different. If health is a gift, we need not only to strive but also to listen, to bear, to wait, to wonder and to worship. For we are what we receive.

I long for healthcare here to embrace community, with a fuller humanity at its heart, to recognise that spiritual and religious care are not just 'add-ons' for political correctness but are needed because they are integral to peoples' journey into health.

It is against this backdrop that the Friends of Vellore Trustees have sought to review the Charity's strategy and redefine our partnership with CMC for the next 5 year period.

The charity has a clear focus on its primary call to further extend the work of CMC to poor, deprived, vulnerable and disadvantaged people. We will support CMC in every appropriate way to hold to its Christian ethos as it seeks to serve the nation of India in the Spirit of Christ. We will strengthen the ability of CMC to reach out in innovative ways to meet the healthcare and wellbeing needs of the impoverished and excluded. The ways we do this may change from year to year but that will be our focus. At present we offer support in many areas including:

- Through the **Person to Person Fund**, promoting the fantastic benefits of donating to the fund and bringing the best of treatment to so many who cannot afford medical help;
- By encouraging the outward-looking drive within CMC to resource **Mission Hospitals** through networking, communication and staff training. We will look at ways of working with CMC to ensure the success of undergraduate and postgraduate placements and explore creative ways of seeing they have adequate professional healthcare cover at all times;
- Looking to help extend the work of the **Low Cost Effective Care Unit** to enable it to widen its reach and strengthen the portfolio of services it is able to deliver;
- By supporting the **Rural Unit for Health and Social Affairs** in their endeavours to develop programmes of support to those living in extreme poverty who struggle to access health and development resources. Grants will be made through the charity's Vellore Rural Communities Trust Fund (VRCT) and preference will be given to innovative schemes that have the longer term potential to become self-sustaining;
- Offering financial support for the domiciliary work of the **CMC Palliative Care Team** and the provision of symptom-controlling drugs which cannot be afforded by those with life-threatening and progressive disease, along with funding some short-term bereavement support for families.

May God bless us with discomfort at easy answers, half-truths, and superficial relationships, so that we may live true to our hearts;

May God bless us with anger at compromise, prescriptive solutions, and political expediency, so that we may work with compassion for a better way, for freedom, healing and peace;

May God bless us with tears, so that we may be set free to reach out our hands to bring comfort, and our hearts, that we may share in the pain and joy of those who are vulnerable, sick and marginalised;

And may God bless us with enough foolishness to believe that we can make a difference in the needs we encounter in India, so that we can Encourage CMC Vellore in what others claim cannot be done, to bring health and healing to all those potentially within their care, but especially to those clinging to the bottom rung.

Any financial gift to Friends of Vellore UK will go to one of these amazing projects that will help to transform the lives of individuals and families as they receive healthcare, love and compassion brought in the name of Jesus. Our charity keeps its costs to an absolute minimum so that all your gift will reach those offering care on the front line.

Gareth Tuckwell

Service & Careers

The trend in Indian healthcare is towards more commercial private work and more specialism. Increasingly doctors in India feel the need to become ever more qualified and a "super specialist" while the essential needs at primary level are ignored. This is apparently a problem as Indian patients always want to see a specialist not a generalist! Family Medicine and General Practice are not highly regarded which has become part of CMC's problem. CMC is a major "Centre-of-excellence" Tertiary hospital which receives over 2 million patients a year. Probably the majority of these do not need the sophistication of treatments that CMC offers which could be addressed at primary or secondary level if there were the capacity and facilities especially nearer their homes.

One solution is to widen the range of provision of health services. In the UK for example there are 85,000 Allied Health workers playing major roles in the NHS and working in multi-disciplinary teams. So while training doctors in India is vital there needs to be rebalancing and re-evaluation of their role alongside the whole range of medical staffing and resources. Even modest local training of Community Volunteers as we did at RUHSA a few years ago will have a role.

Perhaps a sign of progress in this direction at CMC has been the acceptance of nurse practitioners to undertake anaesthetic work. However it was disappointing to learn from staff at CMC that posts at LCECU and RUHSA were difficult to fill as the work was seen as professionally of lower value. I was told that it was not a question of salary but of perception.

Dr Ajit and Dr Pushpa Singh at Khariar.

When you start to look at the wider implications of this, there are some real issues building up. Visiting Mission Hospitals, it is easy to find major staff shortages, the absence of whole disciplines and wards closed due to lack of qualified staff.

CMC has taken real steps to encourage students and staff to look at the needs of Mission Hospitals. Many going there on placements have found the experience highly valuable as they have addressed clinical conditions which they had not previously encountered. However the essential problem is that many such hospitals are existing on extremely modest resources and have basic facilities. Treating the poorest is not a formula for great salaries and it is easy to see the limited appeal.

Staff Accommodation at Ranipet Mission Hospital (complete with leaking roof!)

Many students graduating at CMC return to Mission Hospitals under a commitment (a bond) which requires them to serve for a fixed period. However in addition to the standard and style of clinical work there are major issues for doctors with poor accommodation and for those with families the absence of social life and schooling for the children. Many working in Mission Hospitals have to send children to be educated.

One other way forward is for staff retiring at CMC to help and this approach is being encouraged especially given the high levels of expertise and experience found in this group.

CMC has always promoted Christian service and there are some truly dedicated staff working in these disadvantaged areas. During our recent tour of Mission Hospitals, Dr Tuckwell and I met Dr.Ajit Singh who runs the Khariar Mission Hospital with his wife Dr.Pushpa. They have been there for over 40 years providing quality healthcare in this disadvantaged community but now want to retire. Who will replace them? It is an issue causing much concern as it is a very deprived area.

How can CMC start to change the balance of healthcare provision? On its own it will be difficult. However recognising the changes in Indian healthcare and supporting the extension of the Healing Ministry by promoting service and career as compatible goals in advancing healthcare would be a good model.

GIFT AID

You will all know the benefits of Gift Aid. Every taxpayer can complete the form on the donation slip or downloaded from the website. The charity gets an additional 25%.

The tax office has been tightening things up however! Our return for claims requires us to put in the address of every donor. They have also said that Gift Aid slips must be completed by an individual and "Mr & Mrs" certificates will not be accepted in the future.

Please send in a fresh Gift Aid slip if you have changed address, the original certificate is in joint names, you have not sent in one in the last seven years (the wording is tighter now) or if you have any doubts about your Gift Aid registration. Put simply I would rather have too many than risk a rejection!

"I Never Knew"

Time and again, I meet families whose loved ones have received help for their treatment through the PTP Scheme. They tell me, "If I had known about this assistance, I would have come for medical help much sooner." Many wait days, weeks, months, even years before, at their wits end, they come to CMC.

I think of a nineteen year old, who broke his arm, falling off a wall. He could not afford to go to the doctor. Ten years later the gas stove blew up in his face, leaving him with very significant contractures, both from the arm fracture and the burns. It was only after six months that he eventually came to CMC. With the skilled help from CMC staff, gifts from PTP donors, as well as concessionary treatment by CMC his life is being transformed.

Another little boy, whose story appears below in this Newsletter, was born with a severe deformity of his left leg. His parents are both manual labourers. They exhausted what little savings they had treating the child in a local hospital but the cost of his treatment has now been met by donations from the PTP scheme, with the rest being absorbed by CMC. He is being given hope for the future.

On behalf of all those whose lives have been enhanced and transformed by your gifts I record my grateful thanks.

Ann Witchalls

Jonathan and his parents with their new baby daughter.

JONATHAN

The little boy lay flat on the examination trolley in the crowded paediatric casualty room. His big brown eyes, filled with fear, searched the doctor's face. His parents stood by, anxiously waiting for answers.

The toddler's scarred, disfigured left leg was glaringly obvious. A thin towel was hastily thrown over to dissuade curious onlookers. They had already been through 3 hospitals in the past 2 months and a fairly major operation and he was terrified of needles. With the severe infection and pus from his thigh his already abnormal leg looked grotesque. His mother was 8 months pregnant and it was obvious that she found it hard to hold this worried child and dodge the bustling crowd of the paediatric emergency room. He needed to be admitted to hospital and was quickly transferred to the children's ward.

Jonathan was just one year old. His parents come from a village about 100km (60 miles) south of Vellore, close to a large nuclear installation. Both his parents have only elementary education. His father was a fisherman by profession, but since the nuclear plant was built he no longer works as a fisherman, accepting any odd jobs he gets, including driving, or manual labour, to make ends meet. His wife also does manual work for daily wages, when she can. With luck between them they can earn £20-£30 per month. They live in a small rented house, for which they pay £20 per month. "Jonathan", which means "Gift of God" was the youngest of their children. The mother was expecting the next. From birth there was clearly something wrong with the baby's left leg. It looked swollen in comparison with the right leg and the malformation only got worse as the infant grew. He could not wear normal clothes and the left leg looked unsightly. They took him to a private hospital locally where he was diagnosed with a lymphatic- venous malformation. With this condition the flow of blood through the blood vessels is restricted. The affected area gets repeated infections. The doctors at his first medical centre carried out radical surgery to excise and reduce the swelling. They felt the entire malformation was too large to deal with at once. Later the leg became infected again and was treated with antibiotics. The family was told that the toddler needed further surgery on the left thigh. But they had exhausted their resources on the little boy's treatment thus far. They were advised to bring the child to CMC where their case would surely be sympathetically received. Leaving their other children with relatives, Jonathan and his parents made the long journey to Vellore over bumpy roads in the rattling old bus.

This time the paediatric surgeons operated on the little boy's left upper leg to excise the swelling after treating the initial infection with intravenous antibiotics. The condition of Jonathan's leg has greatly improved. There will always be some malformation and there remains some disfiguration of his left leg, but he is able to wear trousers normally. His parents, and the child himself later on, will always have to watch regularly for any sign of infections. Jonathan should be a normal, lively little boy, taking his place in the family and community. His mother has since delivered a beautiful baby girl, and they are thrilled that she is perfect. Jonathan is proud of his new little sister.

The cost of this expert surgical care came to £460, a sum well beyond the limited means of such a poor family. They were unable to make any contribution towards the hospital bill. We took care of Jonathan in the hope that some kind donor would finance his care and £50 was allotted through the Person to Person Scheme, through your generous donation. The remaining amount was settled by the concerned unit and the institution. We join the grateful family in thanking you for this timely help.

Old Town Successes *for* LCECU

In 2012, we selected work in Old Town as our 50th. Anniversary project. It has turned out to be a good choice and the enthusiasm for the initiative both in Vellore and here in UK has been great.

We are very grateful to the regular donors who support this programme and the amazing fundraising efforts in Aberdeen and Walberswick.

You will recall that we have enabled clinics to be set up at various locations in the poorest areas in this disadvantaged community and our funding for extra staff – Helen, a Community Nurse, Trinity, an Occupational Therapist and a driver – is in its second year.

In February, I was delighted to meet Dr.Sunil Abraham who is now in charge at LCECU after returning from Australia. He was excited by the programme and we discussed ways in which the work might be extended further. Dr.Sunil mentioned a special interest in the street children and is investigating whether they can be helped.

Dr Sunil Abraham who now Heads the Low Cost Effective Care Unit.

He is also still keen to find the "really poor" people who have fallen outside any support and who would not present themselves at LCECU or any of the clinics. We have said that we would fund a field worker if that was helpful to look at the issues with the street children and to see if the really vulnerable can be identified and given help.

There are always some rewarding stories coming out of LCECU and the following is an example of life in Old Town and the unbelievable challenges that people face.

Padmapriya (Priya) is a 28 year old lady who lives in Old Town, Vellore. Her father died when she was about 3 years old. He used to run a small roadside eatery on a cart at the old City bus station. Her mother, Nagavalli used to help him. Following the demise of her father, Priya's mother began to work as a housemaid at 3 households to raise her children. After completing grade XII at school, Priya got married to Ravikumar (Ravi), an auto driver. Her elder brother, a cab driver lives with his family about 17 miles from Vellore. He rarely visited his mother and sister in Vellore, nor did he contribute anything to support them.

After marriage, Priya went to live with her in-laws. 2 daughters, Shankari and Nandhini were born in 2002 and 2004 respectively. By this time her husband was irregular at work and began abusing alcohol. There were regular arguments in the home. The family moved to a house adjacent to her mother's. Ravi incurred heavy debts due to his drinking and had to sell his auto. He was forced to search for odd jobs. Later on, he started working as a labourer in the flower market.He continued to drink and his alcohol consumption grew worse by the day. This exacerbated the torment and beatings that Priya had to face. Eventually, she came to LCECU complaining of body pain and backache. Later she was diagnosed and treated for depression. Then one night, in a drunken fit, Ravi poured kerosene over his wife, setting light to her. The neighbours heard her screaming but initially thought it was the regular fighting going on. Soon they realised what had happened and came to her rescue. After putting out the fire they were about to attack Ravi but he ran for his life. Priya had severe burn injuries and was taken to the government hospital. A case was filed with the police the following day, but Ravi's family pleaded with Priya to withdraw the complaint to save Ravi from getting into trouble. She finally withdrew the complaint and he has since not had any contact with them.

After discharge, Priya attended the Plastic Surgery OPD in CMC where she was told that her initial treatment would cost Rs.80,000. Realising that she was not did not have so much money she was told the subsidised cost for her would be Rs.30,000.Then she heard from her neighbours that if she approached LCECU for help, her costs could be reduced further. So she approached LCECU towards the end of 2012. After LCECU advocated for her with the Plastic Surgeons, they agreed to do the first surgery free of charge. The first surgery

VOLUNTEER WANTED

CMC wants a volunteer to help in the Development and Mission Offices on promotional work including website creation, drafting material and fundraising. This is tied in with the new Hospital Campus at Kannigapuram and the Mission Hospital initiative. The amount of time required is flexible, but there is a substantial programme of work to take forward. If you can help or know anyone with skills in this area of work who might be interested please tell the Director, Richard Smith.

for contracture release on the left elbow was done on 1st February 2013. Following discharge, the doctors in the Plastic Surgery Unit advised her to attend sessions at the Hand Physiotherapy Unit. Trinity, the Occupational Therapist from LCECU, who is funded by Friends of Vellore (UK) followed up with Priya on the home based exercises for isometric strengthening. The Team found that she was going into depression and was emotionally unstable whenever they talked with her. Trinity, the Social Worker and Nurse Helen, also supported by FOV (UK) met her regularly and counselled her and helped her to cope with her situation.

Padmapriya: Outside her home.

On 10th June 2013 the second surgery for the right elbow was done; while she paid Rs.3,000 (£29) for the cost of the medicines, LCECU covered the cost of the rest of the surgery- Rs.23,475 (£232) from its patient support fund. She is likely to undergo another surgery for her left wrist. Nowadays she is bright and cheerful and if you see her smile, you would never imagine the trauma she has been through. To top it all, she has recently started working as a daily wage earner in the same cooking oil shop where she was employed earlier.

RUHSA UPDATE

by Arabella Onslow

Every year, it is wonderful to see how the collaboration between RUHSA and VRCT/FOV increases its impact on the lives of the poorest and most disadvantaged in the rural communities around Vellore. Sometimes it feels like the work is endless, but with the determination of all the staff and support from international friends, the ambitions of RUHSA reach further and further into the community to improve lives. It feels as if there will not be enough space in this newsletter to describe all the wonderful things which are happening there.

Through the generosity of FOV and its supporters which helped build the stall, the goat scheme is enabling local families to earn an income by tending to the animals, which, when sold, will contribute to the running costs of the ongoing elderly welfare centres.

These centres remain an essential project supported by VRCT/FOV as they raise awareness of the plight of older persons in India for whom life can be unimaginably hard. Our key centre at Keelalathur has several new and different members as old friends have passed on, but we know that their last years and months were enhanced by companionship, care, dignity, respect and good food. On every visit, it is striking to learn anew how the simple gift of friendship can bring so much joy. It is humbling to know that with the little we give, so many people who believe themselves to have been otherwise forgotten, feel valued once again. Even though we do not share a language there is a connection made through our shared humanity and a smile speaks volumes.

This year, the RUHSA/VRCT have expanded on their work amongst the younger members of local communities. Their sports clubs were a great success last year and will continue this year. A positive influence is seen on the streets with excited competition between local cricket clubs.

This year they are developing a project aiming to support motivated but disadvantaged students in government schools by improving the teaching of Maths & English - proven to be linked to better employment prospects. RUHSA will start by selecting 45 students from those in straightened circumstances who have the motivation but not the means to shine. We look forward to reviewing the success of this project next year - hoping to refine and develop it and perhaps bringing you stories of young men and women who have benefited from it.

Not all at RUHSA is rosy however, there are still some areas of stark need. As a British GP used to the luxuries of NHS services, observing the clinics in their rural community hospital, was a startling experience. My goodness they are busy; and apparently it was a lean time due to Pongal. It felt like being on a noisy, bustling, exceptionally colourful conveyor belt. 10 minute appointment? No chance. Waiting room with comfortable seats and out of date magazines? No way. The reality was that there were people scattered all around the grounds with insufficient benches to sit on whilst waiting for the few moments with a harried Doctor squished into a short walled, open plan cubicle with an equally harried colleague an elbow poke away in the same space. The luxury of a spacious room with a comfy lean-back chair, a large desk with computerised notes were a dim memory for this GP. In fact, there was not even enough space for me to sit and observe, I had to lean over the partition from the entrance, whilst being bumped and squeezed past by the constant flow of patients, relatives, staff and children moving through the clinic like grains of rice sloshing around on a plate with too much rasam. There is desperate need of a new outpatients department and I experienced their need first hand. It was sobering.

We are so proud to be associated with this innovative, ambitious, humanitarian, humble organisation who have worked for 35 years with their local community in so many ways; we thank them for our friendship and hope we can continue to support their work.

The Bishopston-Kuppam Link

The Bishopston-Kuppam Link has been working in partnership with RUHSA, in KVKuppam, Tamil Nadu, since our foundation in 1978. Originally the idea for forming a friendship link between Bishopston, a suburb of Bristol, and a community in rural India, came from Carolyn Whitwell. The Bristol Christian Aid representative put us in touch with Dr Daleep Mukarji, the founder of RUHSA, who met us in Bristol when he visited England for Christian Aid week.

Elderly and Youngsters interact at Patchikili.

Over the following three decades we worked with RUHSA to develop our link supporting projects and finding many ways to communicate between KV Kuppam and Bishopston.

As an offshoot from our charity, in 1984 Carolyn set up the Bishopston Trading Company (BTC), to provide work for weavers and tailors in the village and to give them an outlet for their products. Several shops were opened providing employment for over 400 people in KVKuppam and its environs. The business was run as a cooperative and worked extremely well for almost thirty years, only closing last year.

I made my first visit to the village in 1991, to set up a play centre/ nursery centre which was originally to have been for the children of the workers at BTC but soon included the children of the poorest in the community. The manager of one of the BTC shops had tragically been killed on her way to work and money was given in her memory to set up this project. Teachers were trained, then in the following years this model of (play centred) learning was developed. With the help of Sekar, a RCO at RUHSA, several more, smaller centres were established in outlying villages.

Fund-raising for this project continued alongside others, e.g. a goat scheme, tiling for thatched roofs, an extra classroom for the Girls' Higher Secondary school and funding for a teacher. In 2002 Pam Morris and her husband Brian made their first visit to the area. They spent several weeks in RUHSA gathering information to create a new online resource for use in

primary schools, on many aspects of life in an Indian village.

The nursery centres were closed down when the Tamil Nadu government began providing nursery classes and food for the children. However, teachers, parents and past pupils felt that learning through play had been most beneficial and should be continued.

That was how we came to buy a coconut grove and to build a purpose-built nursery centre, called the Patchikili (green parrot, in Tamil) play centre, which we hoped would be used as a model school for training other teachers. Whilst visiting one January we encountered Arabella Onslow, who filled us with enthusiasm for the day centres for the elderly which VRCT have established in the area. We decided to use a spare room at the play centre for our own elderly

The Patchikili Centre.

resulting in an integrated project for both elderly and young to interact on a daily basis, to the benefit of both.

Although we still have a small committee which works for our link, most of the fund-raising has been done by just a very few of us in recent years. The young mums who began this venture are now grannies and we have recently thought that we need to plan sensibly for the future of our projects. BKL and FOV have had a relationship from the earliest days when FOV helped us out with the transfer of funds before we were registered as a charity. It seems to us that the aims of VRCT (now formally part of FOV) in particular accord very closely with our own and with this in mind we have made overtures to FOV and to VRCT, to ask whether we might consider some kind of a merger, to come in under their umbrella. We are going through the process of consulting on this with our supporters, with a view to effecting the merger in 2015, if all goes well. As a committee we are excited about this next move in our history, and delighted to be working with a group of people in FOV and VRCT who clearly share our vision and hopes.

Sally Whittingham

PALLIATIVE CARE
Families' Fund

Many will recall the story of Mrs G from an earlier newsletter. Following the sudden death of her husband after support from the Palliative Care Department, she was left nearly destitute with two young sons to look after. She tried very hard to raise funds including making rice cakes to sell in Vellore but she was really struggling. A kind donor has contributed a small amount regularly into the Palliative Care Families' Fund with the aim of supporting the boys' education. This has been an enormous help to the family and we are very grateful for these donations.

This year we decided that funding for Mrs G was no longer required. The boys have finished schooling and both are working – one in a garage and the other in a photocopying shop. Mrs G is working as a maid in three homes and has managed to improve the house by getting a new roof. It is a very positive situation compared to three years ago.

Mrs Kamala with her son.

Mrs Kamala's two school going children.

Needless to say, Mrs G's situation was not unusual and we are delighted to help the Palliative Care team by supporting the Families' Fund.

Almost immediately a new challenge arose with a lady called Mrs Kamala who had been referred to the Palliative Care Department. Again it looked like a situation where we could help through the Families' Fund.

Kamala had been diagnosed with recurrent cancer of the hypopharynx – part of the throat. It had been a devastating blow for this forty five year old widow.

Hailing from a village near Vellore, Kamala has four children : her first two daughters are married and both sons-in-law work as

labourers at local shoe factories. The third daughter, aged sixteen, is at school, studying in Xth grade and her son, aged eleven, is studying in Vth grade. Her husband was a beedi worker, rolling hand-made country cigarettes called "beedies". He was an alcoholic and had died suddenly six months before Kamala came to the Palliative Care Department.

Kamala's only resource is the small two roomed house in which she and her family live. This had been built and allocated to them by local government, since this is a family which falls below the poverty line. Her main source of income is the widow's pension of Rs.1,000 (ten pounds) per month, which she receives from the government. She also gets an allocation of 20kg free rice per month from the authorities.

At the weekly team meeting the Palliative Care Team discussed Kamala's situation and decided how best to help. From funds set aside for just such situations, the school going children were provided with note books, school bags and uniforms. Kamala herself is not charged when she comes to the hospital for consultation and pays only a token amount of Rs.25/- for each fortnightly supply of medication. The Palliative Care Team will now enrol the two school going children in a residential school and underwrite their schooling costs in the next academic year, beginning in June, from FOV's Palliative Care Families' Fund. Support for the funds (including from the donor who originally helped Mrs G) means we should be able to help the children complete their education.

The work of the Palliative Care Department extends far beyond concern only for the sufferer. Their compassion and practical support encompasses the sick person's family and total life situation, continuing when relatives are left bereft. Patients can be at peace knowing that their loved ones are still being followed up, as necessary after they have gone. In this the Palliative Care Team is helped by well-wishers from all over the world who generously support the on-going work. A gift to the Palliative Care Families' Fund will always help people often facing a sudden and dramatic change and help reassure terminally ill patients that their family will be supported.

CHANGE OF DATE FOR CMC JUNE COUNCIL

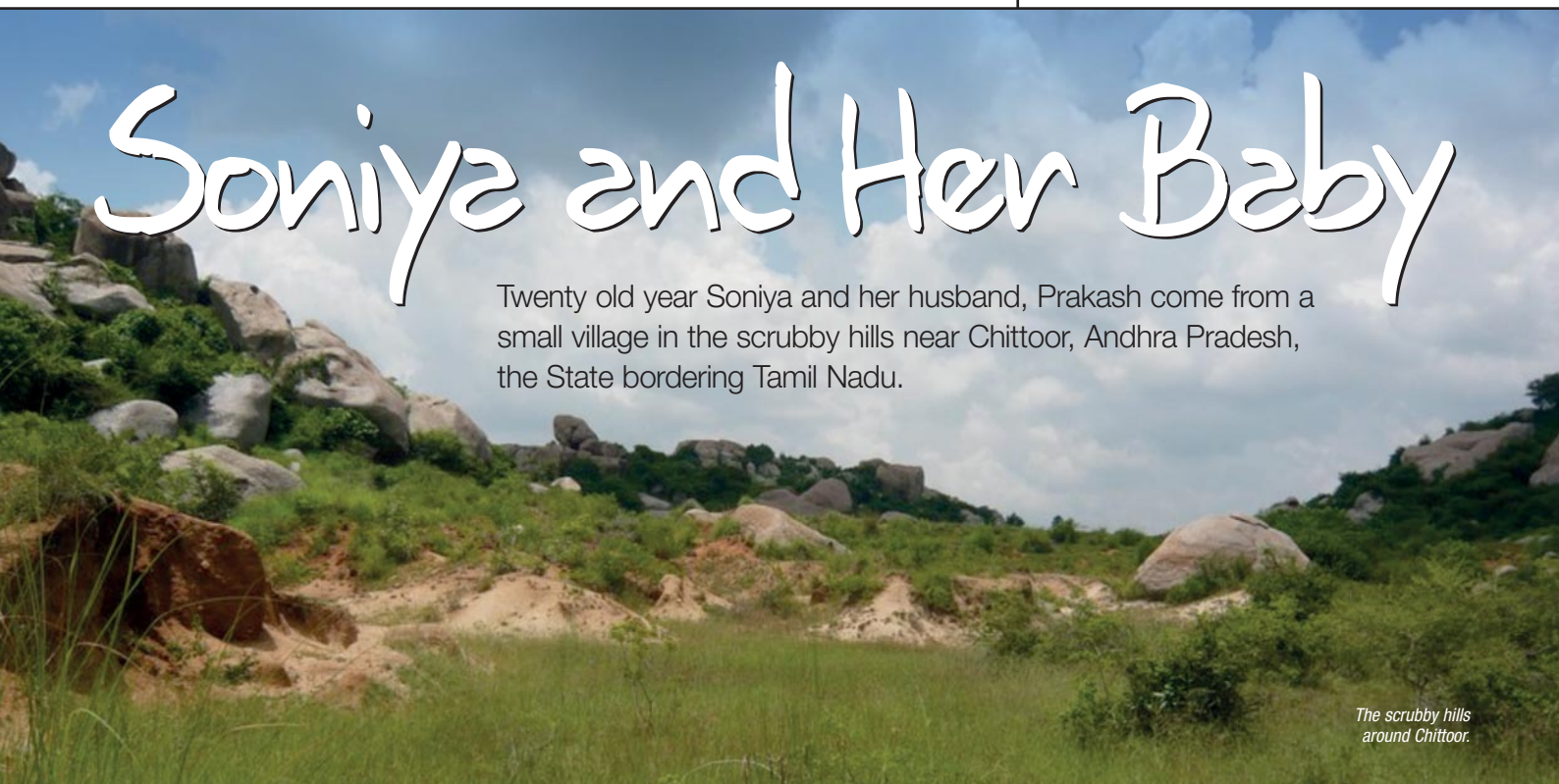
Please note that June Council date at CMC has been changed from 26th & 27th. June to July 3rd. & 4th. to allow Dr Sunil Chandy to make an overseas visit in conjunction with fundraising for the new Kanningapuram Campus.

Please Remember

the 2014 Maitri Prayer Calendar is available on the Charity Website.

Soniya and Her Baby

Twenty old year Soniya and her husband, Prakash come from a small village in the scrubby hills near Chittoor, Andhra Pradesh, the State bordering Tamil Nadu.



The scrubby hills around Chittoor.

Only a few months after their marriage the young bride shyly and joyfully told her husband that she was pregnant. Anxious to do the best for their first born, Soniya regularly attended her ante natal classes locally. She registered to have the birth at their local hospital.

During the cooler part of the year the villages around Vellore are plagued by a significant increase in the number of people suffering from scrub typhus. This is a condition caused by mites which thrive in damp undergrowth and scrub land; hence the name. It is difficult to prevent the disease, especially in rural areas. Thirty two weeks into the pregnancy, Soniya went down with a seriously high fever. She went into premature labour. She reported to the local hospital, but they regretfully said that they were not equipped to deal with such a situation. Prakash was advised to take his wife to CMC, where Soniya would receive the most up to date care. Straightaway, accompanied by Soniya's mother they caught the bus to

make the bumpy, 16-20 mile journey to Vellore and CMC.

Once in CMC Soniya was admitted in the maternity unit where her high fever, which was diagnosed as scrub typhus, responded very well to antibiotics. Within a short space of time her little son was born, crying lustily. He weighed just 1.6 kg (4 lb). Because the baby was born prematurely, and of somewhat low birth weight, he was transferred to the nursery for premature babies. Here he was cared for until he reached an acceptable weight. He was treated with intravenous antibiotics and given phototherapy and kept warm. He remained in the nursery for 12 days until it was clear that he was thriving well. The little family was allowed home, with instructions to make sure that the baby received all his immunisations and regular checks as appropriate.

Prakash is a daily wage labourer, earning about £20 per month, with no other resources while Soniya is the homemaker. He had saved to pay for his wife's delivery. To pay a further £304 for his little boy's treatment was well beyond the limited means of a poor family such as this. They were unable to make any contribution towards the baby's hospital bill. We took care of Soniya's baby in the hope that some kind donor would finance his care and £50.00 was allotted through the Person to Person Scheme. The remaining amount was settled by the concerned unit and the institution. We join the grateful family in thanking you for your kindness.

Youth make music in aid of Vellore

It was close to midnight on Friday the 27th of December 2013, when the last call was made as live music in Patrick Cheyne Lounge filled the room with the deep sense of joyful celebration. It was a celebration indeed as two young musicians with an old Indian drummer made exquisite music which transcended all from the realms of human to those of the divine. It was the night of the Aberdeen Vellore Exchange annual dinner 2013.

The evening began with a service of thanksgiving and celebration - thanksgiving for the blessed service of doctors and nurses in Vellore who care tirelessly for the marginalised and the most vulnerable and celebration for the partnership of Friends of Vellore in the UK who give generously and joyfully. Around 70 people gathered in St John's Church to sing and pray for the work of Vellore after which all moved to the Patrick Cheyne Lounge for a sumptuous Indian curry with Chilean Merlot and delicious Payasam to tickle the taste buds.

The after dinner speaker was Mrs Jemima Santiago, a CMC alumnus of 1953 who gave up her undergraduate training in Bio Medical Science to take up nursing, impressed by the care of a nurse. She recalled her memories of CMC in 3D. She said that CMC trained people in 3D - Dedication, Devotion and Determination and that it changed the course of her life. The gathering was treated to a Tamil Christian Hymn written by her Great Grandfather Ayer Santiago which she rendered with immense beauty.

What followed that inspirational talk was a pure gift. Joe, who was visiting his parents in Aberdeen was invited to the dinner as a guest. On learning that he was a saxophonist, one of the event coordinators asked if he would mind performing after the dinner. He agreed reluctantly. However, just before the dinner he wondered if his friend Allan could join him. It was felt, of course, the more the merrier. Joe was on the saxophone and Allan on the piano and they began to Jazz. A couple of minutes later, one of the guests asked how much it cost to bring the musicians up for the evening. The response was that it was a voluntary offering in aid of the charity. Then the guest asked if we realised who the musicians were. It transpired that Joe, the saxophonist was trained in the Royal College of Music in London and Allan the pianist was trained in the Boston School of Music and also was a winner of Young Jazz Musician of the Year. Excellent food, inspirational talk and exquisite music made the evening so memorable that the guests were asking about the next event. The evening raised £2017 for the Low Cost Effective Care Unit in Vellore.

Edinburgh Friends of Vellore

After many successful years of dedication and generosity, the FOV team in Edinburgh decided to end their operations and transfer responsibilities to Aberdeen. Marion Conacher who served as the FOV Scotland Treasurer has passed on her mantle to Lorna Andersen in Aberdeen. Likewise Helen Cooper who served as the Secretary to the FOV Scotland committee has passed on her mantle to Amudha Poobalan with immediate effect. Contact details for Lorna Andersen and Amudha Poobalan can be obtained from the FOV UK Office. A public event to acknowledge the brilliant work of Marion and Helen was reported in the last Newsletter.

Meanwhile, Edinburgh University is teamed up with Vellore to provide health care to parts of the world both in Asia and Africa which are hard to reach through telemedicine. This collaboration would enhance the FOV UK focus on Christian Mission Hospitals in India. Watch this space for more information in the next Newsletter.

SO? WHAT HAS FOV DONE

A New Arrival at Prem Jyoti

Thanks to your generosity and support, the last 15 months have seen a huge amount of progress and success in the programmes we support at CMC.

We hope you will be encouraged by what we have achieved together and will try to make the next period even better. We have sent out over £110,000 and achieved the following outcomes:

- Contributed £50,000 to PTP – helping around 1,000 patients and their families.
- Sponsored the Palliative Care "Home Care" Team as well as gifts to the Palliative Care Department.
- Continued help for the Palliative Care Families' Fund.
- Supported the Paediatric Orthopaedic team with the purchase of portable surgery equipment.
- Supported the Old Town Clinic programme run by LCECU including 3 extra staff salaries.
- Bought equipment for the Paediatric Intensive Care unit.
- Established a Mission Hospital Co-ordinator post in the Missions office with salary & expenses provision.
- Supported a range of work at RUHSA including the Elderly Centres, Farmers' Clubs and Goat Rearing project.
- Initiated Youth Education and Sports Programmes at KV Kuppam block.
- Supported Drs Joe & Denny Fleming through Interserve.
- Sent Funds to the Rehab Children's project.
- Collected and forwarded gifts for Alumni Batch appeals.
- Helped arrange a large number of visits, exchanges and tours
- ……..and much more!

One of our highlights was to be able to welcome Dr Sunil Chandy and his family to UK last Autumn. This really helped bridge the distance between CMC and UK and reaffirmed the strong partnership we have with Vellore.

Remember that if you support a particular project ALL your gift goes to that often topped up with Gift Aid. We are always happy to tell you exactly how your donation was used.

DIARY DATE FOR 2014: ALUMNI REUNION

The Annual CMC Alumni Reunion in UK is moving North this year. We plan to have the Annual Reunion in the picturesque Lake District. Please note the weekend of September 14th to 16th, 2014 in your diaries for the annual reunion which will be held at

Rydal Hall, Rydal, Ambleside, Cumbria, LA22 9LX.
Phone: 015394 32050
Web: http://www.rydalhall.org/contact/faqs/

We would love to have you join us for the reunion this year, which promises to be a great event in the beautiful settings of Rydal Hall. For further information and registration forms, please contact any one of the following:

Ernest Jehangir: ukcmc2014@gmail.com
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ACTION POINT:
> ***GET INVOLVED***

Last years visit by FOV to Old Town, conditions under which healthcare can be quite challenging. Water and drainage are huge issues.