SPECIAL REPORT:

AFRICA PROJECT by Mary Cowley, PhD

with Alvaro Hernandez and Chris Milbank

Background

The background to any TFT story always begins with the brilliant Dr. Roger Callahan who discovered and developed this revolutionary approach to healing.

Since Roger's first cure of a phobia in the early 1980's, he has continually expanded the types of psychological issues that can be successfully treated, including traumas, anxiety, addictions, anger, stress, obsession, depression, jealousy, and other negative emotions.

And, in spite of the fact that Roger never imagined TFT could be used for physical problems, practitioners of all types, including physicians, naturopaths, chiropractors, dentists, massage therapists, acupuncturists, and other healing professionals, have been using TFT with ever increasing effectiveness on various kinds of physical problems, such as nausea, fatigue and pain.

His discovery several years ago (thanks to Dr. Fuller Royal) of the unprecedented effect TFT can have on one's Heart Rate Variability (HRV) has enabled the TFT community to effectively and objectively demonstrate the power of TFT to affect the mind-body healing system at a profound level.

Even with all that, Roger and wife Joanne continue to be startled when a practitioner reports successful treatment of a "new" symptom. It was just so when Dr. Jenny Edwards and Fr. Luis

Gonzalez told them that during one of their TFT training trips to Africa they successfully used TFT to help a few people who were suffering from malaria.

Also notable was the ability of Alvaro Hernandez and his wife, Georgette, to withstand two multi-week trips to a malaria-infested area of Africa, and many mosquito bites, without getting sick--even though they took no malaria prophylactic. Alvaro had been traveling to the Carmelite College/Mission in Morogoro, Tanzania, for a few years to teach TFT algorithms to local students and caregivers. Georgette, who accompanied him, had previously had a violent reaction to Larium so they chose not to take it on the next two trips. They thought that perhaps all the TFT tapping they did during the trainings helped them be stronger and more resistant to disease.

Then in September of 2004, during a TFT training in Mexico City, one of the nurses from a nearby village told Joanne and Roger how she helped with dengue fever using TFT algorithms. While at dinner that evening with friends, including Alvaro and Dr. Racquel Hazas, Joanne and Roger talked about an article in Science News that reported that mosquito-born illnesses, such as malaria and dengue fever, are an electrical phenomenon in the body. Racquel, a physicist, verified this fact.

They realized this might offer an explanation why TFT has been able to help with these problems and talked about the possibility of the ATFT Foundation, of which Joanne is President, sending a team to Africa to explore how TFT might help relieve the suffering caused by malaria.

Knowing the College/Mission in Morogoro wanted to host further TFT workshops, Alvaro thought this might be a good home base from which to carry on the research. His inquiries to the superior at the College, Fr. Marlon, were met with much enthusiasm, the Foundation Board of Directors heartily approved, and the Africa Project was on its way.

The purpose of the Africa Project research would be to find out whether TFT could reduce the physical and emotional suffering associated with the deadly disease of malaria and, if so, to investigate whether similar treatment sequences could be found. This would enable the treatment of malaria victims by algorithms that could be administered by patients themselves or with the help of others. In addition, we would teach TFT at the Diagnostics level to local caregivers and establish relationships with trainees willing to carry on the collection of pertinent data in the team's absence.

As plans developed, it became apparent that follow-up trips to Tanzania would probably be needed for supervision, further training, and monitoring purposes. With much gratitude to all those who volunteered, the Foundation chose its team of four: Alvaro Hernandez, TFT-Dx practitioner and engineer from Mexico; Christopher Milbank, TFT-Voice Technology (VT) practitioner from the U.K.; Cecily Resnick, PhD, TFT-Dx practitioner from the U.S.; and. Mary Cowley, PhD, TFT-VT practitioner and President of ATFT, from the U.S.

ATFT Africa Mission team arrivaing at Dar es Salaam airport. Left to right: Alvaro Hernandez, Mary Cowley, Cecily Resnick, (standing in back) Chris Milbank.

In order to determine what kind of effect Thought Field Therapy had on malaria patients, we needed to collect certain data before and after TFT treatment. The plan was to focus on people whose blood tested positive for malaria.

We would then obtain four *pre-* and *post-* TFT measurements of people testing positive for malaria:
1) **Ratings of malaria symptoms**, from 0 to 3 *(0=none, 1=mild, 2=moderate, 3=severe)*;
2) **Body Temperature** (fever is a common symptom of malaria);
3) **Subjective Units of Distress** (SUD), from 1 to 10, for the overall problem;
4) **Heart Rate Variability** (HRV).

Symptoms included fever, chills, shakes, muscle aches, palpitations, shortness of breath, loss of consciousness, problems urinating, nausea, vomiting, diarrhea, jaundice, cough, seizures, dehydration, and headache.

The HRV variable SDNN (Standard Deviation of Normal to Normal intervals) indicates the variation of intervals between heartbeats as measured in microseconds. Research demonstrates that HRV is a powerful predictor of all-cause mortality and indicates the state of one's overall health, is placebo free, stable over time, and has strong individual reproducibility.

Cecily developed a TFT Treatment Record to be completed for each case where the above measurements could be indicated as well as patient identification, past medical history and history of current illness.

Diagnostic TFT treatment would be given on an individual basis both to tailor the treatment and to see if there were common treatment point patterns. The specific TFT treatment diagnosed for each individual would be recorded on the Treatment Record by the therapist or therapist's assistant.

Thanks to Joanne Callahan, who researched appropriate blood tests for our purpose, we were able to bring with us 200 test kits produced by ICT Diagnostics. The kits are relatively simple to use and only require a wait of several minutes for results as opposed to the most common type of malaria blood test used in Africa, blood smear, which takes up to 45 minutes. For HRV collection, Alvaro brought his laptop computer with HRV software and ear clip monitor.

The following is a summary description of our sojourn to Tanzania and the research we accomplished there. It includes bits and pieces from Alvaro and Chris with contributions from Cecily's team notes and data collection. There is no room for it all and no way we can find the words to adequately describe all the thoughts and feelings we had while there.

We were four people from three different countries, with very different educational and experiential backgrounds. We shared one common purpose: ***to try to discover how TFT could best help the huge population that suffers from malaria.***

We were in a different world, with none of the usual resources and little local preparation with the exception of the establishment of treatment sites and invitations to potential participants. (Special thanks to Fr. Marlon and fellow Carmelites).

It is our sincere desire that the following words and pictures will allow you to share in our adventure as you certainly do in our success...

The Trip

Chris: *"As usual I wondered what I had let myself in for—here I was again volunteering to travel off somewhere to help in something that was exciting and way out of the norm for most people.*

This was it — the big adventure. A bigger adventure than I had imagined when I put my name forward last November and volunteered to help the ATFT Foundation Project in Africa.

The usual comments from family: 'you be careful,' 'it won't be a beach holiday,' and 'are you going to be doing any of that funny stuff?' This is my family/friends—DOT DOT DOT DASH DASH DASH DOT DOT DOT—tapping gets me beyond their doubt and skepticism. All I envisioned was a mud hut and rain and mosquitoes the size of baseball bats. I tapped until the mud hut was a Holiday Inn, the mosquitoes were all stuck inside a honey jar and I was excited about the trip."

On Saturday June 9, 2005, the four team members met at the London airport and flew together to Dar es Salaam, Tanzania.

Chris: *"The big day arrived. I completed the trip to London airport somehow knowing I would first meet Cecily, then Mary and then Alvaro in that order--my intuition was correct. After tickling*

Dr Cowley's thoughts about jungles and giant mosquitoes and mud huts we all went shopping for torches and extra mosquito gear. Soon we were flying to Tanzania."

Alvaro: *"Mexico-London, London- Tanzania seems a long trip and it is. However, with the excitement of knowing we were involved in a project related to our favorite subject, 'TFT', the time went fast and the trip seemed short. Our objective was to help people in one of the poorest countries in the world by teaching and treating them with TFT, and doing research to help them in their fight against one of their more devastating enemies 'MALARIA'. At our arrival the adventure started. The feeling of being in Africa is some-thing special that makes you want to return. Our friends from the mission were at the airport, waiting to take us from Dar es Salaam to the town of Morogoro, a beautiful place surrounded by the Morogoro mountains. We always felt safe—the Carmelites took our security as their own responsibility."*

Chris: *"The first test came when Mary's luggage did not arrive. Mary, as President of the ATFT and most experienced VT practitioner, was heading our team. She shrugged her shoulders and proudly said, 'OK, so it's all of you that will suffer if I have dirty clothes,' and smiled. The first sign of the strong leader we all saw during our trip."*

After arriving at the mission, we had a couple days to settle in and prepare as much as possible for the next week of research.

Chris: *"Mary held a first meeting and Cecily swung into action as our research heroine. Our first task was to organize interpreters, nurses for blood tests, and someone trained with the HRV. Alvaro swung into action and used his contact skills with a certain daring sense of humor and risky-type language with the priesthood that only he could get away with. (They all loved him out there). We were rather in the dark before we arrived, not knowing what we would find or what our resources would be. Our main job was to set up from scratch a research project, find the do's and don'ts, and get going."*

We learned that Fr. Marlon had procured five different sites for the research. Announcements were made at Masses the week before, inviting anyone who thought they had malaria to come try a new therapy that might help them feel better.

We gratefully discovered we would have the assistance of two nurses and three other helpers most of the time.

Our tasks for the research were many and varied. We made the obvious assignments: The nurses would take blood tests and temperatures; the two assistants (whose native language was Swahili) would be our main interpreters; and the four of us would conduct the TFT treatments. Other tasks would be assigned later.

We had no idea yet what we'd find at the sites, what the site layout would be or how many people would show up and how sick they would be. We needed to remain flexible, at least for the time being.

On the evening of Saturday, June 11, the team was driven to the Holy Cross Dispensary to meet with the nurses (Srs. Bindu, Jackie and their superior) to talk over research plans and show them the ICT blood test kits for malaria.

During our visit, we were asked if we wanted to try TFT with a teenage girl who had malaria and had just been admitted to the dispensary. When we arrived at her room she was on a quinine

drip. She had a high fever and was agitated, writhing, moaning and sat up in anticipation of vomiting into a pail, which she never actually did. We started treating her right away with Chris as therapist and Alvaro as surrogate as the patient was too uncomfortable and weak to be muscle tested.

Alvaro: *"I took her by the hand and started tapping. The tapping lasted long as the reversal was not easily eliminated, but by the end of treatment the nurses thought her fever was decreasing and she had fallen asleep. The next day, when we asked about her, they simply reported that she left the clinic because her response to the quinine was very good. They did not believe that our TFT treatment did part of the job and at this stage we could not prove anything or come to any conclusions. However, we felt encouraged because for us it was a signal that TFT could be of great help in the treatment."*

Research

This was the site schedule for our week of research:

- June 13 Carmelite House, Kola
- June 14 Catholic Church, Kihonda
- June 15 Catholic Dispensary, Malolo
- June 16 Holy Cross Dispensary, Kihonda
- June 17 Catholic Church, Kiroka

Above photos: ATFT Africa Team meets the nurses

We were so glad when Monday arrived. Not only would we finally get an idea of what to expect during the coming days, or so we thought, but we could finally get started teaching staff the procedures, testing how our expanded team might work best together, assessing our needs, and developing the most efficient process for helping people while at the same time collecting the needed data. This made for quite a hectic day, but one rich with opportunities to learn and refine our procedures.

More people showed up than we had expected. Many thought they had malaria but only one out of 19 blood tests taken tested positive. (We learned that most people in that area of Tanzania have the malaria parasite. It is believed that once someone has the parasite, he will always have it although it may not be active enough at any given time to show positive on a blood test. Many we talked to said they have malaria recurrences often, some of them monthly.) We were able to treat everyone who came, for whatever symptoms they were experiencing, with great success.

Nurses, Sisters Jackie and Bindu, giving malaria blood test

One of our nurses giving a malaria blood test to a baby.

Cecily & nurse measuring patient's HRV

On our second day, we were greatly surprised at the large number of people who showed up (150-200)! How could our small group possibly help all of them? Certainly not on an individual basis. So we decided to try to work with groups of people and split them up into those who thought they had malaria and those who did not. We started working with those who did not think they had malaria. The others were interviewed by the nurses, who gave a blood test to the people they thought might test positive. Only one did; he was treated individually with TFT-Dx.

The necessity of treating many people at one time had never been anticipated. And as far as we knew, treating groups of people suffering from severe and varying symptoms had not been done before.

We started with large groups (35+) but quickly found it more effective to treat no more than 15 at a time. We found ourselves working with groups throughout the week. We tried varying protocols and strategies. Different therapists had different styles. Protocols usually included PR corrections and the complex trauma algorithm. Sometimes collarbone breathing was necessary. When time permitted, we used diagnostics with those whose SUD was not yet to "1". We were not prepared to collect data on five groups. Group work had varying results, with increasing success.

Our third site was in Malolo, a bush village with no running water or electricity.

Alvaro: *"Malolo is a town lost in a very remote area with many mosquitoes. We were told everybody there has or has had malaria. The people were very nice. Baobao trees competed with acacias for the beauty of nature contrasted with mud houses and people dressed in colorful kangas. On our way*
to Malolo we crossed 50 kilometers of the famous Mikumi National Park where we saw monkeys, zebras, elephants and gazelles in their natural habitat. Sometimes we had to wait for elephants to cross the road or ask the driver to go slowly ('pole pole' in Swahili) to enjoy the view and take photos of the animals."

Only one patient who showed up at the site tested positive for malaria that day. She was very sick but felt much better after TFT-Dx treatment.

Several groups were treated for malaria-type symptoms and other problems.

Chris: *"I took on 26 school children reducing their SUD all down to a 'one' and the teacher promised he would use TFT in the schools. They also sang us the Tanzanian National Anthem--*

the first day I felt tears in my eyes. Later that day I gate-crashed a classroom. The teacher was approximately 13 years old. I walked in and said, 'Hi! I am from England. Do you fancy doing something different for an hour?'

I treated four kids with bad malaria symptoms, from all over body pain to headaches and fatigue. After eliminating all their symptoms, I taught the rest of the class some basic TFT tools. At the end I handed out about fifty pens and crayons I had brought along with me. Today was my best day so far."

During the ride back to our home base in Morogoro, a fellow traveler felt extremely ill. We stopped the van and discovered she had malaria AND typhoid and was feeling very nauseous with extreme stomach pains and headache.

Alvaro learned she had taken quinine for the malaria and, through testing, discovered she was sensitive to it. He had her treat herself with the appropriate Seven Second Treatment (SST). This single treatment eliminated her symptoms. Her relief extended into the next day, which greatly pleased her, and she asked for TFT treatment on related issues.

People showed up on the fourth day with varying problems. No one tested positive for malaria. All were treated with TFT, individually when we had the chance and in groups when we did not. We taught the trauma algorithm and copied individually diagnosed sequences when possible so people could help themselves at home.

Chris: *"I managed to talk one of the patients into watching me tap with her mother and friend, ridding them of their fear of getting malaria. The medical chief of the dispensary was watching and joined in to learn the algorithm. Soon a mother came in with her six-month old baby who had malaria and high fever. The medical chief tried TFT on the baby using the mother for surrogate tapping when necessary. The temperature normalized and the baby settled.*

An observing nurse was now interested so I gave her some TFT lessons and she performed the same 'miracle' on a sick toddler. After that I worked with a group of mothers and their kids with a little more difficulty as our interpreter went missing, but we somehow pulled through."

The final day was entirely different from the others and by far the most challenging. When we arrived at the site at a mountain village church, we were shocked to see about 200 very sick people of all ages waiting.

They had walked up to two hours through difficult terrain to get there and their problems were varied and severe. Conditions were difficult. We had only one small room for testing and intake.

We were short-handed as Alvaro had stayed back at the mission to prepare for the next week's TFT training. The day would be shorter than usual because the villagers had to allow plenty of time to walk home. And we ran out of blood tests, at which point a priest drove 45 minutes back to home base for more.

Sixty patients were given blood tests for malaria and about 45% of them tested positive. Although we were frustrated knowing it would be impossible to give relief to everyone who came for help, we would do what we could—and at least would have the opportunity this day to treat more blood-identified malaria patients.

Only Mary and Chris were available for individual TFT-Dx treatments as Cecily was needed to help with processing tests and collecting data. The nurses had brought some medication, which they gave until they ran out. For the malaria positive patients who would be treated with TFT, they waited to give the medication until after TFT treatment was complete and post-TFT data had been obtained.

While waiting for blood test results we worked with a group of people who did not have malaria, but had come for help with other severe problems such as leprosy, blindness and elephantitis!

We soon discovered that many had the misunderstanding that foreign medical doctors would be at the site with medications to cure them. We took them inside the rather dilapidated church because there was nowhere else with relative privacy to go. All we could do was explain why we were there and use algorithms to try to reduce stress, trauma and pain. Many had difficulty tapping.

During this time, we learned that almost half of the blood tests were turning out to be positive and realized it might be difficult to treat all the malaria patients in the time available. In order to get started working with them right away, we left those still remaining from the group under the care of an assistant who continued with teaching an algorithm.

Chris: *“Cecily had indeed organized the unorganizable and at last we had people whose blood tested positive for malaria. Mary and I took over two very small rat-infested rooms in the old church, each of us having a good solid interpreter at hand, and worked flat out using TFT-Dx.*

We each worked with about six malaria patients. The SUD of seven patients went down to a 'one'; two others went to a 'two'. Symptoms included fever, all over body pain, headache, sore eyes, fatigue and nausea. Of course, the babies' SUDs couldn't be determined, but they appeared to settle and mothers thought they felt cooler."

Diagnosis of these malaria patients was done with surrogates because the patients were either too young or too sick for muscle testing. In addition, surrogate testing speeded up the work because of the surrogates' relative understanding of the testing process and language.

Chris: *"We were exhausted. Now we had to collate the results and prepare for the next week's training."*

TFT Training Plus

The research portion of our trip was followed by a five-day TFT training that included Algorithms and Diagnostics (Dx), with Alvaro having primary responsibility for teaching Algorithms and Chris for teaching Dx.

Chris: *"Alvaro started with his wonderful teaching and humorous style which the students thoroughly enjoyed. During the rest of the week it was my job to lead the Dx training with Alvaro, Mary and Cecily each bringing in their own style and unique gifts. Handing out 81 certificates to these dedicated students was a real highlight. So many promised to use Dr Callahan's gift in the villages, AIDS and malaria clinics, schools, hospitals and churches."*

Alvaro: *"Also for the workshop we had the material required to make it a success: manuals specially prepared and donated by Joanne Callahan, TFT audio and video cassettes, ten laptop computers donated by an American company, and an HRV program donated by Biocom. Part of*

the training was accompanied by a PowerPoint presentation with projector, which helped the students understand better, as some had difficulty understanding English. We included a positive side of the algorithms that people liked very much. For example, the stress algorithm was also used to increase the feeling of peace, the depression algorithm to increase joy and so on. During the teaching, as always, many people had the opportunity to treat and be treated but team members were asked to help in difficult cases."

After the official Africa Project was complete, Cecily visited Dr. Lucy Nkya at the Faraja Clinic [you can read about this in an accompanying article] and Alvaro, Chris and Mary went on a five-day safari that Fr. Marlon helped arrange after the team arrived in Tanzania.

Alvaro: *"We were able to go to the Ngorongoro Crater and the Serengetti, one of the largest plains in the world created by volcanic ash, to see the migration of animals. We visited a Masai village on the Serengetti where we learned about their tradition and way of living. I loved the feeling of being sometimes surrounded by lions, other times by buffalo, elephants, zebras, hippos, monkeys, etc. The feeling of sleeping in the lodges in the middle of this 800 sq kilometer plain, hearing at night the noises of the animals right outside the bedroom, the feeling of seeing the sunsets and the starts at night."*

Chris: *"After the safari, Mary and Alvaro made their way home and I traveled to Zanzibar and met up again with Cecily and treated a few locals with malaria. Then we made our way to* Nairobi where Cecily and I taught a two-day Algorithm course at the American University. The Dean very much loved the teaching and has invited both of us back.

Chris: *"Mary proved to be an exceptional team leader defying the odds and never swaying from what was best for the locals and ATFT, and I do believe no one would have matched her skills in organizing this project out there on the ground. Cecily did an incredible job dashing around, from organizing the unorganizable to treating and teaching and collating the research. Alvaro's contacts and humor and diagnostic skills helped keep us all going. I am truly honored to have worked with these people and for this project. It has no doubt impacted me personally in a big way and was the significant drive for my success with helping children with TFT last summer."*

Alvaro: *"I hope that we can continue the TFT work to help the people in Africa and that many of you have the opportunity to live this incredible experience."*

Research Results

Individual Treatment of Malaria Positive Patients

Data was obtained from 15 people including 12 from Kiroka, 2 from Kihonda, and 1 from Kola with ages ranging from infants to adults. Gender was divided evenly with 8 males and 7 females.

Although most patients were taking medications, many still had malaria symptoms. All patients had a previous history of malaria except for one infant. One patient had a history of TB and one had a history of typhoid. Most patients were significantly affected by malaria. Seven people said the malaria affected their ability to work. Five cited inability to farm; two children cited inability to study. The malaria negatively impacted their well-being: 6 patients severely, 7 moderately and 1 mildly.

Before and after TFT treatment measures were obtained for temperature, SUD, specific symptoms, and HRV. Temperature went down for 11 patients, remained the same for 1 patient, and went up for 1 patient. The average temperature decreased from 37.10 °C (98.7 °F) to 36.39 °C (97.50 °F). Note that temperatures were taken under the arm, possibly lowering readings as much as 2 degrees. The average overall SUD on a scale of 1 to 10 before treatment was 7.08.

After TFT treatment the SUD decreased to an average of 1.21, indicating that most patients felt significantly better after treatment. All 12 of the patients with recorded SUD showed a reduction in SUD after treatment.

The severity of specific malaria symptoms as reported on a 0 to 3 scale (0=no symptoms, 1=mild, 2=moderate, 3=severe) decreased after treatment on all symptoms reported, i.e., fever, chills, shakes, muscle aches, palpitations, shortness of breath, nausea, vomiting, fatigue, cough, and headache, except one patient who reported mild diarrhea both before and after treatment. The following table gives a summary of the average severity levels before and after treatment. The table below gives a summary of the average severity levels before and after treatment for the most commonly reported symptoms. These results show a substantial drop in symptom severity after TFT. For every patient, symptom severity either decreased or stayed the same. There were no reports of symptom increase following TFT. In most cases severity decreased 1 to 3 points.

Before and after HRV measures
were obtained for 7 patients. The SDNN increased for 6 patients and decreased for 1. The average increase in SDNN, the vital measure of variability itself and the best predictor of illness and death, was 43 microseconds, about 77% above the pre-treatment average of 55.7. An improvement of this magnitude is unprecedented in the medical literature for any treatment and warrants more research. (Further analysis of the HRV data is presented by Dr. Roger Callahan in a separate article, "Africa Project HRV Analysis".)

Nurses reported that in one case the patient tested positive for malaria on the blood test before treatment and negative afterward. For all other patients there was no change in blood test.

The impact of TFT on patients can be seen by comments as well as quantitative measures. "Patient was very sick and unwell. Now laughing and feeling good. Lots more energy and no other symptoms." Quantitative measurements supported these observations: temperature decreased 0.8 ° C, HRV SDNN increased from 21.6 to 89.3, and SUD decreased from 8 to 1.

Group Treatment

Working with people in groups was not part of the original plan and was done in response to the large number of people who showed up for help at a few of the treatment sites. These people felt very ill and thought they had malaria. As there was not enough time, staff or blood test kits to test all of them, nurses gave blood tests to those who were most symptomatic of malaria and most of them tested negative. In spite of this, the research team wanted to give these people as much relief as possible, and as there was not enough time or personnel to treat them individually, working in groups was tried. Usually group treatment was for malaria-like symptoms. A couple of groups did not feel like they had malaria and their treatment was for the fear of malaria, a seemingly prevalent fear among those who came to the treatment sites. Group work had varying results with increasing success. With a few groups, the presenting symptom for each member was completely eliminated.

These results warrant further investigation into using group TFT to reduce malaria-like symptoms of those whose blood tests negative as well as to reduce or eliminate the fear of malaria.

A question is raised as to whether by reducing malaria-like symptoms and/or the fear of malaria, the actual incidence of malaria as shown by blood test might also decrease, given the significant amount of research linking stress and illness. We highly recommend further study of group work as in many situations it is the most efficient, and sometimes only, treatment choice available.

Developing a Standard Treatment Sequence

While there were too few malaria patients to develop standard treatment sequences (algorithms), the data collected was suggestive that a pattern may emerge with additional diagnosed cases.

Two researchers, Mary and Chris, came up with similar sequences through diagnosis and these sequences differed from previous known algorithms. A frequency analysis of treatment points showed high counts for G50 and Eyebrow (range 21-25), slightly fewer for Under Eye, Little Finger and Side of Hand (range 16-20). Middle Finger and Collarbone were less (6-10), and Under Nose, Liver, Chin and Under Arm were under 5. (Numbers indicate how many incidences of these points occurred in a listing of recorded treatment points.)

Interestingly, the usual high incidence of Under Arm and Collarbone did not occur with these patients. Side of Hand as a treatment point had an unusually high incidence.

Typical sequence combinations with malaria patients included EB/SH, SH/EB, G50/E, SH/G50, G50/SH, G50/TF, and TF/G50. These are unusual and suggest that algorithms for malaria patients differ from previous algorithms.

Individual diagnostic work with people whose blood tested positive for malaria suggests that an algorithm specific to this population may emerge with further investigation. Because malaria patients were weak and diagnostic work was required, most of the treatment was done using surrogates. This takes a large degree of expertise by the therapist. Such expertise will be hard to find in Africa.

What is needed is solid data on a large sample of patients with malaria in order to find algorithms that can be used by local practitioners. This data can be derived either by arm testing or by voice technology. The algorithms can then be tested locally either individually or in groups. It would be beneficial to learn whether these algorithms would also work for people who have malaria symptoms but whose blood tests negative.

Algorithms require minimum training to administer, enabling training of greater numbers of local caregivers. Algorithms also enable treatment in groups with the obvious benefit of treating many more people than can be accommodated on an individual basis. Furthermore, algorithms can be self-administered, whenever needed, significantly expanding the potential for relief.

Much was learned from this pilot study. As it was an investigatory study with a relatively small group, results are not conclusive but are robustly suggestive that TFT can significantly reduce the symptoms of malaria. We also learned what further information is needed and how future investigations might be designed in order to develop the most effective and efficient TFT treatment for malaria victims that can be taught to the greatest number of local caregivers.

The marked reduction, and in most cases elimination, of malaria symptoms as reported by malaria patients after TFT treatment is supported by reductions in temperature, SUDS, and therapist observations. Further compelling evidence of the efficacy of TFT for this population is given by the significant improvement in objective, placebo-free HRV measurements. All the data collected reflects significant improvements in most patients' conditions as a result of TFT treatment.

More research on the effects of TFT on populations plagued by malaria is clearly warranted.

A question is raised as to whether success in reducing symptoms of malaria such as nausea, chills, cough, headache, body aches, etc., suggests that TFT may help relieve such symptoms whether or not they are associated with the disease of malaria and investigations into this possibility are also recommended.

The Africa Project was a tremendous success. Continued and expanded TFT training, treatment and collection of treatment sequences and results in Africa remain primary goals of the ATFT Foundation. We sincerely welcome your participation, suggestions and donations.

Thanks

The Foundation's deepest thanks go to Fr. Marlon, superior at the Morogoro Carmelite College/Mission. He tirelessly looked after our team--housed, fed, transported, guided and advised us, organized research site locations, and organized the TFT training. He even set up the 5-day safari that Chris, Mary and Alvaro added to the end of the trip. We are ever grateful to all his fellow Carmelites, both at the College/Mission in Morogoro and at other Carmelite houses, who helped host our stay and project. They were most gracious in making us comfortable, safe, and successful in our efforts; their patience with us disrupting their home and lives for almost three weeks was impressive and most appreciated.

We wish to particularly thank Bros. Renatus, Felix, Rovel and Aureus, and Srs. Jackie and Bindu, who accompanied and supported us with our research most every day. We could not have done it without them. As professionals we give all of you our profound thanks and appreciation for furthering the ATFT and its Foundation's efforts to relieve suffering in the world. As individuals we give you our love and gratitude for taking such good care of us with boundless kindness and humility. You have touched our hearts and will remain there forever.

Many thanks to the Ruth Lane Charitable Foundation for generously donating the funds needed for this phase of the project, to the U.S. company that donated 10 laptops, and to Biocom for donating an HRV program and hardware. Their generosity will enable local caregivers to continue helping people and collecting data.

As well, to the World Health Organization for explanations of different malaria blood tests we might use in the field, to R & R Marketing for supplying us with 200 ICT Diagnostics blood test kits at their lowest price, and to Novartis Pharmaceuticals for donating the medication Coartem for the team to have on hand should it be needed.

Much gratitude goes to Alvaro, ever ready with his camera, for most of the photos-and especially for introducing the ATFT Foundation to the Carmelite mission, giving us a venue for training and research.

Thanks also to Bob Bray for help with the research plan. And special thanks to office hero Chris Trautner whose good cheer and help with the details were vital.

Finally, but most importantly, we thank Roger Callahan, without whom, well, where to start? You've opened up a whole new world of possibility and good health to everyone on the planet, Roger. And Joanne, whose enthusiasm and determination to find a way to help the children of the world found an outlet in the ATFT Foundation and the Africa Project. The children, and all of us, thank you.