# resonance

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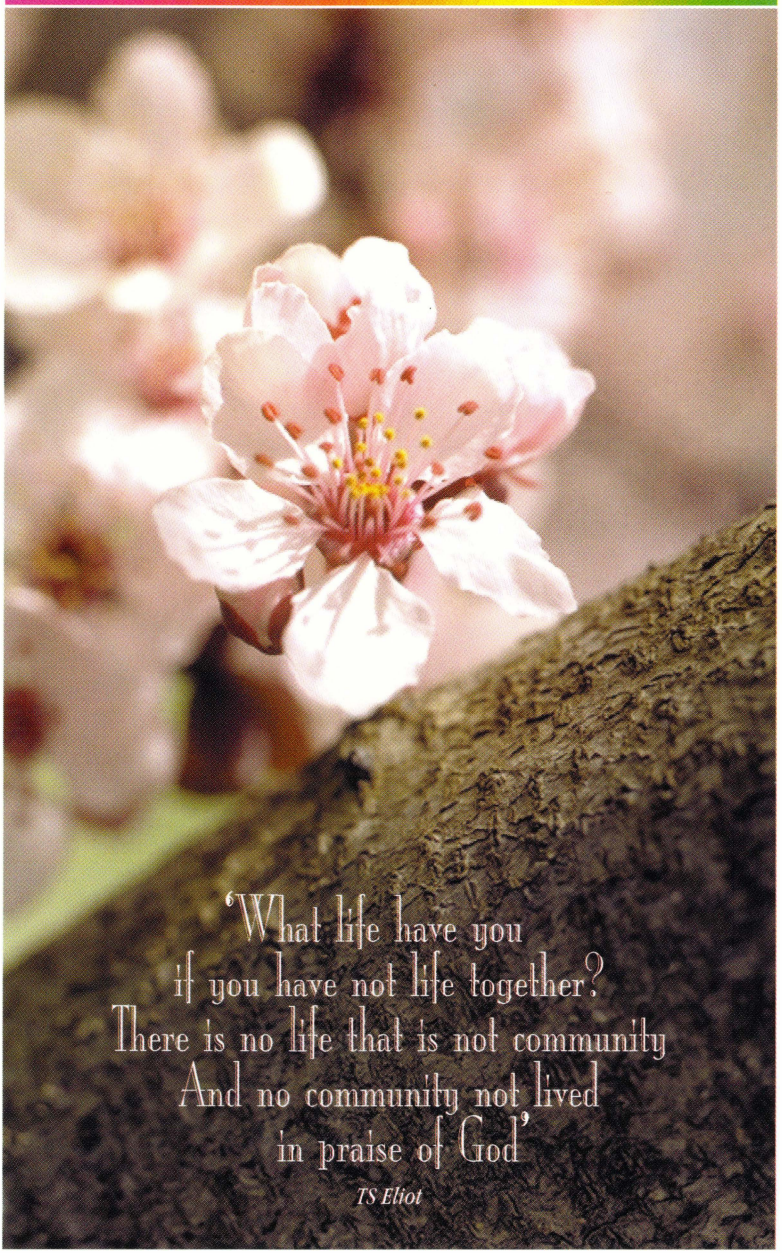
## in this issue






resonance
The Quarterly Journal of SIHA

Subud International Health Association

Subud International Health Association

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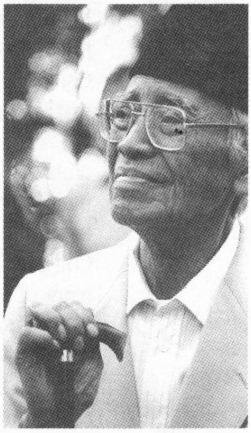
## A QUOTE FROM BAPAK



....through helping the poor and looking after the sick, and so on, there is an opportunity to make up for or to correct the sins which have been committed in the past by our ancestors and by ourselves.

*Bapak (1981) Quoted in Subud and Human Welfare*

## CONTENTS

## EDITORIAL COMMENT

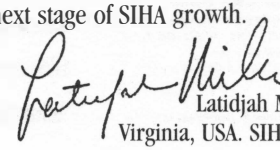
### *The Growth of SIHA*

As the next Subud World Congress approaches, it's time to take stock of progress made and to evaluate where we want to go from here. In three short years SIHA has grown from an infant to a toddler, and now it's time to prepare for the pre-school years. In brief: we have developed a SIHA Registry, a wonderful journal – Resonance, an active email listserver, a website, and have also held some substantive workshops on healthcare. We implemented a pilot Medical Aid program. We grappled with the issues of organization, such as defining our relationship to the World Subud Association, developing an active steering committee, and writing the SIHA Mission Statement. We've also managed to stand on our own feet financially, being fully supported by the pledges from SIHA members and from one enterprise sponsor, while enlisting the volunteer efforts of the steering committee members, who have generously donated their expenses too. Having succeeded thus far, the greatest challenge facing SIHA is to identify and initiate the next stage of growth.

One of the immediate issues facing us as we grow is the increasing amount of workload on the SIHA committee members. When any family grows, there is an increase in the amount of house keeping, laundry, cooking and transporting, and with the corresponding expenses. With SIHA, the increased work comes in the form of emails to be answered, data to be managed, members to be cared for, meetings to be organized, congresses to attend, news articles to be written, bank accounts to manage, and so forth. This is often stretching for the steering committee members, because we sometimes face work we've never done before. Now, we have added to this the development of the hospital project in Kalimantan, and the extensive preparations for healthcare during the next World Congress. As a result, the circle of people working in SIHA has begun to widen. We've seen the development of the 'KaliHealthTeam', a group of 20 SIHA members working together by email to begin the heath care preparations for Congress. We've seen the development of a team of experts coming together via email to work on the development of the hospital pavilion in Palangkaraya. In future, we may also see the size of the SIHA steering committee increase to accommodate a greater amount of work.

We've had some wobbles. A lethal computer virus threatened our database, slowing down correspondence and the issuance of mailing labels. And, more sadly, our beloved sister and SIHA Treasurer, Robyn Burke, passed away in November. Her enthusiastic support of SIHA and her devoted work as Treasurer will be sorely missed. With the complex international financing of the hospital project underway, it will be of utmost importance to find the next Treasurer of SIHA as soon as possible.

Without a doubt, the existence of SIHA depends on the commitment and hard work of its members. The development of a dedicated group of SIHA volunteers will be the most important ingredient for the next stage of SIHA growth.



Latidjah Miller,
Virginia, USA. SIHA Coordinator

## JOURNEYS

*Rohana Darlington, Cheshire, UK*

Bapak always advised us that if we followed the latihan sincerely, patiently and persistently, our talents would eventually emerge. Now middle-aged, perhaps mine have. I joined Subud when I was 18, the only member of my family to do so. I never had any problem in knowing how I wanted to spend my life, and was fortunate enough to achieve my childhood dream of becoming an artist, writer and maker of beautiful things by the time I was in my twenties. It certainly never occurred to me that I would ever become involved in healing work.

However, I always had a social conscience, and was interested in the early efforts of Subud to help disturbed young people at the remedial centre at Watcombe House in Dorset. But when I offered to help there, I was advised by amused helpers that I was far too young and inexperienced to be useful, and to concentrate on my fashion design career instead. So apart from fundraising for what is now Susila Dharma, and helping Fountain House, Subud's home for handicapped children, as a fundraiser and editor of their supporters' newsletter – where I first met Hermione Elliott, our Resonance editor – I did not get involved in any other Subud social or health care projects for many years.

Time passed. I married Mashud and became a wife and mother of four children, and continued to develop my love of the arts with great enjoyment. I always felt my work was worship. It was not until after the tragic suicide of my mentally ill mother, and the demise of Anugraha – which Bapak told us meant 'the unexpected gift' – that my own 'unexpected gift' appeared. Mashud and I had invested heavily in Anugraha, and when it collapsed – together with my illusions that Subud was an association of people who would pull together through thick and thin – we were financially devastated.

***'This was my first experience of this kind of work, and it was hugely transforming for me; every day, with no training, I had to try to help people in drastic situations who had attempted and failed suicide.'***

I desperately needed money immediately as our four children were at the expensive stage. I had to take the first part-time job I was offered, as I was under a time contract to complete a design book I was writing, had already spent the advance payment, and would get no royalties until the book was published. So I went down to the Job Centre, and the only job they had for me was a temporary one, every morning for a week, to work as an office organiser in the psychiatric social work department of a nearby hospital.

This was my first experience of this kind of work, and it was hugely transforming for me; every day, with no training, I had to try to help people in drastic situations who had attempted and failed suicide. While the social workers were out of the office many patients phoned, threatening to jump off bridges or swallow pills if no one came to help them immediately, and I taught myself

how to reassure them and wait until the social worker arrived. As no one else could stand this work, they begged me to stay on. So I did, as I really needed the money – and I worked on my design book in the afternoons in blissful contrast. All the time I worked there, I felt a sense of being graced. It was as if the pain I'd experienced after my mother's death was being cleansed from my heart. Although, in a state of latihan on the way to her funeral, I'd had the unforgettable spontaneous experience of being shown her condition and whereabouts, this had not healed my inner suffering.

In this experience I left my body, although fully conscious – I was simultaneously aware of sitting in our car – and witnessed her being welcomed and comforted by Jesus in a beautiful, plain, clean church in a heavenly place beyond this world. My father and I progressed down the aisle with my mother, who leaned heavily on our arms looking dreadfully ill. We walked down towards the altar, where Jesus was waiting for us. His face was so bright I could not bear to look at it, and from his heart great waves of warmth and love emanated. I am still moved to tears as I remember this to write it. We presented her to him, watched by all my white-robed deceased relatives, who formed the congregation, while Jesus administered Holy Communion For the Sick to her, then opened a door and ushered her through to a place of healing. What made the experience interesting to me was by that time I had converted from Christianity to Islam, following inner latihan guidance, but was not rejected by Jesus for doing this.

Yet through all those years, the pain of the manner of her death, which was particularly gruesome, remained despite regular latihans and Ramadans. Looking back, this time at the hospital social work department was one of inner purification and preparation for the work I am doing now. In the end I worked there for two years part-time, while I finished writing my book.

At the end of this period, after the

book was published and had become a standard work in its field, I was offered the post of Creative Activities Co-ordinator with East Cheshire Age Concern, a local branch of a national UK charity dedicated to providing services for older people.

I knew it was the right thing to accept this job; so now I manage this creative therapy project for older patients, which is funded by the local health authority, in the nearby Macclesfield District General hospital.

Although working in a National Health Service (NHS) setting, I have complete freedom and encouragement to develop a programme of activities for patients that is as imaginative and innovative as I can make it. Despite all the recent criticism of the NHS, our hospital strives towards excellence within the government's new

policies to improve public services for patients, and has gained the prestigious Charter Mark in every department.

I'm assisted by a wonderful team of volunteers from all walks of life, who I train and who come in daily to help me. These have included students from the local schools, keen to gain experience on the wards before starting medical studies at university, people between jobs, disabled people, retired people, who have a great deal to offer, and the congregations from local churches. Although I've offered myself as a SIHA mentor, in the SIHA mentorship scheme, the only Subud member on my team is my husband Mashud, who transports my older lady volunteers home from the project in our car. I greatly value the volunteers' varied skills and life experiences, which I try to match to patient's particular interests and needs.

We work on the stroe unit, the rehabilitation wards, orthopaedic wards and in a psychiatric ward, and I plan my programme in conjunction with medical staff, nursing staff, social workers, occupational therapists and physiotherapists, with the hospital's own volunteer co-ordinator and with the hospital chaplaincy. Patients are referred if we think they can benefit, although there is no compulsion for them to participate.

Since pioneering this project for Age Concern, I've gradually introduced an increasingly wide range of alternative health activities, many of which would have been frowned upon when I first started work in the hospital over nine years ago. Times are changing, and the current climate is much more favourable towards an holistic approach to healing.

My alternative health education sessions have a specific place within the programme and are advertised as my 'Something Different' spot. I offer a wide range of workshops focusing on alternative health, including crystal therapy, psychological astrology (in which I'm professionally qualified), and look-after-yourself-on-discharge sessions, which include information on flower and animal essences, herbs, nutritional advice, acupressure techniques and relaxation. For the relaxation sessions I often use the SIHA tape, *Open to Relax*, which is really good. And articles in Resonance form interesting discussion topics.

***'I've gradually introduced an increasingly wide range of alternative health activities, times are changing, and the current climate is much more favourable towards an holistic approach to healing.'***

Later, after noticing how many patients were not cured with conventional medicine, and having becoming ill myself, I trained to become a homeopath, as homeopathy had cured me and spared me major surgery. I now run a homeopathic clinic in the hospital Occupational Health Department, for staff. This has been another innovation of mine, as I'm the first homeopath to do this in the UK. So at my 'Something Different' spots I also present 'Introduction to Homeopathy' workshops, recommending first-aid remedies for patients to try when

they go home, and distributing information leaflets to people about how to find a qualified homeopath in their area.

In addition, we offer all the more usual activities such as arts and crafts, music and movement, games, video afternoons on specific themes such as gardening or old movies, reminiscence, poetry and creative writing, local history and whatever else the patients like the sound of. We invite special guests in to help us entertain our patients – recent examples have been a couple of Irish folk singers, and a lottery-funded clay workshop where the facilitator did brilliant work in ceramics with stroke patients who only had the use of only one arm. We also work with the Red Cross who conduct a hand and neck massage service for patients, and with the Pat Dog Association who bring in dogs for patients to pat and cuddle. We also hold weekly Patient's Forums where we listen to any complaints or requests and try to improve the service.

The project has attracted national and international attention, with people coming from far and wide to see us in action. I was also invited by The Royal College of Physicians to contribute to a study on how to help the increasing number of mentally and physically infirm older people in the UK. I've helped other Age Concern groups to set up similar projects in their areas and in nursing and residential homes, and some of my volunteers have won awards for their excellent work with us. I give talks to carers groups on alternative self-care help and my work for Age Concern, at the request of social services, and I've just been asked to speak next year at a national conference of hospital volunteer co-ordinators to talk about the innovations we have introduced at our hospital.

I can hardly believe my luck to be able to work in such an interesting way, although I consider it the fruit of the latihan over many years. I even have a room in the hospital where I can perform my daily Islamic prayers, and I can feel the descent of joy, a 'baraka' of happiness and peace whenever I enter the hospital to work. It is particularly strong in the psychiatric ward, and I have had to train myself to tone it down when working there, as the patients are often so sensitive. Now, with the advent of SIHA, I feel my work is entering a new phase, and I hope I can share my experiences in the health field with other Subud members, and together we can learn how to set up projects that will relieve the suffering of humanity, including our own.

## LIVING WILLS

*Hermione Elliott, Hampshire, UK*

I am not intending to take off in the near future, but the death of my father earlier this year has made me consider the circumstances of my own death, and how much or little control I have over it. After hearing of my father's collapse, and during the two-and-a-half-hour manic drive to the hospital, I ranged from panic to utter calm. As I drove, I did latihan, prayed, talked to him and pleaded with the doctors not to be heroic in their attempts to resuscitate him. They tried, but I thank God that he was quite determined to go and that the doctors had the good sense to allow him a reasonably dignified death. I am also eternally grateful to him that we, as his family, were not forced to make any difficult decisions

on his behalf about his treatment.

When I was still working as a hospital nurse, I watched with increasing alarm as ill and elderly people, who were not classified as terminally ill, were at times subjected to quite brutal treatment following cardiac or respiratory arrest, in an attempt – often fruitless – to pull them back from death. It seemed to me that there was no framework or guidance for anyone in that situation. The family were powerless, the patient certainly was; and although it may appear that the doctors and nurses were powerful, I realised we were just as much victims of the situation as everyone else. We were victims of the fear of failure; ie, the death of a patient, the fear of litigation and especially we were victims of a system devoid of spiritual content, where all we had was our conditioned responses – to resuscitate first and ask questions later. The more the latihan grows in me the more I believe this is unacceptable.

***'When I was still working as a hospital nurse, I watched with increasing alarm as ill and elderly people, were at times, subjected to quite brutal treatment in an attempt – often fruitless – to pull them back from death.'***

Although my father and I had discussed his views and wishes, he had never written anything down. My mother and I are now engaged in clarifying her wishes, as I am my own; simultaneously I am working with an elderly Subud friend, creating what is known as a Living Will. *The Natural Death Handbook* [see book reviews, Page 26] is the most wonderful resource for such an exercise.

A Living Will – or an Advance Directive as it is sometimes known – is the means for making your views and wishes around death and dying known to your family and health professionals. In many countries they are legally binding documents, setting out the kind of medical treatment a person wishes to receive, or not receive, in order to help families make those life-or-death decisions on behalf of the dying person if they are unable to communicate. In creating a Living Will we not only have the satisfaction of mapping out our wishes, we liberate our families from difficult decisions, and free doctors from guilt and the fear of litigation. Without such a document, within the modern healthcare system we enter territory that is a moral and legal minefield. So, as you can see, I'm all in favour of them.

In Britain, the British Medical Association actively supports Living Wills and suggests that people carry a card, rather like a donor card, and that they lodge a copy of the document with their local doctor or general practitioner. In America, in certain States, anyone going into hospital can complete a Living Will, which comes in a standardised form.

Of course it is clear that a Living Will is not to be confused with any act that could be described as assisted death or voluntary euthanasia. Rather it is a simple request to allow nature to take its course, to honour the process of dying without interference and to create an atmosphere of dignity, rather than distress around the event.

Many people go one step further and create a set of instructions alongside the legally binding document. Requests outlining the atmosphere they would like around them in their final hours, how they would like to be treated, how they would like to be buried/cremated; some people even go so far as to devise their own funeral.

My Subud friend has given me strict instructions to make sure her teeth are in; my mum simply wants 'no fuss or bother'. As for me, I aim to have a few of my chums around me with laughter and latihan all the way.

Source: *The Natural Death Handbook.*
Editors: Nicholas Albery, Gil Elliot and Joseph Elliot.
Publishers: Virgin Books.

## THE JOURNEY THROUGH M.E.

***Sophia Hughes, Gloucestershire, UK***

I developed M.E. in the autumn of '96 following a bout of flu – I just could not get really well again. A friend told me I had M.E. and that if I didn't change my personal attitude and start really to look after myself I would be in a wheelchair within two years. She was out to shock me – she knew that otherwise I would continue to put the demands of my family and my work (pottery and sculpture) before my own care. I slowly took on board that she was right. I was not severely ill, just in that stage of weakness you experience after an illness but before you are really well again. So it was sleep every afternoon, really plan ahead for the things I had got to do, and persuade myself to let go of the rest (difficult). For two and a half years I could not rely on either my body, or my mental strength. An emotionally draining long distance relationship during the first year made it worse.

M.E. is an illness of mind and body together, and probably happened to me because I had overstretched myself for years. I am a single parent of two boys; the younger is dyslexic, the elder has Asperger's Syndrome (high achieving Autism), which wasn't diagnosed until he was twenty-two. As soon as he could handle minimal supermarket shopping on his own without freaking out, I crashed.

So I tried lots of things. People suggested different minerals and vitamins, treatments to build my immune system etc. This resulted in rows of bottles, none of which seemed to help much but which probably prevented my reaching the wheelchair stage. What I gradually learnt were basic rules. State of mind is as important as state of body, so latihan was vital. Daily exercise was very important, but it was as much about raising my mental well-being as keeping the physical body going. Even walking up a small slope was exhausting (it's all hills around here), so I drove the half-mile to the top of the Common each day and walked there on the flat. I could see across the river Severn to the Brecon Beacons and just being there was a spiritual uplift. If I was still too exhausted after my afternoon sleep I would tell myself that I was only driving up to see the view, but once there I always managed to walk, at least to the first bench.

For two and a half years my strength came and went. I had to fine-tune my awareness of the amount of energy I had 'in the bank'. Get overdrawn just a little and it might take days to replenish. Never do on a good day what I was not able to

achieve on a bad one. One glorious sunny morning I ignored this and walked the 600 yards uphill to the post office. The post-mistress had to close up shop to drive me back down. I spent the next two days in bed. If something was really important and I had a lot of warning I managed it, like being treated to three days in Paris with my sister. We walked miles from gallery to gallery, and because a lot of sleep was important I took Nytol, an anti-histamine sleeping pill, each night. I know that I could not have done it without that extra long sleep every night, but I thought I was virtually recovered.

However, the M.E. came back with a vengeance, so that by the second summer two hundred yards on the flat was all that I could manage, and having to sit in a doctor's waiting room for half an hour had me shrinking into a shattered heap, crying. (I had to visit the doctor to get sick notes so that I could claim incapacity benefit).

Friends were wonderfully supportive, and another of my sisters decided I should stay at her beautifully peaceful house in Bournemouth until I was fully on my feet again. It took only a fortnight. On day one I walked two hundred yards then collapsed into bed too tired to even turn over for two hours. By day thirteen I walked for two hours on the flat including in and out of shops in the morning and swam in the sea for half an hour in the afternoon. I even managed a short hill. Two weeks of not being allowed to do any work (told off if caught washing up), in a household where they go to bed at 9.30 pm, worked wonders.

When I got home I went rapidly downhill again. So I decided that henceforth I would only cook three meals a week for the boys (it still applies) and that, despite looking very fit, I must continue to walk most days and treat my needs as having priority or else everyone else would suffer. But I still had to avoid anyone with a cold or flu as even a cold would have me unable to work for three weeks. By this time I was long past the stage where I only felt fit and well for the first hour of each day, but this still was not full recovery. Life continued like that until the spring of '99 when I was introduced to a liquid called Maximol Solutions (it contains all 90 minerals and vitamins that our bodies need) and a Bioflow magnet.

It may be that the time for me was just right, but it was from the time that I started taking two capfuls of Maximol each day and wearing a Bioflo double magnet on my wrist that at last I could pronounce myself recovered.

I realised that I could catch the current cold doing the rounds of the local neighbourhood and recover as fast as

everyone else. I even experienced a bout of 'flu in the household missing me completely. I continue to be aware of the necessity of walking regularly, although when my workload is heavy I am apt to forget; but provided I listen to my need to rest, I get away with it for short periods without my health deteriorating.

Mental well-being, I found, is equally important and the discovery of the book *The Artist's Way* increased my creativity and showed me how to structure my time to feed my own needs. I am an energetic enthusiast who pushes herself too far – that is still there, but now I also care for myself and know how to say, 'NO!'

**LEARNING DIFFICULTIES IN CHILDREN 2**
***article two in a series of four***
*Maxwell Fraval, Canberra, Australia*

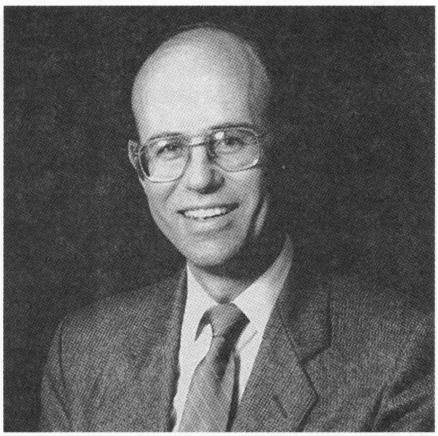
## The effects of unresolved birth strain on vision, hearing, speech and proprioception with consequent impairment of learning ability.

The development of a child as it progresses through its first decade depends upon the ability to hear, see and communicate, as well as upon having the motor skills to execute the results of those auditory, visual and cognitive interactions and processes.

Developmental delays and learning disorders often arise from deep-rooted problems within the visual, auditory or vestibular sensory systems; there can be a communication breakdown between these systems.

Dr Harold Magoun[1] has described the period of labour and delivery as the most critical one in the life of any individual. Many possible complications such as trauma to the very vulnerable head or reduction in the supply of oxygen may occur due to a variety of causes. Some of those described by Dr Magoun include: an abnormal shape to the maternal pelvis, a prolonged labour, a particularly difficult presentation, greater force than usual or abnormally directed force.

Where a child has a history of a prolonged labour, an unusual presentation, or where forceps have been applied at birth, there may be an enduring effect upon the mechanical function of the head. This dysfunction can affect the sensory systems. Dr Viola Frymann, the Director of the Osteopathic Centre for Children in San Diego,



California reported in 1976[2] that in the sample of 106 children with no learning difficulties 28.3% had a history of considerable trauma before or during birth, whereas of 103 with learning difficulties 72.8% had a history of a traumatic birth.

Osteopaths observe in clinical practice that osteopathic treatment can help visual function, the perception of sound and the child's ability to achieve balance and

co-ordination. In a subsequent study published in 1992, Dr Frymann showed that the neurological performance of the 186 children in the study improved significantly and continued to show improvement over an interval of several months following treatment. More recently, Dr Stephen Blood[3] was able to demonstrate a change for the better in the slow wave activity in the central and frontal portions of the cortex of patients in the pilot study. Dr Jaspers and various other researchers had previously identified this pattern of increased low-frequency EEG power to be characteristically present in ADD/ADHD patients. For children with ADD/ADHD, the goal is to reduce Theta, slow wave activity associated with daydreaming, which interferes with concentration, information processing and other organized cognitive activities.

In the 1970s Dr Sato[4] showed a direct somatic to visceral connection by cannulating the stomach of rats and measuring the pressure there. Dr Sato then used some tissue forceps and pinched the skin of the rat, producing a painful stimulus in the skin. When he did that over the abdomen of the rat he got a big reduction in gastric pressure through activating the sympathetic fibres at the level of the mid-thorax. Dr Sato calls this a cutaneo-gastric (skin-to-stomach) reflex, and confirms the osteopathic clinical observation of the somato-visceral response.

When Sato stimulated the skin in the cranial area he found that there was an increase in gastric pressure because of the vagal (parasympathetic) response. Dr Sato has shown that not only viscero-somatic reflexes occur but also that somato-visceral reflexes are present.

At the recent conference in Sydney on the Mind of a Child, United States paediatrician Dr Michael Goldberg presented evidence, based on Positron Emission Spectroscopy, which showed that children with learning difficulties exhibit a hypo-perfusion (reduced blood flow) of the temporal and frontal lobes. Interestingly, children with ADD will show hypo-perfusion of the temporal lobe that is predominantly right sided, whereas those diagnosed with ADHD will show temporal lobe hypo-perfusion which is predominantly left sided. Sato's work suggests that somatic dysfunction of the cranial sutural system (where the bones of the skull join) may lead to an impairment of arterial supply and/or venous drainage, which may affect perfusion in the temporal lobe of the cerebral cortex. Osteopathic treatment seeks to correct somatic dysfunction with consequent normalisation of perfusion (blood flow).

**Visual function**

Improved visual function will of course lead to improvements in the ability to learn, and osteopathy has much to offer those children who have mechanical strains. When learning difficulties arise, vision is often the first area to be checked. Distance vision is only one component in the complex sense of sight. Our perception of what we see is the result of a complex series of connections and neural developments which should have taken place in the early formative years, and which are dependent upon adequate maturation of the central nervous system (CNS). As a result of perceptual problems, the child may

misread words or repeat words or lines. He or she may read very slowly or become easily fatigued, or even read with one eye covered or sit sideways when reading so as to make sense of the images. As osteopaths we assess the body for the presence of somatic dysfunction to see whether it has influenced physiological function; we look at the interface between structure (anatomy) and function (physiology).

Dr Sutherland[5] noted that, at birth, the sphenoid bone is in three developmental parts, a central one consisting of the body and lesser wings and two lateral ones, each comprising a greater wing and pterygoid process. Fusion of these three parts takes place by the time the child is one year old. Prior to that time an intraosseous strain (with some warping, however small) may occur – either prior to, during or after birth. If that happens, a distortion of the shape of the superior orbital fissure between the greater and the lesser wing may occur. This may affect the function of the four rectus muscles, which control movements of the eye. This distortion through warping is the most frequent cause of restrictive strabismus (squint) and is amenable to osteopathic treatment. The orthodox medical approach to a restrictive strabismus would be surgery.

Pressure on or stretching of the nerves controlling the muscles of the eyeball can occur as they pass in relation to the forward reaches of the free and attached borders of the Tentorium Cerebelli (the tent-like dural membrane that roofs over the cerebellum and brainstem). The petrosphenoid ligament coming off the apex of the petrous portion of the temporal bone and attaching to the posterior clinoid process of the sphenoid is of particular importance insofar as the Sixth Cranial Nerve (Abducent) is concerned. The abducent nerve controls the lateral rectus – flaccidity of this muscle results in an esotropia (where the eye turns inwards), whereas spasticity results in an exotropia (where the eye turns outwards).

Additionally, as a result of the somatic dysfunction described, a phoria (defined as a transient tendency to malalignment), or other difficulties which involve dysfunctions of convergance, accommodation, or tracking, may occur. The child may say that the letters he or she sees are blurred, or that he has difficulty seeing them. Sometimes the child does not attempt to describe the difficulty he or she has in seeing letters or numbers because she assumes that everyone experiences the same difficulty.

The difficulty may have been there since birth. Osteopathic treatment can remove somatic dysfunction, neutralising intraosseous strains of the sphenoid (thereby normalising the annular tendon of Zinn and restoring normal venous drainage of the orbit) and restoring balanced tension to the dural membrane, so removing irritation to one or more of the nerves controlling the external occular muscles.

**Auditory function**

Sound perception develops slowly from the 24th week in utero onward. At this stage, the ear is tuned specifically to the sounds heard in utero, but the fetus will respond to some external auditory stimuli as well.

Frequent ear, nose and throat infections in early childhood resulting in

intermittent hearing loss over a period of time can prevent the development of auditory discrimination skills. Lack of auditory stimulation, or even a constant cacophony of background noise in early life can discourage early 'listening' and the child may learn to shut out and ignore sound from an early age.

Hearing too much or 'auditory hypersensitivity' can be just as much of a problem as hearing deficit. The inability to filter or occlude miscellaneous sound suggests poorly developed listening skills, and can have profound effect upon later learning, language, communication, and behaviour.

A child with auditory problems may have a short attention span, be easily distracted or misinterpret questions because it is so hard to hear what is being said. As a result, instructions are ignored or there is an inability to follow sequential instructions. He or she may confuse similar sounding words and often need to have a word repeated. Often the child will be unable to sing in tune or will demonstrate confusion or reversal of letters.

Dr Sutherland noted a general situation, which makes certain apertures anatomical function more vulnerable to mechanical embarrassment, with consequent effects upon fluid systems. The petrotympanic fissure opens just above and in front of the tympanic ring. It is a mere slit lodging the anterior process and ligament of the malleus, and gives passage to the anterior tympanic branch of the internal maxillary artery. The tympanic branch of the internal maxillary artery supplies the tympanic membrane. This supply can be affected by compressions of the petrous portion of the temporal bone thereby affecting the physiology of the area.

Dr Sutherland noted a regular physiological action that opens and closes the auditory tubes, the active effect of swallowing yawning and squeezing being added events. As stated above, he also noted a general situation, which makes certain apertures more vulnerable to mechanical embarrassment than others. These are places where two bones meet to form the aperture. The case of the cartilaginous portion of the auditory tubes meets this characteristic of vulnerability, for it lies in a groove formed by the junction of the petrous portions of the temporal bones and the greater wings of the sphenoid.

As the sphenoid turns on its transverse axis into its flexion position, the posterior border of the greater wings rises and the medial pterygoid plates move down and back. At the same time, the petrous portions of the temporal bones are moving into the position of external rotation as the occiput carries them forward. The effect of this action opens the auditory tubes and allows for a change of air in the middle ear. As the sphenoid turns on its transverse axis into its extension position, the effect of these changes in relationship is to relax and close the cartilaginous portions of the auditory tubes. Dysfunction of this anatomical-physiological mechanism may modify or handicap the function of opening and closing the auditory tubes, so that mucus does not drain from the middle ear and then an otitis media often occurs. Besides aerating the middle ear and mastoid air cells this physiologic opening and closing is important clinically.

With catarrhal conditions and inflammation of the mucosa the drainage of excess secretions is of great importance. These air spaces, which are part of the air sinus system, cannot function properly when filled with liquid. Osteopathic management of problems of this sort has much to offer in diagnosis and treatment when drainage through the auditory tubes as outlets is desired.

**Vestibular function**

The vestibular system is the first to be fully developed and myelinated. The vestibular system operates closely with the reflexes to facilitate balance. It is located in the inner ear, and its job is to monitor and make adjustments to any movement of the head or the environment.

The labyrinth, in the inner ear, contains both the auditory receptors and the two types of vestibular receptors. The receptors in the ampulla respond to the force of gravity, sending sensory input to the vestibular nuclei of the brain stem via the vestibular nerve. Because we are always subject to gravity whilst on this planet, the gravity receptors send out a constant stream of vestibular messages throughout life. The second type of vestibular receptor, the semicircular canals, record head movement in any direction. The receptors send impulses via the vestibular nerve to the vestibular nuclei in the brain stem. This sensory input charges whenever the head changes the speed or direction of its movement. The combination of input from the gravity receptors and the semicircular canals is very precise, and tells us exactly where we are in relationship to gravity, whether we are moving or still, how fast we are going and in what direction.

The semicircular canals provide essentially the same information as a gyroscope in an airplane. If the gyroscope on an airplane fails there is no way of knowing in which direction the plane is travelling. In the same way, visual information is useless unless one can relate what is seen to some physical reference. The semicircular canals provide the physical reference that gives proper meaning to our vision.

As a result of perinatal trauma, the motion of the two temporal bones may be asynchronous. For example, the left temporal bone may be externally rotated whereas the right one may be internally rotated. This will result in the paired semicircular canals reporting slightly conflicting information to the central nervous system.

Some children may be sufficiently supported by virtue of all other systems being well integrated to enable them to cope with the confusion generated from the vestibular system, others will be subject to constant confusion. Interactions between the vestibular apparatus and the eyes, and the proprioceptive reflex response to incoming stimuli will adversely affect the rapid exchange of information between the systems, thereby affecting the smooth operation of the whole.

**Summary**

During cranial evaluation and treatment, it has been the observation of osteopaths that certain cranial abnormalities are present in children after difficult labour and delivery, and in children with ADD/ADHD. Osteopathic treatment promotes symmetry, changes in the mechanical function and tissue

tension in the cranial articular mechanism, normalisation of arterial supply and venous return, and a consequent normalization of behaviour, with improved concentration and learning and reduced impulsiveness.

In part three of this four-part discussion, a review of sensory-motor integration and the use of pulsed electro-magnetic fields will be made.

[1] Dr H Magoun *Osteopathy in the Cranial Field* Journal Printing Co 3rd Ed 1976
[2] Dr Viola Frymann *Learning difficulties of children viewed in the light of the osteopathic concept* J Am Osteopathic Assoc 76.46–61
[3] Dr Stephen Blood *Brainwave patterns in children with ADD/ADHD following osteopathic manipulation: a pilot study.* J Am Academy of Osteopathy 1999
[4] Dr A Sato et al *Changes in Vesicle Function Produced by Cutaneous Stimulation in Rats* Brain Research 94:465–474 1975
[5] Dr W G Sutherland *Teachings in the Science of Osteopathy* Rudra Press 1990

## WHAT IS... THE BOWEN TECHNIQUE ?

*Grace Edgar, UK*

Bowen Technique is one of the lesser known therapies, but it is developing a solid reputation because of its effectiveness in treating back and neck pain, frozen shoulder, sports injuries, whiplash, repetitive strain injury etc. It is also producing a favourable healing response to such problems as migraine, M.E., asthma and hay fever.

The Bowen technique is one of remarkable simplicity and gentleness. It involves specific 'moves' across tendons and muscles, using fingers or thumbs whilst applying a small amount of pressure. The move takes the form of a rolling action across the skin, which disturbs the muscle, creating energy surges. Throughout the treatment a series of breaks are taken, during which the patient rests quietly, allowing the body to adjust and respond to the changes taking place.

Tom Bowen, an Australian and the originator of the Bowen Technique, was himself not able adequately to explain how and why it works. He had limited medical training – he was forced to give up medical school before the war because of the financial situation in his family. After the war his career as an industrial chemist fell by the wayside as his reputation as a healer grew, and he was compelled to take up healing full-time in 1955. He never made any claims other than the work was simply a gift from God. By the time he died in 1982 he was seeing thousands of people a year, most requiring only one or two visits to affect a cure. Before his death he invited Oswald Rentsch, an osteopath and naturopath, and Elaine Rentsch, a homeopath, to observe his work to study the moves, and to document the technique so that it could be taught to others.

***'The Bowen technique is one of simplicity and gentleness. It involves specific 'moves' across tendons and muscles, using fingers or thumbs whilst applying a small amount of pressure.'***

A treatment session can range from 40 to 90 minutes. The therapist will take a medical history, but the approach to treatment is based upon the symptom picture, rather than any diagnosis.

According to the symptoms, a series of appropriate moves will be carried out on different parts of the body over muscular or connective tissue. By combining moves, both in placement and in combination, the practitioner is able to address the body as a whole or to target a specific problem.

A unique tool of the Bowen practitioner is 'tissue tension sense,' meaning the practitioner is able to discern stress build-up in muscle groups and then utilize Bowen moves to release that stress. There is no manipulation of hard tissue and the treatment is very non-invasive, mainly because the Bowen therapist does not impose their will on to the patient. The theory is that it is the patient who does the work and not the therapist.

It is this very subtlety that can lead people to wonder whether anything at all significant has happened during treatment. It is usual to feel the benefits and effects of treatment within 48 hours. And if patients do not drink the recommended several litres of water a day they can experience significant levels of discomfort. It appears that the water assists the detoxification process and without it – it hurts. In many cases, problems other than the primary ones are addressed, without the therapist even knowing of their existence.

Simply stated, the Bowen Technique resets the body to heal itself. There is much speculation as to how it works. It is clear that it balances and stimulates energy flows, which results in a deep sense of overall relaxation; the healing then seems to occur by affecting the body's autonomic nervous system, which creates homeostasis at the cellular level.

The Bowen Technique is referred to as a 'complementary' modality. This means it will enhance and complement – not interfere with – other medical attention. However, doing other manipulative therapies too soon after a Bowen session can undermine the effectiveness of the continuing Bowen work. Waiting a week before commencing additional body treatment is therefore recommended.

Several research projects are underway. Information can be obtained on the Bowen Therapy website. www.bowtech.com Bowen centres and therapists are also listed country by country on this site. Non-computer users please contact Resonance editors, specifying the information you require.

## COWS FOR KOSOVO

*Lucia Cargill, RN, Ph.D, Illinois USA*

On July 21, 2000, I went to Kosovo to participate in the post-war development projects, having been hired as a consultant for the International Medical Corps (IMC) for a six-week research project to evaluate the maternal child health referral system in the country. Also, I was asked to gain understanding of the primary, secondary and tertiary levels of health care provision.

I was to do research on the way pregnant women and those with reproductive system health needs use the medical system. To do this project I had to interview numerous people, from the surgeons and medical directors at the big city hospital in Prishtine, to the country people whose homes were destroyed in the war, which ended a year ago.

I enjoyed three weeks of travel and investigation throughout the country. Geographically, I went from the far southern border where we crossed from

Macedonia on the way to Prishtine, the capital city, to North Mitrovice and beyond into the countryside of Serbian Kosovo in the north. I also traveled from Klina in the West to Ferasaj in the east. It also turned out be journey full of the unexpected.

**First Subud Member in Kosovo**

I flew into Skopje, Macedonia, where I was to be met by one of the IMC drivers. My bags were lost when my flight from the US was late, and no driver was at the airport. I had not slept the previous night. I found myself wandering through the throngs of taxi drivers at the entrance trying to be very quiet as I looked for some assistance. I had no idea how to get to Kosovo. After the third or fourth lap around the airport, a tall, kind young doctor came up to me and said something like, 'Did you just arrive? Do you have transportation?' He was also working in Pristine, for one of the non-governmental organizations, the International Organization for Migration. His job is to meet the refugees who are returning to Kosovo by airplane. We made friends and he gave me some suggestions. Eventually, my driver arrived and he left; we had exchanged cards. Little did I know I had been found by the first Subud applicant in Kosovo.

His name is Dr Arber Veliu, a 29 year old Albanian gastroenterologist who has studied in Bosnia and Albania, as well as in the underground medical system the Albanians set up during the ten years of Serb occupation. He finishes his residency program in Tirane, Albania this year. Arber has two brothers, an economist and a veterinarian. His father is a well-known historian who teaches college and high school, and his mother is an elementary school teacher. They have lost their beautiful home in Presheva, an agriculturally rich area that ended up in a territory just over the Kosovo border in Serbia, under Milosevic's control, and they are now living in Prishtine.

One night, while at the local Indian restaurant, the Taj Mahal, in Prishtine, we began talking about Subud. Arber went home and surfed the Subud Portal, and came back to me with the statement that this all seemed totally familiar to him; it was not a problem for him; and of course he would like to be a Subud member. He was opened this October in Tirane, with another Albanian brother who lives in Corfu, and Robiyan in attendance. Arber and I talked every day by email while I was in Kosovo for the three weeks until the middle of August, and occasionally met for dinner, at times with other IMC colleagues. His best friend, Fezja, also works for IMC. As time went by we discussed the work of the wings of Subud, especially Susila Dharma USA (SDUSA), Susila Dharma International (SDIA), and

American Overseas Medical Aid (AOMAA).

**Evaluating Health Programs in Kosovo**

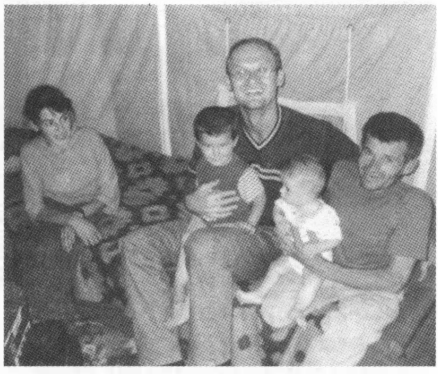
The work I had come to do was accomplished by observing and interviewing all day long, every day, at each level of the system. I spent several days in the large, central hospital in Prishtine, observing labor and delivery, surgical procedures, and interviewing all levels of personnel. This hospital, and the others in the few major cities, receive an estimated 80% of pregnant women for delivery; the other 20% receive no medical care.

The primary care system is very tiny, as is true tertiary care. The overburdened secondary care system works to exhaustion, because under the old Serbian system, gynecologists were the only providers allowed to take care of pregnant women. Although there are wonderful, capable midwives, they are technicians, trained to do the deliveries, but not educated to be independent providers.

The system is paternalistic, and reflects the old communist hegemony of the former Yugoslavia, which pre-dated the now Albanian system. While the Serbians were in control of the Albanian population during the previous ten years, the Albanians were not allowed to practice medicine or nursing. So they created their own underground system in which medical school was taught in garages and living rooms. Health care for their people was provided in a few health clinics sponsored by the Mother Theresa system. Now they are free, but tentatively so, pending the continued support of the KFOR peace forces. WHO heads the public health department, and is working with their Institute of Public Health to develop a good primary care system, starting with the training of 100 Family Practice doctors, and the revision of old ideas that prevents primary care from being practiced at the community level.

**Hajdin and Vjolca's Story of Love and Struggle**

One day while I was doing interviews at a 'health house' (polyclinic), in a town called Klina, I met a very nice handicapped couple, Hajdin and Vjolca



Hodaj, who had their little four-month old baby boy with them. They were making a visit to the clinic to follow up on Vjolca's health after her recent delivery by C-section. We struck up a conversation and I asked their permission to take some photographs. Vjolca and Hajdin both have severe kyphoscoliosis, which is characterized by severely bent spine and small stature. In Belgrade, Vjolca had had a rod implant in her back twice, but both times the procedure failed. Both Hajdin and Vjolca are very intelligent, and Hajdin is quite strong and hardy, an amazing contrast to the delicate Vjolca, whose name means 'Violet', and who is very

beautiful and quiet. The baby is called Brahim, and they also have a sweet little three year old girl called Hana. They are both healthy children, except Hana has one crossed eye. Hajdin is quite philosophical, but said, 'When you have nothing in your hand, what is the use of philosophy?'

In my conversation with the women, I inquired about Vjolca's experience delivering the children and asked if she had had any problems. Apparently, she did not have difficulties, nor did her sister-in-law who had delivered two breech babies and had five children in total. Both had taken a chance by going to the Serbian run hospital in the nearby central city of Peja, famous for its beautiful architecture and Orthodox church going back to 1300 AD.

Hajdin and Vjolca said everything was all right with the children, but they are really struggling, and living in 'very bad conditions' in the aftermath of the war. When the Serb Army understood that the NATO forces were going to bomb their strongholds and infrastructure they went on a rampage, killing and destroying as many homes as they could on their way out. Hajdin very boldly just threw out a challenge to me: come see for yourself. I had been waiting for invitations to visit homes and his was my second. I was delighted and also a little apprehensive as to what I might find. I responded with thanks and said I would like to come and visit them.

With Eleanora Emra, my translator – a young dental student – we loaded up on fruit and vegetables, and a box of medicines and vitamins from the IMC pharmacy as gifts to the family. We arrived at the farm mid-morning, after stopping

to ask directions on the road several times. There are no street signs. The Albanian Kosovars, who we protected in the war, took them all down as they were in Serbian language with Cyrillic script.

Hajdin was not at home when we arrived. He had walked and hitch-hiked 12 km to Klina that morning to try once again to get the Italian NGO, Movimondo, to commit to rebuilding his home, which was in rubble. I saw the stone walls had been torn half way down; the roof was missing. Vjolca and Hajdin slept in a tent put up by UNHCR, and had built one tiny room, 5ft x 6ft, inside the broken walls on the foundation of their former home, with wood and plastic. The baby slept there, and the cook stoves were inside this space. Vjolca admitted being afraid of snakes coming in while they were asleep. (Later, I did some reading and discovered there are two types of vipers in this area.)

They have a small electric stove, but only the burners work and they rarely have electricity, a major problem throughout Kosovo. They also use a little wood-burning cook stove to bake bread, the staple food. They had a few clothes, and the baby had a little cradle. UNHCR had left some bags of white flour. The small treats we brought were much appreciated.

**War and Survival**

Their talk turned to stories of war and survival. They were still in shock from the whole experience, but stated hopefully that they were surviving. They just didn't know what to do next. Our time to visit was almost finished when Hajdin came home, discouraged after yet another bureaucratic run-around from the agencies, regarding rebuilding the house. Of course he was surprised we had taken him up on the invitation immediately. We talked about what they needed to make it through the winter. He showed us the flour, but said what they really needed was a cow – a cow for yoghurt to spread on the bread, as is traditional, and for milk to feed the children. I asked him if he could handle a cow. His response was something along the line of, 'You bet your boots I can!'

We gave instructions regarding use of the medicines and vitamins, thanked everyone and were off on our way, having had a most bittersweet experience with this delightful family. I immediately sent a letter through the IMC office representative in Klina to Movimondo asking them to prioritize rebuilding Hajdin's house in support of Hajdin's efforts.

***'While the Serbians were in control the Albanians were not allowed to practice medicine or nursing. So they created their own underground system in which medical school was taught in garages and living rooms.'***

**Cows for Kosovo Project**

In order to relieve logistics, as their cut-backs had started in the Kosovo office, IMC decided to send me out of the country to the headquarters in Macedonia to write reports. I had three weeks in Skopje again to write and think. I talked with Arber about doing something to help Hajdin and the family. After hearing the story of my visit, he expressed a desire to do something as well.

I'd been disturbed when Vjolca told me that as a child she had been kept at home, not allowed to go to school, and could not read, as is the way of life for handicapped people in Kosovo. She said she didn't know what she could do – 'If only I could read'. So, I decided to buy Vjolca a sewing machine so that she could start an enterprise of her own. We can work over time to teach her to read through her sewing. She has a wonderful sense of aesthetics, but I think she only has one skirt and blouse to wear, and it is hard for her to find something to fit her body. She will make a wonderful seamstress, very careful and creative.

As Hajdin's expressed need was for a cow, I made some inquiries regarding the cost of a cow in Kosovo and was told $1500–2000, as they are pretty scarce now. I then wrote an email to several Subud members and asked if they would be willing to donate or put forward $2000 to purchase a cow for a handicapped family. I had one week left when I received a response from Daniel Cheifetz, who was able to put the money upfront if I would be willing to raise it when I returned.

In the meantime, Arber had travelled by bus to spend the weekend with me in

Skopje, and we had lots of time to plan in case we had a positive response. It just so happened that Arber's brother, Abdullah (Duli), a veterinarian who had just completed his studies, was job hunting and so had a little time. He was willing to do the research, attend an auction, choose and inspect the cow. Then, a magical Subud story unfolded, which I will let Arber tell in his own words:
'Oh, I found the Cow in very lucky way. One man is a driver in IOM, and I asked him as a joke: do you have a Cow for the sale? He smiled a lot and asked me ...what the doctor need the Cow? I smiled

too, but after I told that is serious and I need one, and he told me that he has one at home, good, and with lot of milk, but he has no time to send in auction place so it is in his home. We discussed a lot for that Cow, and Duli saw, so we decided to buy. He promised that we will go again to visit Hajdin and ask him if he is satisfied with the Cow....this is the way how I found the Cow...smiles...'

So, while Arber and Duli were starting to focus on the cow, I found a solid old, one stitch German sewing machine made by the Veritas company. In addition, the two wonderful young men at the shop rigged a treadle for use by someone with short legs, and encased it in a lovely new cabinet, with the machine mounted on top. After many times of going in and out of the shop, judging size and estimating Vjolca's strength, etc, we finally got it right and I felt immediately rejoiceful. They built a box for it, and I ran behind an old man on a bicycle cart who took it to the bus station. We labeled it to Duli and Arber, who met the bus after my email telling them the departure time. They delivered the sewing machine that very day, to the absolute glee of the family. Arber told Hajdin we had raised the money for the cow and confirmed with him that they were going to inspect the cow and bring it to him on the weekend. He was ecstatic. He couldn't believe his ears. Hana danced all around.

Arber and Duli inspected the cow, found it healthy and had it delivered with buckets, ropes and necessary equipment. They had also taken Hajdin to Klina to purchase enough firewood for the winter, staple food items, diapers and many things the family needed to survive. Arber will meet with him next week to re-check on the condition of the cow and to present him with any cash remaining, as the cow was not as expensive as if it had gone through the auction. His mother is making an eye patch for Hana to help strengthen her weak eye. Arber will locate a woman to help teach Vjolca how to sew. He wrote:

> They were so happy, especially Hana, all the time she smiled and danced, waiting for the Cow...Oh you can imagine how happy were all: Hajdin, Vjolca and children, and Hajdin's brother too, for children of Hajdin's brother I bought some books for the school and for Hana some colored book, she was sooo happy, all the

time she colored the book and smiled, she remember you very well... and smiled every time.

The Cow is very good, healthy and with lot of milk..smiles..I went to Hajdin home at 10 am and he was very happy to see me, I send best regards from you.... After we went in Klina to buy a food for him, clothes, shoes for him and Vjolca, some medicine (paracetamol, analgin, Pampers, etc)... and some vegetables ... Also we went to buy a flour, oil and sugar with more kg, and also we bought a wood for him, he was very happy for this because now he will have warm shelter, we bought for all winter, so he will not be worried. Also we arranged this week to buy a food (hay or straw) for the Cow, because if he don't buy this, the Cow is not worthy, so and this problem we resolved...smiles... I think that day he smiled more than ever in his life. Also I enjoyed and smiled with them, I was part in their happiness, also and you and Daniel and SUBUD.

I asked Arber to inquire of Hajdin's brother what they needed to survive. He replied, to just take care of Hajdin now. He said of course they have big needs, including their home to be rebuilt, but Hajdin's situation is the most desperate. Hajdin then replied, that they do not have water. If it is possible to assist in digging a well, at the cost of $1800, this would relieve the major problems for the extended family.

Of course, I am amazed at the success of this project, because who ever could have expected that this intention could have really been fulfilled in one week with three people working over the border of a war-torn country? The guidance and grace of God for completion of this project was an inspiration for all involved, especially me. The immediate connection with Arber was amazing grace.

I made certificates suitable for framing, and receipts using the Subud symbol Leonard Dixon had emailed the national helpers (thanks). At the top was the symbol; underneath: Subud USA, Susila Dharma International, and the American Overseas Medical Aid Association 'One-to-One Project'. At the bottom is an explanation of Subud and the work of SD and AOMAA with 'members inquiries welcomed'; and on our web sites I listed Arber as the Chairman of Subud Kosovo, which he liked very much and I asked him to be the Balkans advisor to AOMAA. I will make sure he has all the latest gastroenterology books for his studies.

Arber will frame the certificate for Hajdin and mail one to me, which I shall frame for the Chicago Subud house, sending copies to SDI with photographs he took of the Cow Celebration.

We ask your support to raise first the $2000 for this project and then an additional $1800 for a well. After completion of this project we will continue to be open to expressed needs of individuals and work to assist. Anyone who wishes to participate, please send donations directly to AOMAA via my address, and earmark for Kosovo. Donations of any amount are welcomed and all are tax deductible as AOMAA is a 501©3, non-profit corporation registered in Chicago. Your comments and advice are also welcomed. Don't forget! Cows for Kosovo!

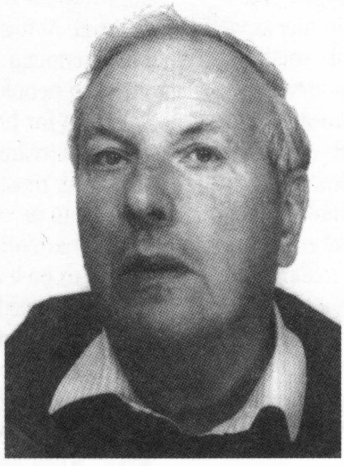
[Lucia Cargill is Vice-President AOMAA]

*Many opportunities abound for people at all levels of the medical system to practice either on short term or medium term consultancies, or on a volunteer basis. Go to: www.charity.org for a quick look at most of the NGO/PVO organizations and faith-based organizations that have programs abroad. Hot links will take you to the job postings, including volunteer or internship possibilities.*

## THE ARTEMESIA STORY

*Sachlan North, Surrey, UK*

Despite all efforts to eradicate it, malaria remains the greatest insect-borne threat to human health globally. At the present time over 400 million people are infected. It causes or contributes to the deaths of one to three million of us – mostly children under five – every year.



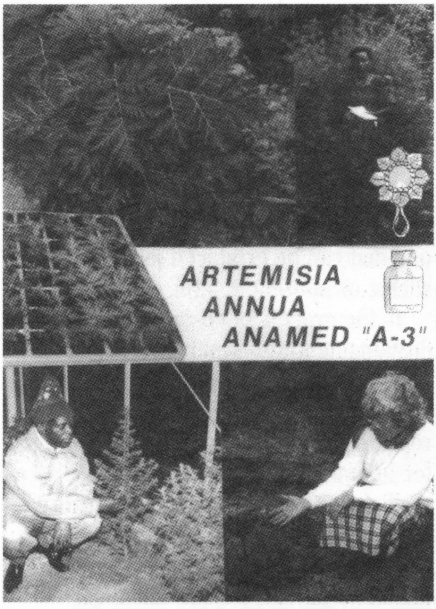
Quinine has been used as a treatment for centuries, but it lost ground eventually because of the growing resistance of the malarial parasite *Plasmodium*. Many of the synthetic drugs designed to replace it are now also becoming less useful, for the same reason. An ancient Chinese cure, based on the herb Artemisia, is now re-emerging from obscurity. The leaves of one species, *A.annua*, have been found to contain a powerful antimalarial compound called Qinghaosu (or artemisinin, as it is known nowadays). A drug company has recently succeeded in isolating, purifying and marketing it.

For the rural poor in the so-called developing countries however, the cost of a pharmaceutical product such as this is unimaginably expensive. A more affordable alternative is much needed, one that can be produced locally at a village or household level.

In the process of co-ordinating a Sustainable Rural Livelihoods project in Central Borneo for the UK charity, Susila Dharma Britain, I have been struck by the repeated requests from the local people for organic agriculture and herbal medicine. This is just as much because these are more in line with their traditional practices as because they are unable to purchase costly chemical fertilisers or allopathic remedies.

My chemical engineer son David, knowing my interest, had sent me an article from a journal that described the work of a small group in Zimbabwe, using Artemisia with the aim of reducing malaria throughout Africa. They were extracting the cut-up dried leaves in n-hexane to produce the remedy. This is quite a toxic solvent, so we bent our minds to a safer substitute.

The active molecule was described as a sesquiterpen-endoperoxide, with the two oxygen atoms acting as its lethal weapon. As an evidently non-polar compound this would not be expected to be sufficiently




soluble in water, and it emerged that it was only sparingly soluble in oils as well. We needed to carry out some small-scale experiments to take matters forward.

We therefore began to investigate the possibility of obtaining seeds of *A.annua* for the village people to grow. It soon became clear from the literature that not all strains are suitable; many are either too toxic or lacking in anti-malarial activity. In the end it was by a happy chance that I picked up an email message on the SIHA listserver, from Lars Herhacker in Austria, telling of a form of *A.annua* that gave a high yield of the active ingredient.

This high-yielding strain (A-3) had been hybridised by some researchers in Germany, Drs Hans-Martin Hirt and Keith Lindsey of an organisation known by the lower-case name of anamed (Action for Natural Medicines). It is particularly leafy, and its leaves contain 1% to 1.4% artemisinin – many times more than the amount found in wild strains.

They also gave the welcome news that, contrary to expectation, the active ingredient could be dissolved in boiling water to give a sufficiently high dosage. Normally, artemisinin is only 3% soluble in water, but in the presence of other substances in the leaf it is increased to 40%.

This paved the way to the possibility of producing Artemisia tea. We plan to put five grams of the dried, pulverised leaf into a conventional teabag, with additional substances suggested by American herbalist Dr Rohanna Salom to help counteract any side effects. Not exactly Earl Grey, but more beneficial.

The curative dose has been estimated at 50 grams, so 1 cup a day for 10 days should suffice. A packet of 1,200 seeds can produce 10 kilos of dried leaf material. At that rate, one plant has almost enough of the active ingredient to cure two people.

Except for homeopathic remedies nearly all treatments, whether allopathic or herbal, must have some side effects if they are to be effective. From the research done on artemisinin, the adverse effects appear to be few; it is less toxic than the commonly-used Chloroquine. Artemisia tea has been used for its preventative as well as curative properties (though rigorous clinical trials remain to be done), and it works well with the usual malarial prophylactics. So carry on taking your Paludrine and Chloroquine, but take also your Artemisia tea.

Artemisinin is effective for other conditions; haemorrhoids, chronic dysentery, AIDS and bilharzia are mentioned in the literature. Sharifin Gardiner, acting as a development

consultant for Susila Dharma Britain, visited its projects in D.R. Congo recently. These projects include schools, clinics and an agricultural venture. He found malaria to be very widespread, and bilharzia even more so. Hans-Martin Hirt has been to Congo since, and he has told us that anamed has clinics there, like SD. So contacts are there for the asking – and Artemisia cuttings, a preferred, quicker method of propagation.

Artemisia then, provides a new-old method of dealing with the scourge of malaria, one that can be replicated simply and inexpensively throughout the tropical and subtropical regions of the world, for the use of all its people.

The Artemisia Story still unfolds, with a surprise discovery at each turn of the page.

sachlan@northkal.demon.co.uk

## NEWS AND EVENTS

**Our dear Robyn**

Dear Sisters and Brothers,

I am very sad to have to let you know that Robyn Burke passed away on Wednesday November 29th 2000.

As most of you know, she had been ill and was in a critical condition for over a month, battling pneumonia and congestive heart failure.

In my latihans with her during this illness, I always felt her spirit filled with boundless joy, and I pray that Almighty God will bless Robyn and guide her on her journey. She has been a dear sister, a devoted and hard working Subud member and helper, and a charming vivacious person. In the last year, she served as the SIHA Treasurer, the SEC Treasurer, the Subud Herndon Treasurer, while continuing to serve as a local helper. At the age of 77, she was also working full time as a CPA. To her great delight, she also bought her first house earlier this year. Robyn was always so full of life and joy. Always helping those around her.

It happens that the Palankaraya hospital project was one of the last things she spoke to me about while she herself was hospitalized, before her illness made it impossible for her to talk any longer. She remained enthusiastic and totally interested in this project even when hardly able to breathe. I think it would be a tribute to her to publish this letter now. We will miss her very much.

With love,
Latidjah

*Below is the original letter written by Robyn Burke to raise funds for the hospital project in Palangkaraya.*

'The SIHA team for the Hospital Project in Palangkaraya respectfully request your support in building a ten room hospital pavilion. The pavilion is for the Dr Doris Sylvanus Hospital, a government hospital under Central Kalimantan Provincial Government.

On completion, and in honor of Bapak's Centennial, the pavilion will be gifted to the City of Palangkaraya, during the World Congress, on the birthday of Palangkaraya, July 17, 2001. The hospital pavilion will be called the Muhammud Subuh Pavilion.

The pavilion will have ten first class bedrooms, each with a private bathroom, and will be air-conditioned. A doctors' lounge, nurses' station, kitchen and

housekeeping area, and a medicine preparation area will be a part of the pavilion. The plan includes furnishing each room and providing the necessary medical equipment.

The hospital has a 70% post-operative infection rate, and part of the Project plan includes the development of Continuing Medical Education (CME) courses for doctors and nurses with the goal of improving the infection rate and increasing the quality of care provided in the hospital.

SIHA has received a request from the hospital for used equipment such as x-ray machines, incubators, respirators, and EKG machines. We will make every effort to locate equipment of this nature, and have it donated to the hospital.

The Project is broad in scope, and will be a blessing from God for the community of Palangkaraya. It will serve Subud members attending the World Congress in 2001. Members of the Project team are: Latidjah Miller, SIHA Coordinator, Robyn Burke, SIHA Treasurer, Dr Muninjaya, ISC chairman, Dr Rachman Mitchell, CME Program Director, Dr Rahardjo, SIHA Indonesia Coordinator, Pak Joyowidarbo, Project Manager, Ibu Rukmini Joyowidarbo, SIHA International Representative in Indonesia, and Ridwan Dobson, Architectural Assistant. We will be working closely with GHF also.

The Project will require generous financing from people touched by the concept. We have drafted a proposal for the Project, and are working on obtaining accurate costs for the building and equipment. A copy of the Project Proposal will be sent to you as soon as it is available.

Your financial support can be wired in US dollars to: First Union National Bank, Vienna Office, 212 Maple Avenue East, Vienna, Virginia 22180.
ABA No. 056007604, Subud International Health Association,
Account No. 2050000227750.

If you wish to contribute in British pounds, the bank is: Barclays Bank PLC, 73/75 Calverley Road, Tunbridge Wells, Kent TN1 2UZ, Sort Code 20-88-13, Subud International Health Association, Account No. 10901482.

We look forward to hearing from you regarding your support, and we thank you.

On behalf of the Subud International Health Association Hospital Project Team,

Latidjah Miller, SIHA Coordinator
Robyn Burke, SIHA Treasurer'

## LETTERS

Dear Hermione,

I very much enjoyed the 'homeopathic perspective' (Letters No 2 Vol 2) Curiously enough, the symptoms listed for the use of Lac Lupaninum apply to me!
Love,
Rasjid Lyle

[*See Rasjid's article Wolves as Therapists No 1 Vol 2*]

## THE NATURAL DEATH HANDBOOK (1993)

***Editors: Nicholas Albery, Gil Elliot & Joseph Elliot.***
Pub: Virgin Books Price £9.99

Reviewed by Hermione Elliott

*The Natural Death Handbook* is a refreshing and inspiring exploration into all aspects of death and dying. It seeks to break the taboos and restore death to a natural and conscious process; returning it, as far as possible, into the hands of the

dying person and their family.

The editors saw the need for such a book when they set up The Natural Death Centre, an educational charity, which recognises that natural death is as much a right as natural birth.

The book is a combination of discussion, experience and practical guidance, with a respect throughout, that death is an experience of the most fundamental and spiritual kind.

In the earlier part they draw together material from history, biography, as well as articles and letters from ordinary people, sharing their experiences of death and dying. Some remarkable and beautiful deaths are recounted. I was especially moved by the teenager who was flown with her parents across the world, to swim with dolphins before she died – she knew then that she wouldn't be afraid. And so it was. Her weak little body was nudged and nurtured by the dolphins, as she floated and 'swam' with them for over an hour – it was pure joy. The very next morning she died, asking that her ashes be scattered where the dolphins swim. It is humbling to read of the awareness and openness with which so many people have welcomed this transition.

In the same format there is a chapter on Near Death Experience and the undimming effect it has on the people who have 'died' and returned. The chapter on Training for Dying, reviewing courses, workshops and techniques, I found especially heartening. After all, how to die well is a question for all of us, and free and open discussions around this subject are rare. It describes how the group work supports people to 'hear' what death has to say, reflecting upon the life they have lived, writing their own obituary, imagining they only have six months to live and identifying how they would like to live it etc. Not surprisingly, their experience shows the more we face up to death, the more likely we are to know how to live.

The sections on Living Wills, Wills, Dying at Home, Natural & DIY Funerals etc are all very illuminating – demonstrating much more freedom to act outside the system than I had thought possible. The latter sections provide a fantastic array of resources, mainly for people living in Britain, and the extensive booklist will be valuable to all. It is a very worthwhile read.

## RESEARCH SNIPPETS

A recent BBC TV programme 'The Valley of Life or Death' highlighted some vitally important research into the spread of HIV/AIDS. In Africa, scientists and anthropologists have identified variations among groups of people, some of whom are four times less likely to get HIV than others. Sometimes these groups are living just yards away, across a single valley, and are people with apparently similar behaviour and lifestyle. After 15 years of detective work it turns out there may be a remarkably simple answer: the high-risk areas for HIV coincide with tribes who are uncircumcised.

There have now been 27 statistical studies that show a big difference in HIV infection between circumcised and uncircumcised men. For example, among the uncircumcised people of Kisumu in Western Kenya, a man is three times as likely to get AIDS than his circumcised neighbours. Among truck drivers in Mombassa the difference is four-fold.

The work of scientists and microbiologists indicates that the foreskin

may be a key entry point for HIV. Research has shown that the inner surface of the foreskin has no keratin. Instead it is well supplied with Langerhans' cells, which are the first line of defence against infection, except it seems, in the case of HIV. In an experiment using live foreskin taken from a recently circumcised patient, two samples – one taken from the external, keratinised surface and another taken from inner non-keratinised surface – were infected with HIV. The samples were stained, and within minutes the Langerhans' cells from the inner surface of the foreskin were shown to be infected. The sample from the outer surface remained uninfected.

After studying all the statistics, Professor Richard Hayes from the London School of Hygiene and Tropical Medicine suggested that circumcision reduces the risk of HIV by 60%. However, the programme stressed that this fact is not a substitute for protected sex, as HIV can still enter through cuts and grazes in both circumcised and uncircumcised men.

Information about the programme can be found on: www.bbc.co.uk/science/horizon/valley_hiv.shtml with links to other resource sites related to this issue, in particular The British Medical Journal www.bmj.com/cgi/content/full/320/7249/159

## *GLOSSARY*

For non-Subud readers, we hope this will explain some of the terminology commonly used.

*Helper* .... a Subud member responsible for informing enquirers about Subud, witnessing a new member's wish to receive the latihan, and being available to help members.

*Latihan* .... the practice of the worship of God in Subud

*Opening* ....the initial receiving of the latihan

*Testing* .... the practice of asking and receiving guidance in the latihan


## *Acknowledgements*

We would especially like to thank all the contributors to this seventh issue of Resonance and give thanks to all those who have donated their time, expenses and expertise in helping us to produce this journal.


## SIHA on the Internet

You can join the SIHA List server by emailing Lukman Ramsey at lramsey@UCSD.EDU
If you would like to see the SIHA website it is at www.Subud-Health.org
It is a work-in-progress and we would value your comments

Forthcoming SIHA Meeting at Loudwater Farm ..... Bring a picnic lunch.
– Saturday 17th March 2001, from 10.30am to 5pm –

***"Helping ourselves, Helping others"***

***... "a day of latihan, testing, sharing and reflection for health professionals." ...***

We plan to stay on for an evening meal together, and if you would like to stay the night at Loudwater, please book directly with Rosalyn Bolt: tel: 01923 777750.

*Please let me know if you are able to come. Lewis Roberts SIHA UK Coordinator 01747 811367*

For your diaries there will be a weekend meeting at Bristol on 11th – 13th May 2001. Programme details TBA