WRITING ABOUT HEALTH

Say what you mean and mean what you say
INTRODUCTION
Ever since we published Contact 134 on Resource Centres, we have been inundated with requests for copies of an article announced on the back of that issue. It is called “Controlling your language: making English clear”. The interest in this article gave the editorial team of CMC - Churches’ Action for Health an idea. Why not produce an issue of Contact on the theme of “Writing about health”? This is exactly what we have done.

First, we have reproduced the article by Felicity Savage and Peter Godwin in full. It is not new. It was first published 12 years ago. Since then an adaptation of it called “Simple English is better English” has been made available from TALC (for details about TALC see page 15). But we think that the original version is even better. Despite its title, our translators tell us that the article will be just as useful to those wanting to write clearly in French, Spanish and any other language.

Our two other articles are about writing with sensitivity. The first is about “inclusive language”. Sometimes the choice of words that we use makes some people feel left out or “excluded”. Consider the woman who is sitting amongst a group comprised mainly of men when she hears the question: “Who shall we have for chairman?” Isn’t it better to ask: “Who shall we have as a moderator”? Thinking about “inclusive language” means thinking about the sensitivities of those groups who might otherwise be excluded. It means asking women, members of ethnic minorities and indigenous people for their views in order to communicate the full, and more inclusive, story.

Finally, we include an article about the care needed in our communication about AIDS. It describes the challenge that AIDS presents to health professionals and the Christian community. It emphasises the need for health professionals and writers to be fully informed about AIDS. All health workers have a special responsibility to use terms and vocabulary accurately, and in a way that does not cause people living with AIDS to feel isolated or rejected. Being in solidarity with people affected by AIDS means being attentive to the language we use.

In this issue, we also acknowledge the need for good written materials to be translated into local languages. Contact itself is translated from English into French, Spanish and Portuguese, with some issues also translated into Arabic and Swahili. CMC publications such as “What is AIDS?” and “Learning about AIDS” have also been translated. Some other publications have been translated by other groups and organizations and we include a listing of some of these in Useful contacts on page 14.

We hope that this issue of Contact helps you to write more clearly and more sensitively. By writing more clearly, we communicate better. We are more able to “Say what we mean”. In thinking more about the feelings of others, our understanding grows. As a result of this greater awareness, we may also be more able to “Mean what we say.”
CONTROLLING YOUR LANGUAGE: MAKING ENGLISH CLEAR

By Felicity Savage and Peter Godwin

Traditionally, "good English" has meant a style which employs long complicated sentences, rich in synonyms and subordinate clauses, and which carefully avoids repetition. But this manner of writing does not communicate practical information efficiently. It may be stirring but it is not clear.

To communicate about technical matters, you need to use language in a much more controlled way. Sometimes, the product is called "simple". But that term refers only to the elementary structure of the language which results. It does not describe the ease with which the material is composed: nor necessarily, the complexity of the ideas conveyed. For authors long used to following the style of scientific textbooks and journals, "simple" English (which we prefer to call "controlled", or even just "clear") is far from "simple" to write. And the attempt to do so often exposes unsuspected confusion in the thinking of the writer. But with practice, most people can learn to write simply; and it is perfectly possible, too, to avoid the unnatural kind of simplicity that offends the sophisticated, and which brings the style into disrepute.

So far, the main use for simplified English is to improve technical communication to workers to whom it is a foreign language, and especially to those who also have a limited education. Non-native speakers, and inexperienced readers, even if they are socially fluent in the language, often have much more difficulty with reading than we realize. Modern readability texts have shown how simplifying a text can make it very much easier to read. Also, a simplified text is easier to translate and, if recorded on tape, it is easier to listen to.

Technical material accessible to the non-native English speaker is valuable, because so little has been satisfactorily translated. But the gain in clarity - particularly the improved organization of the ideas behind the words - also helps communication between fellow Anglophones.

Here are the main rules for writing "controlled" language, which educationalists have worked out, and for which there is some sound experimental evidence (Cripwell, 1974:

April 1994
Srivastava, 1978; Wright, 1977). Our concern is to increase the usefulness of manuals and other teaching materials for health workers in developing countries.

Most of the quotations come from the script of a slide tape set which is distributed through TALC (address on page 15). A group of non-native English-speaking nursing students who studied the "simplified" version commented favourably on the greater ease with which they could understand it. The same students have found non-simplified scripts much more difficult to follow.

1. **Use short sentences**

Each sentence should contain not more than 20 words (and, if possible, less than 16). Sentences like this, with 51 words, are too long:

“To help mothers with malnourished children, in some areas a special supplement has been prepared, which they can feed to the child and which will make good the lack in the child's diet and start him on recovery whilst he gets used to the diet that is taught to the mother.”

Many readers can understand all the words, or even all the phrases, but they get lost on the connections and miss the meaning as a whole.

2. **Use only one or two clauses in each sentence**

Or, to make the same point the other way round: Keep each idea in one simple sentence.

The above example contains seven clauses, connected by the words in italic letters. A simplified version might read like this:

“We must teach mothers of malnourished children to feed their children a better diet. In some areas a special food supplement is made to help these mothers. While they are learning about the new diet, the mothers can give their children the food supplement. The supplement improves the child's diet, and he starts to recover.”

You could break down these sentences even further: “Malnourished children need a better diet. We must teach their mothers to feed them a better diet.” But there comes a point at which not only is the result longer, but it starts to get more difficult to connect up the ideas again.

3. **Use simple familiar words**

Use “try” not “endeavour”; “everywhere” not “ubiquitous”; “between”, not “interspersed”; “needs” not “requisites”.

If an unfamiliar word is essential, define it the first time it is used, and use it in context several times, so that it becomes familiar. Some of the words that we have had to use this way are: “Rosary” (string of beads); “Pigeon” (a bird); “transitory” (passing in time); “contaminate” (make impure). For health workers, obscure general vocabulary often gives more difficulty than medical words.

4. **Use the same word each time**

Many words have synonyms. Choose one, preferably the most commonly used, and use it every time. “Legume” (vegetable that can be eaten) or “pulse” in nutrition, both mean the same thing. “Deficiency” or “lack”, “far” or “lipid”, “regular” or “control”.

5. **Use precise words**

Precise words are easier than words with several meanings, or those with idiomatic uses, even if they are a little less familiar to a native speaker. Instead of “get”, try to use catch,
obtain, become, fetch, etc. Use "expensive" instead of "dear" or "beyond the means of"; and "previous" instead of "last". "Next" may be clearer than "then", when you give instructions like, "Next, examine the child's mouth". "After", may be clearer than "when", on occasions such as "After you have examined the child wash your hands".

6. Make positive sentences
You can't completely avoid negatives, but many are not necessary, and positive sentences are more easily understood. For a native English speaker "Do not give skimmed milk to babies under six months old", may be unambiguous. But for the non-native speaker it may be better to say: "Give skimmed milk only to babies over six months old." For the same reason, instead of "You cannot feel a normal thyroid gland", say "If you can feel a thyroid gland, then it is probably enlarged".

In particular, avoid double negatives, as in "Rickets is not uncommon in Indian children". The subtleties of "not un-" are likely, at best, to be lost. Why not say, "Rickets is common in Indian children"? If that is not accurate, perhaps it is better either to give precise figures, or to leave out the references to frequency altogether, or to say (simply), "Many children in India have rickets".

It is especially important to avoid a negative conditional, like "Unless he eats protein, the child will not recover". This means: "To recover, the child must eat protein". But people easily read "unless" to mean "if", which completely reverses the message.

7. Make active sentences
They are clearer than passive sentences. This is one of the most difficult rules to follow in practice, because the passive voice is so fundamental to conventional scientific style, that it can be hard to find a suitable subject. Be careful if you want to say: "It is good if children are given fish", because someone might not be clear that your meaning is different from "It is good if children are given to fish," and from "It is good if children are giving fish (away)". It is safer to say "It is good if mothers give fish to children".

To take another example, "Her attention will soon be directed towards another baby" in the active voice becomes, "She will soon direct her attention towards another baby". (But perhaps "Another baby will soon take all her attention" recaptures better what the passive suggested - that the baby is the dominant subject.)

You cannot follow these rules slavishly. Often a negative is unavoidable, or a simple passive less clumsy than a difficult active form. For instance, how do you avoid babies being born?

8. Use the personal and imperative form
This is especially useful when you give instructions about how to do things. To say "Advise mothers to give children more food" is clearer than "Mothers should be advised", and "You can see wasting of his arms" is better that "Wasting can been seen in his arms." Do not say "The pregnant woman is asked if she remembers the date of her last menstrual
period”. Say “Ask the woman about the date of her last menstrual period”.

Notice how adopting this personal form also involves changing from the passive to the active - and may incidentally provide you with the “missing” subject.

9. Use few pronouns
Readers may not be able to work out to what subjects a pronoun such as “they” “it” or “he” refers. Try to avoid, “Tell her to give it to him three times a day”, and instead say: “Tell the mother to give this medicine to her child three times a day.” On many occasions the pronoun problem is less obvious, as in the first example below.

10. Repeat words if necessary
Repetition is forgivable if it makes things clear, and if you are careful with the over-all construction, it need not sound unduly repetitive. There are several tricks we have to avoid re-using a word, and they can all confuse a non-native speaker.

(a) We use a pronoun to refer to a noun in the previous sentence or before. “Often the conditions of paid work make it difficult for mothers to breastfeed their children. So we should try to change them.” (Change what? The mothers, the children, the conditions, or all three?) You have to say, “So we should try to change those conditions”.

(b) We use a new word to refer to something said before. “Hyderabad mix consists of wheat, groundnut, Bengal gram, skimmed milk and sugar. The first three ingredients are roasted...” Not everyone realises what “the first three ingredients” are. It is much safer to repeat and say: “The wheat, groundnut and gram are roasted...”

(c) We use the word “so” (meaning “also”) to refer back to something said earlier. Again, it can be difficult for people to identify what is referred to “The cod stores Vitamin D in the liver, and so can the human.” “Mothers become anaemic, and so do children.” To be clear you may have to repeat thus: “Mothers become anaemic, and also children become anaemic”.

The phrases “like this” and “in this way” can cause similar confusion.

11. Keep comparatives simple
Avoid comparatives which imply degree. “Distinctly better” means “better”. “Somewhat similar” means “similar”. The cod liver oil must be “reasonably fresh” (just “fresh”).

Whenever possible, specify exactly what you mean. For example, how do you know if cod liver oil is fresh? Say how long it keeps. And instead of “rather younger” (if “younger” is not enough) say “(about) two years younger”.

12. Put in the connecting words “who” and “which” and “that”
Often these words are omitted and their sense is just implied. But they are precise and always refer to something in the same sentence, and for non-native speakers they are very helpful.

In the following sentence, four connecting words are left out: “This is a form of anaemia found in babies born to mothers living on a vegetarian diet deficient in Vitamin B12.”

If you put the connecting words all back, it becomes: “This is a form of anaemia which is found in babies who are born to mothers who are living on a vegetarian diet that is deficient in Vitamin B12.”
But sometimes for a native English speaker, it can be difficult even to see where the connections have been left out.

13. Avoid difficult constructions
(a) Try not to use the word by in “by doing” something, such as “Prevent rickets by giving cod liver oil”.

(b) “As” is another word often used in a confusing way. “Give children oil, as this is a good source of energy”, becomes clearer if you substitute “because”.

14. Use simple tenses
Where possible, use the simple present or past. Other languages do not all have such a complex system of tenses as English, and the future perfect in particular causes difficulty. The future is used mostly from habit in “The child with measles will have a rash”. “The child with TB will have been losing weight,” is only saying that “A child with TB loses weight.” And “Mary had been eating poorly for three months before her illness,” means simply that “Mary ate poorly for three months before her illness”.

15. Explain things in a clear, logical order, and in time sequence
Think about students’ problems in ordering information. In this sentence, which is 34 words long, the ideas are backwards: “The model of the pelvis on the left suggests the severe obstetric difficulties that a woman may run into whose pelvis has been softened and become contracted as the result of rickets in childhood.”

We do not learn about rickets in childhood, (which it is all about) until the last three words. The order of ideas is really: “Child-rickets-pelvis softened-pelvis contracted-adult woman (pregnant)-obstetric difficulty—we made a model to show you.”

However, the model must be mentioned early, because this text is describing a picture of one. A simplified version might read: “On the left is a model of a woman’s pelvis. This woman had rickets in childhood. Her pelvis became softened and contracted. In adult life, the contracted pelvis caused severe obstetric difficulties.”

Surely this is better than the original for levels of communication, and it is not offensively simple. It is two words shorter. The only individual words that might need defining are “contracted” and “obstetric” which it is reasonable to teach in this context. Even the original sentence did not contain many difficult words (apart from the unnecessary idiom “may run into”) - it is the way in which it was strung together that is confusing.

16. Write in “situational” terms
Try to make statements about things that happen to people in real situations - rather than abstract or generalized statements about processes. Although we put it last, this is probably one the most important rules. In conventional style you might say: “The skin grows to cover over gaps made by cuts. But dirt in wounds prevents healing.”

However, it is more real to readers if you say: “Your skin can grow to close a cut. This is healing. But if you get dirt in a cut, the cut will not heal well.”
Make statements about things that happen to people in real situations: it makes reading more interesting.

People often have difficulty relating abstract or generalized statements to real life. But if you write in these "situational" terms, people can more easily see it related to their life and practice.

17. Break up the text by any means you can think of
All the points so far have referred to the language itself. But for readers, it is important to remember the visual form of a page. And however linguistically simple, a solid grey page of prose can be very hard to read. Putting things in lists, and a new paragraph, and varied script, and pictures, helps to emphasize and clarify, and to reinforce by conveying information in a different way. An organized page helps the reader to organize the information.

Conclusion
We hope that this paper will help people who are teaching technical subjects in non-English speaking countries to write more understandably. Medicine and nutrition have been the subjects of our endeavours but the ideas should also be useful in other fields.

Acknowledgements
We would like to thank Ken Cripwell, of the Department of English as a Foreign Language, Institute of Education, University of London, to whom we owe so much of this. Thanks also to Professor David Morley for encouragement and support in preparing this paper.

References
Srivastava, R N (1978). Evaluating communicability in village settings. Dept of Linguistics, University of Delhi, Delhi, India and UNICEF, New Delhi, India.

Source: Transactions of the Royal Society of Tropical Medicine and Hygiene, Vol 75, No 4, 1981
WORDS CAN HURT

The World Council of Churches - of which CMC-Churches' Action for Health is a part - takes seriously the issue of "inclusive language". Inclusive language means language that is carefully chosen so that it does not exclude anyone. For example, it means not using words for only one gender when both are being referred to. It also applies to a sensitivity with regards to racism and other community relationships. Here, Bob Scott of WCC's Programme to Combat Racism explains why he believes it is important to choose the language we use carefully.

Bad language hurts people. If someone abuses me with their tongue, even if I get angry in return, I am still a diminished person because of what has been said. Words can hurt.

I would never dream of using language that would offend a dear friend. In the same way, when I talk about something I care about, I will certainly describe it in careful language. The care I take in describing something gives a sense of how important I believe the topic to be.

The words I use are a clear indication of what I think and what I believe. More importantly perhaps, the words I use, or the images I create, help shape what other people think and feel. There is no getting away from it, we can hurt or we can help with the language we use; we can reinforce prejudices or confirm negative attitudes by the words we choose to employ.

This is especially important for those who write about health. Many issues are sensitive and need careful explanation. This is only to be expected because health is about wholeness. Those writing about health do not wish to damage that wholeness. They therefore have to make sure that they do not use language that makes anyone feel marginalised or ignored.

It is very easy to slip into using words that make judgements. Just last night I heard a politician, reacting to a parliamentary vote on lowering the age of consent among homosexual males. He said: "All 'decent' people know this would unleash all kinds of disastrous behaviour among older gay men". The small word "decent" conveyed the judgement, for clearly those who think otherwise are "not decent" in his opinion.

So often the language used to convey information about HIV/AIDS can be judgemental and can feed ignorance. For example, some uninformed people have suggested that AIDS is a punishment from God. Clear and factual information is what is needed for genuine understanding.

Exclusive gender language, or sexist language, is particularly painful. For years I have argued with those who maintain that "he" encompasses both men and women. These people
argue that it is perfectly acceptable to use "he" on all occasions. I have been told countless times that to change the world to a more inclusive one is time-consuming and, anyway, trivial. But this is not what every woman and girl thinks.

Some people say that changing the words that we use means nothing unless attitudes change as well. What do we say to these people? I can only speak from personal experience. When I became aware of how hurtful exclusive language could be, I found the task of revising my vocabulary a difficult one - especially when reading Scripture, or taking part in public prayers. It was a special discipline. But the more I had to concentrate, the more aware I became; the more skilled my tongue at "translating" into inclusive language, the more open I became. The more inclusive my language, the more positive the response received from other people.

Words are the windows into our minds. When the words change there is something going on in the mind as well.

Test yourself: Go back to the article on page 1-6 and try to find examples of non-inclusive language. How would you change the language to make it more inclusive?

COMMUNICATION FOR CHANGE

Counter stereotypes (fixed mental images) by presenting the reality of people's lives
For example, starving Africans is one media stereotype and wealthy families in US television series is another. The reality is that most Africans are not starving and some Americans are homeless beggars.

Recognise the significance of racism
Take care not to use racial stereotypes or language which reinforces prejudice and discrimination. One of the most significant is the uncritical use of the word "black" to portray something negative. In response, many people with that skin colour wish to affirm that black is a positive colour.

Source: Adapted from communication section of "Guidelines for good practice in gender and development", National Alliance of Women's Organisations, 279/281 Whitechapel Road, London E1 1BY, UK.
Health professionals must be informed about AIDS in order to give informed messages to others. In this article, Beverley Booth, a medical consultant with Christian Medical Association of India, offers some guidance in this important and sensitive area.

The AIDS (Acquired Immune Deficiency Syndrome) epidemic which has already hit India presents an enormous challenge to members of the health profession and to the Christian community in India. Health workers play a pivotal role in trying to convey the seriousness of the epidemic and the need for action while at the same time, trying to minimise the panic that can come to the uninformed.

Sitting on a volcano
Up to now very few people living in India have been personally affected by the AIDS epidemic. Thus many people feel that too much is being made of this epidemic. But we are sitting on a volcano which is about to erupt. The rate of sero-conversion to HIV (Human Immuno-deficiency Virus) positive in India is following the same pattern as that of sub-Saharan Africa 10 years ago. Because of the very long incubation period of the disease (7-10 years), most of these HIV positive people are currently asymptomatic, since the epidemic has reached India only fairly recently. And yet these HIV positive people are infectious. In some areas of sub-Saharan Africa, 20-25 per cent of the young adult population are HIV positive. Is that what we in India will face in 10 years? We, as health workers, must educate the general public on the severity of the AIDS epidemic, and the ways to prevent it.

Keeping informed
As health professionals, it is very important that we ourselves are fully informed about AIDS, especially the modes of its transmission. The facts are that HIV can be transmitted through exposure to blood and semen. It cannot be transmitted through casual contact, that is, through touching, shaking hands, etc. We cannot ‘catch AIDS’ by merely entering the room of a patient with AIDS, nor from touching a patient with AIDS.

Avoid isolating patients
Thus patients with AIDS do not need to be put in isolation. In fact, isolating a patient with AIDS may not only interfere with the quality of care that the patient receives, but also will convey to the patient’s family and relatives, other patients and hospital staff the erroneous impression...
### An HIV/AIDS Glossary

**AIDS**: Stands for Acquired Immune Deficiency Syndrome. A group of signs and symptoms caused by the Human Immunodeficiency Virus (HIV).

**AIDS test**: A misnomer (misnaming) for the HIV antibody test, which is a laboratory blood test that detects the presence or absence of antibodies to HIV. Though the presence of antibodies indicates that a person has been exposed to the virus their absence does not necessarily mean that the person is not infected with HIV (see **Window period**).

**ELISA**: Stands for Enzyme-Linked Immuno-Sorbent Assay. The type of test used to screen for HIV antibodies.

**HIV**: Stands for Human Immunodeficiency Virus, the virus that causes AIDS.

**HIV positive**: means that the HIV antibody test has indicated the presence of antibodies. If the test is truly positive, then it means the person has been exposed to HIV and that his or her immune system has developed antibodies to the virus.

**Immune deficiency**: The ability of the body to resist infection is impaired (weakened).

**Immune system**: The body's natural defence system against infections caused by bacteria and viruses.

**Incubation period**: The period of time between infection by the disease-causing organism, and the onset of signs and symptoms of the disease. In people with HIV infection the average incubation period is seven to 10 years.

**Transmission**: The spread of the disease-causing organism from one person to another. The major modes of transmission of HIV are: penetrative sexual intercourse, shared contaminated equipment of intravenous drug users, transfusion of unscreened blood (blood which has not been tested), and from mother to unborn or newborn infant.

**Western blot**: A type of test to detect HIV antibodies. It is more accurate, but also more expensive, than the ELISA test. Used to confirm positive results by ELISA test.

**Window period**: The period of time between the person being infected and when he or she produces antibodies against the virus. Most people with HIV infection begin to make antibodies within three months of infection. However, the window period can be as long as three years.

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that AIDS is 'catching' just from breathing the air, or touching someone with AIDS. The health worker should take precautions when performing activities that put him or her in contact with the patient's blood or other body fluids. But otherwise, the patient with AIDS should be treated just like any other patient. The *WHO AIDS Series* provides detailed guidelines for nursing management, laboratories, and disinfections and sterilisation.

It is imperative that we, as health professionals, do not allow ourselves to be swept away in media hysteria. The way we handle a patient with AIDS who is admitted to our hospital is an example for other hospital staff, as well as for the general public. We must set the correct example. If we are afraid to start an intravenous drip on a patient with AIDS, then how can we expect a sweeper to clean the patient's room? If we refuse admission to a patient with AIDS, what signal does that give to the public?

Owing to the impact of AIDS on society in general, the media and the public hear and use medical terms that are often incompletely or
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<th>Terms to avoid</th>
<th>Why?</th>
<th>Use instead</th>
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<tr>
<td>Carrying AIDS,</td>
<td>This confuses the two distinct phases of being infected with HIV and</td>
<td>HIV antibody positive; people with HIV</td>
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<td>AIDS carrier,</td>
<td>having AIDS. People can have AIDS but they cannot “carry” it.</td>
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<td>AIDS positive</td>
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<td>AIDS test</td>
<td>The most commonly-used test; detects antibodies to HIV. There cannot</td>
<td>HIV antibody test</td>
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<td>be a test for AIDS, as the diagnosis of AIDS is based on clinical</td>
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<td>AIDS virus</td>
<td>Can cause confusion between HIV and AIDS</td>
<td>HIV (Human Immunodeficiency Virus)</td>
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<td>Catch AIDS</td>
<td>It is not possible to “catch” AIDS. It is possible to “catch” HIV,</td>
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<td>but even this is misleading because it suggests transmission is</td>
<td>HIV positive</td>
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<td>similar to colds or flu</td>
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<td>AIDS sufferer</td>
<td>Having AIDS does not mean being sick all the time. Someone with AIDS</td>
<td>Person with AIDS</td>
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<td>can continue to work and live a normal life for some time after</td>
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<td>diagnosis. The term “suffering” is therefore not appropriate</td>
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<td>AIDS victim</td>
<td>Suggests helplessness</td>
<td>Person with AIDS; person who has AIDS</td>
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<td>Innocent victim</td>
<td>Suggests that anyone else with AIDS is guilty</td>
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<td>High risk</td>
<td>There is risk behaviour, not high risk groups. The fact of being</td>
<td>AIDS</td>
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<td>classified as a member of any particular group does not put anyone</td>
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<td>at greater risk, but what he or she does, regardless of groups, may</td>
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<td>Full-blown AIDS</td>
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<td>then there is no need to use the term “full-blown AIDS”</td>
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incorrectly understood. It is important that we understand the terminology, so we don’t contribute to the misunderstanding. It is important that we avoid certain phrases that are commonly used but convey the wrong information or impression.

As the nature of the major modes of the transmission of HIV brings up moral issues, judgemental attitudes are often reflected in the terminology we use when talking about AIDS. Health workers, in particular, should take care to avoid terminology that is incorrect, misleading, or even subtly judgemental in nature.

The AIDS epidemic presents a truly wonderful opportunity for Christian witness. Today, all over the world, people with AIDS are being treated much as lepers were treated at the time of Christ. The way we act when we meet people with AIDS will be the true test for those of us who profess to follow in the footsteps of the greatest healer, Jesus Christ.

References

* For details of WHO AIDS Series (numbers 2, 3 and 9), write to World Health Organization, address on page 15.

Source: Shortened version of an article published in CMJ (Christian Medical Journal of India), vol 8, number 3, July-September, 1992.

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MAKING AIDS INFORMATION “POPULAR”

Claudia Guerra provides educational materials about AIDS. They are produced in Spanish by EPES, the health programme of Evangelical Lutheran Church in Chile.

Claudia says that EPES field staff want materials on AIDS to share with popular (or people’s) groups. She is able to offer an educational game, videos, written materials and guidance on many books and publications.

According to Sonia Covarrubias, who also works with EPES, the resource centre has become an open space for educational support to improve the health of the popular sectors. “We hope to continue to give our support with each and every passing day,” she told Contact.

EPES (Popular Education in Health), Evangelical Lutheran Church in Chile, Castilla 360-11, Santiago, Chile.
OVERSEAS OFFICES HAVE THE BACK UP FROM UK ADVISERS AND INFORMATION OFFICERS, LIKE OURSELVES. PARTICULARLY EXCITING DEVELOPMENTS HAVE OCCURRED IN COUNCIL LIBRARIES IN SIERRA LEONE AND LAGOS, NIGERIA, BUT ALL OUR INFORMATION OFFICERS WOULD LOVE TO SHARE THEIR KNOWLEDGE AND SKILLS.

RUTH HOPE AND SARAH METCALFE
HEALTH ADVISER AND
HEALTH INFORMATION OFFICER,
THE BRITISH COUNCIL, MEDLOCK STREET,
MANCHESTER M15 4AA, UNITED KINGDOM

WE ALSO RECEIVED A LETTER FROM THE ISRAELI MINISTRY OF HEALTH.

DEAR EDITOR,
I READ CONTACT 134 WITH INTEREST, AND NOTED, SADLY, CERTAIN UNHELPFUL REMARKS IN THE ARTICLE ENTITLED "BUILDING LIVING LIBRARIES", REGARDING THE PALESTINIANS AND ISRAEL.

HAVING LOOKED INTO THE CLAIM ATTRIBUTED TO HALA SALEM OF THE BIRZEIT UNIVERSITY THAT "...RESTRICTIONS OF LIVING UNDER ISRAELI LAW MEANS THAT PALESTINIANS ARE VERY ISOLATED FROM HEALTH ORGANIZATIONS ABROAD", I CAN TESTIFY THAT SUCH IS NOT THE CASE AT ALL. THE RED CROSS, RED CRESCENT, UNICEF, WHO, CRS (CATHOLIC RELIEF SERVICE) AND LUTHERAN WORLD FEDERATION - ALL HAVE BEEN ACTIVE FOR YEARS IN THE AREAS IN QUESTION. THERE ARE FREQUENT VISITS BY REPRESENTATIVES OF THESE BODIES, AND SENIOR PALESTINIAN HEALTH OFFICIALS HAVE BEEN PARTICIPATING IN INTERNATIONAL CONFERENCES ON THE ISSUE OF HEALTH, IN EUROPE, EGYPT AND JAPAN. HENCE, CONTACT 134, I AM SORRY TO SAY, SEEMS TO HAVE OFFERED ITS READERS SOME INCORRECT INFORMATION IN THIS RESPECT.

BUT I FOUND MORE DISTURBING ALLEGATIONS ATTRIBUTED TO HALA SALEM, QUOTED VERBATIM: "WHAT WE NEED MOST IS TRUE SOLIDARITY, AND FOR OTHERS TO MOBILIZE THEIR OWN COMMUNITIES ABOUT THE PALESTINIAN PROBLEM". HEALTH APPARENTLY IS NO LONGER THE PROBLEM; IT IS REVEALED THAT THE "PALESTINIAN PROBLEM", A POLITICAL MATTER, IS THE REAL POINT OF THE ARTICLE, AND PRESUMABLY THE REAL PURPOSE OF HALA SALEM.
At a time when conciliation is in the making, it is more important than ever to discourage initiatives which can only feed hard feelings.

Y Sever
Medical Officer, Bet El
Ministry of Health, Jerusalem, Israel

We asked Hala Salem to respond:
Concerning Dr Sever's claim that the main point of my article is a political matter and not a health problem, one of the main principles of Primary Health Care is community mobilisation and participation. Within the Palestinian setting in the Occupied Territories, besides the very poor health infrastructure, people suffer from anxiety, stress, etc, and their related physical problems. The "Hebron Massacre" gives a very clear message about the safety of the Palestinian civilian population under Israeli occupation. Peace and health are inseparable.

The work of many international agencies in the Occupied Territories is completely controlled by the Israeli authorities. Every organization must obtain permission from the authorities before being allowed to carry out any meaningful work. Applications for the supply of hygienic piped water to the villagers in remote areas, for example, have been either refused or not answered after years of delay.

Some Palestinians do participate in local and international conferences, but before being allowed to travel, they have to go through lengthy and complicated vetting procedures. To join one of these conferences one has sometimes to face several days of questioning by the Israeli civil administration and airport authorities. More often, applicants are refused permission to leave the country to take part in these activities without any reason or explanation being given. Moreover, I am sure Dr Sever is quite familiar with the harassment Palestinians face if they decide to move from one city to another in their daily business.

Hala Salem
Community Health Department
Birzeit University
West Bank, via Israel

USEFUL CONTACTS

The following organizations and groups have translated primary health care materials into local languages:

AMREF
The African Medical and Research Foundation in Nairobi, Kenya organizes workshops on writing and publishes books for health workers, including several titles in Swahili.

For further details, including information about the books available and book distribution units in Tanzania, Uganda, UK, Canada, USA, Germany and South Africa, write to: AMREF Book Distribution Unit, PO Box 30125, Nairobi, Kenya.

AHRTAG
The Appropriate Health and Technologies Action Group publishes many practical newsletters promoting primary health care in a variety of languages. For example, Dialogue on Diarrhoea is available in English, Bangla, Chinese, French, Nepali, Portuguese (Africa), Spanish, Tamil, Turkish, Vietnamese and occasionally in Urdu. The Group has also produced a directory of Free and low cost international newsletters. Due to be available soon is a Directory of primary health care resources for the Middle East which includes publications, educational materials and bibliographies produced in Arabic and/or adapted for use in the Middle East.

For a "Publications List" and further information: AHRTAG, 1 London Bridge Street, London SE1 9SG, United Kingdom.

ARC (Arab Resource Collective)
This group has translated and adapted a wide range of publications into Arabic. They include Contact, Where there is no doctor and many Child-to-Child materials and other resources in disability, early childhood education, rational use of drugs and primary health care.

For more information, write to: Ghanem Bibi, General Coordinator, ARC, PO Box 7380, Nicosia, Cyprus. There is also an office in Beirut.
Teaching aids at low cost (TALC)
TALC is non-profit organization which supplies teaching aids and books to raise standards of health care worldwide. It is professionally advised by the Centre for International Child Health, Institute of Child Health, University of London. Please write to TALC for the “Books, Slides and Accessories List”. Some materials are available in English, French, Spanish, Portuguese and Arabic.

Please write to: TALC, PO Box 49, St Albans, Herts AL1 4AX, United Kingdom.

World Health Organization
Many WHO publications are available in several languages. Write to WHO headquarters in Geneva for Publications Catalogue - New Books 1992, and for WHO Publications - Primary Health Care which lists and reviews WHO primary health care publications. It also indicates the languages in which each publication is available, including some translations into Arabic, Chinese, English, French, Russian and Spanish.

For address, see next column.

Courses

Writing better learning materials: a workshop for authors
This four-week course is designed for authors and would-be authors who want to develop their talents to write better learning materials under supervision and guidance, or those who will be required to conduct courses for would-be authors and writing teams.
Cost: approximately £1,300.

Details: Jonathan Deer, Short Course Assistant, Department of International and Comparative Education, Institute of Education, University of London, 20 Bedford Way, London WC1H OAL, United Kingdom. Fax: 44 71 612 6632.

Visual communication for primary health care
This course aims to help health and development workers to develop their understanding of the principles, use and practical skills involved in the production of various types of visual media. It is aimed at health and community workers from the various health disciplines.

The 3-day course is held every year in a rural setting in Suffolk, UK. This year, it will be held 20-22 May 1994. It costs £300 for individuals and £350 for organizations (includes accommodation and refreshments).

Details from International Health Exchange and Health Images. International Health Exchange is at Africa Centre, 38, King Street, London WC2E 8JT, UK. Tel: 44 71 836 5833.

World Health Organization
WHO has organized training courses on writing about health in many countries of Africa, including francophone countries. Participants have included government, NGO and university personnel wishing to improve their skills in this field. Depending on funding availability, WHO’s Health Learning Materials Project will respond to requests for assistance with future courses. Otherwise, it may be possible to provide contact with those who have already taken part in the training programmes.

For further information, contact Roberta Ritson, Health Learning Materials Project, World Health Organization, 1211 Geneva 27, Switzerland. Fax: 41 22 791 0746. For those wanting contact with networks in the Americas, please contact WHO/PAHO, 525, 23rd Street, NW, Washington DC 20037, USA. Fax: 1 202 223 5971.

USEFUL PUBLICATIONS

(continued on page 18)
CMC - CHURCHES' ACTION FOR HEALTH

Here at CMC - Churches' Action for Health, we are now a complete team again. We look forward to developing our programmes in the context of Unit II, World Council of Churches. Unit II's new name is Churches in Mission: Health, Education, Witness, and its executive director is Ana Langerak.

As you can see, CMC - Churches' Action for Health includes 10 people in all - four executive secretaries, one consultant and five administrative staff. Since the restructuring of the World Council of Churches (WCC), the position of director of CMC has disappeared. However, we have nominated Margareta Sköld as our coordinator.

The CMC staff works as a team towards the goal of health, healing and wholeness for all. The emphasis is on encouraging communities to participate in building primary health care services. In fact, CMC has no programmes of its own in the field. Instead, it concentrates on making its resources available to community groups, member churches and coordinating agencies which are improving the adequacy of health services and operating their ministries and programmes effectively.

CMC has six main areas of activity:
• Communicating concerns about health, healing and wholeness through publications. This is achieved primarily through Contact which has a wide and enthusiastic readership among both urban and rural community workers.
• Encouraging the churches to reflect on their roles in holistic health care and healing; equipping the churches for the ministry of healing. The emphasis here is on the role of the church as a healing community. A special focus is given to AIDS which continues to be a challenge for the Christian community.
• Capacity-building for health and healing, including work in community-based health care and innovative training and curriculum development. “Capacity building” means offering support for training that will equip and strengthen the churches for the ministry of health and healing.
• Enhancing and strengthening the health coordinating agencies as a witness to the unity of the Church.
• Facilitating the development of compassionate, just and sustainable health care systems by promoting appropriate health technology and a fairer distribution of health care resources.
• Promoting sustainable and comprehensive health care systems, for example, through raising awareness of the concept of “essential drugs” and through support for human resource development.
1. Tina Pfenninger is administrative assistant in Unit II’s finance office. She is also part of the CMC, handling our yearly budgets and maintaining contact with our donor agencies.

2. Jenny Roske is the administrative assistant working with Erlinda Senturias on the AIDS programme.

3. Margareta Sköld is the CMC coordinator. She is responsible for human resource development which we call “Capacity-building for primary health care”. The aim of the programme is to train facilitators, or team leaders, for community-based health care activities. The programme is collaborating closely with a number of community training institutions around the world. Margareta also liaises with our constituency in Latin America, Europe and French and Portuguese-speaking Africa.

4. Erlinda Senturias is our programme person responsible for “AIDS and the church as a healing community”. Erlinda’s task is to enable and equip churches to support the challenge of HIV/AIDS in society. She will also continue to liaise with our constituency in Asia, Pacific, North America and the Middle East.

5. Kofi Asante is our programme person responsible for coordinating agencies and sustainability in health care. Kofi’s main task is to help the churches and their health institutions to analyse their own programmes of health and healing. Kofi will also liaise with our constituency in Africa.

6. Marilu Fornerone is administrative assistant working with Eva Ombaka on pharmaceuticals.

7. Eva Ombaka has been the pharmaceutical programme consultant to CMC for two years. She is leading the team in our work of raising awareness of both the essential drugs concept and of rational drug use. The activities of the programme include promotion of human resource development, networking, information sharing and support in the provision of professional advice to church-related health services.

8. María Victoria Carles-Tolrà is administrative assistant to our coordinator, Margareta Sköld and to Kofi Asante.

9. Diana Smith, editor of Contact and responsible for health learning materials. I have been with CMC just over a year. Our plans include an evaluation of Contact, a book of Bible studies relating to health and, longer term, a book on CMC - its early triumph in promoting primary health care and its vision for the challenges of the future.

10. Fernande “Nanda” Chandrasekharan is administrative assistant for health learning materials, and is responsible for the mailing of Contact.
Rubenson, then a member of the Contact editorial team, takes the theme of writing health manuals. If you would like a copy, please write to us at the address below.

**Helping health workers learn**

In this book, David Werner and Bill Bower describe how to teach village health workers. It includes a useful two-page section called “Suggestions for good writing”. It is available from TALC (see address on page 15) in English and Spanish.

**The copy book**

A 110-page book of “copyright-free illustrations for development”. Any of the drawings on food, health and water, shelter and work or of figures, groups and comic strips, can be reproduced without seeking permission.