ETHICS

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ETHICS IN HEALTH CARE

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Issues in medical ethics receive more and more attention, especially in technologically-advanced hospitals and research institutions. However, it is the ethics of resource allocation for health care and the dilemmas surrounding the spread of AIDS which many people consider to be the most urgent challenges today.

One of the many supporters of this view is Kenyan doctor Lucy Muchiri who wrote recently in *Tam Tam*, the magazine of the All Africa Conference of Churches. In "Killing or letting die?", reprinted in *Contact*, Dr Muchiri asserts that the biomedical model of ethics concentrates too heavily on the doctor-patient relationship. She says that, as a result, the more important debate about the distribution of resources is marginalized.

Another voice advocating "Health for All" (HFA) comes from World Health Organization's Dr E Tarimo. In a brief article on page 5, he argues that WHO has been too lenient on health ministers' accounts of their own achievements in primary health care. He believes that there is an urgent need for a "Code of Ethics for Health for All".

The next article in this issue of *Contact* describes a workshop programme which encourages debate on health resource allocation. Developed by Church Women United (CWU) in the US, programme coordinator Sally Timmel says that many Americans now think differently about health spending in their country. Having taken part in a workshop, many middle class participants recognized that government taxation was the best means of paying for health care. The project is an example of a highly successful initiative from the ecumenical movement which is relevant and adaptable to many contexts.

CWU used participatory methods to help groups take ethical decisions on issues which are of great importance to their communities. The methods adopted are similar to those applied by the WCC study on "Participatory Action Research on HIV/AIDS in East Africa", and the approach has also been of considerable influence in the development of the statement of the WCC on "The impact of HIV/AIDS and the churches' response". This statement, reprinted on pages 13-20, together with a comprehensive study on the theological and ethical issues of HIV/AIDS has been developed over the past two years. Together, they are being published as a book (details on page 26) and we hope that the results will help churches respond to the urgent questions surrounding this issue.

In a similar way, churches worldwide could use participatory methods to stimulate community-based reflection on ethical issues. Thoughtful ethical positions developed with the help of this approach would be closely related to the experiences of the people concerned. Issues such as population policies, priority-setting in health care or gender relations might usefully be further explored using this approach.

The WCC has huge potential for addressing ethical issues and for changing current thinking. Unlike academic institutions, this fellowship of over 300 churches can bring together people with wide-ranging experience and from many nations, cultures and church affiliations to discuss any ethical challenge in an environment in which people can work together on common ethical principles. With this global and multicultural approach, the problem of cultural bias and ethical imperialism, which is often associated with ethical theory originating from one particular philosophical tradition, can be avoided.

From the experience of both the WCC and Church Women United in the US, it is clear that by drawing on the experiences of many communities and groups, a more ethical and just approach to health care can be shaped. Ethics has to do with right and wrong decisions and people disagree about the best way to arrive at these decisions. Apart from thoughtful analysis of the questions concerned we need to involve people who are directly concerned and who have to bear the consequences of the decisions taken. It is our hope that churches and communities will become more involved in this process and take part in the ethical decision-making which is so crucial for our world today.

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MAKING CHOICES: KILLING OR LETTING DIE?

Lucy Muchiri, lecturer at the University of Nairobi and a member of Kenya Medical Women's Association, believes that conventional ethical thinking camouflages the significance of deaths caused by an absence of health care. She presents her own ethical viewpoint and suggests a strategy for health for the last years of the decade.

In thinking about ethics, we are familiar with both the bioethical model which focuses on the doctor-patient relationship, and the ethical issues which surround various types of research. Because of our reliance on the bioethical model, we evaluate a death caused by active intervention differently from a death caused by omission.

In cases which are evaluated as killing, a primary causal responsibility for a person's death is assigned to an agent's intervention in a person's life. Whereas, in cases of letting die, primary responsibility for the death is attributed to factors other than any intervention by the agent.

An alternative analysis would allow that the failure to prevent death (or harm) can count as a cause of death (or harm). I argue that the distinction that is made between killing and letting die is not sufficient to support the full moral significance attributed to the distinction. Nor do I believe that making this distinction absolves us from our moral responsibility.

Colonial inheritance
Since independence, the African elite, who inherited the colonialists' exclusive medical services, have cultivated these privileges for themselves. S O Alubo in his book "Debt crisis: Health and health services in Africa" describes how a complete renal dialysis unit was imported and installed at Lusaka Hospital in order to allow a Zambian permanent secretary to return from England to be treated at home. Overseas treatment for African heads of state and top government officials is another dimension of this exclusivity.

In addition, an estimated 40-60% of the health budget in Africa is expended on a few hospitals in and around the urban
centres catering to the elites. A report from Kenya states that a full 40% of the health budget has been spent on Kenyatta National Hospital while rural health centres received a mere 1.4%. The unchanging inherited colonial system has resulted in gross distribution inequities. Although 70% of the population is rural, health services and other amenities are available mostly in the urban areas. Governments have neglected the majority of their citizenry. Consequently, there are wide disparities between urban and rural health indices. For example, infant mortality is often 2-5 times higher in rural areas compared with urban areas, while life expectancy is 3-5 years less.

Declining expenditure
In sub-Saharan Africa, health spending has declined during the 1980s to an average of less than 4% of public expenditure* and less than 2% of Gross National Product (GNP)**. Despite widespread calls for more donor investment in human resources and in poverty reduction programmes, aid flows to the health sector declined from 7% of total development assistance in the early 1980s to 6% in the late 1980s. Donors have not always matched verbal commitment with action. I would like to suggest that passive or wilful neglect raises important ethical issues. Many governments and external agencies are actively participating in programmes that continue to marginalize Africa's poor, and particularly women. These policies condemn people to lives of poverty and suffering.

Challenges
It would be unrealistic for the World Health Organization (WHO) strategy to continue dogmatically with "Health for All" in last few years of this decade. Rather than trying to make health services available to everyone it should ensure "that as a minimum all people in all countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live" (Rifkin). The basis of this strategy is that of primary health care (PHC) is that health involves not only the provision of a service but understanding and improvement of the range of social and economic factors which ultimately influence the status of health.

There is evidence to suggest that, particularly among the poor, the provision of a health service does not dramatically improve health status. For the poor to benefit, additional time, effort and money has to be made available to overcome the social and economic problems of the majority. Selective
intervention programmes not only fail to address equity and inter-sectoral issues, in addition they tend to consolidate power in the hands of health professionals who emphasise the importance of medical technology and facilities while giving insufficient recognition to the importance of attitudes and perceptions.

**Top-down approach**

The prevailing approach to development is one of “top-down”. Projects are designed in a way which controls how women and local communities participate in project activities. The approach also raises important conceptual issues of influencing or controlling social change. For example, interventions based on the top-down model often fail because they have unrealistic and inappropriate goals and objectives. Since they are designed without local input, the projects are not locally identified as “ours” but as “theirs”. Without a sense of local ownership there is likely to be less long-term commitment for consequent change.

The management of health needs to include not only health services but also the management of agriculture, school education, irrigation and markets for produce. Action taken outside the health sector can have health effects much greater than those obtained within it.

**Local technology**

Perhaps the greatest single need in Africa is food. African women produce 70% of the family food. Failure to invest in increasing women's productivity in agriculture means lower food production and increases food insecurity. Women are the only financial support for as many as a third of the world's families. Because women generally have little control of wealth and property, and little access to education, information and technology, their families tend to be and remain poor. In order to avoid the malnutrition and disease associated with vulnerability to famine, hunger and poverty, African women must be considered a vital resource meriting long-term investment.

My conclusion, then, is that health is not merely a disease problem of the poor.
A CODE OF ETHICS FOR HEALTH FOR ALL

"At the World Health Assembly, ministers of health give their reports, everyone claps and no-one takes them to task," says Dr E Tarimo of the World Health Organization. He believes there is a need for a code of ethics to monitor governments' achievements in Health for All by the Year 2000 (HFA). "Otherwise, sitting there clapping, we are accomplices to those who have nothing."

He proposes that there should be a code of ethics which would set rules of conduct among partners in a social contract. He says what is wanted in terms of a social contract is now fairly clear, namely:
1) a health care focus on the underprivileged and a reduction in inequities in health and health care systems;
2) an overall improvement in health with reduced infant and maternal mortality rates, an increased life expectancy, and an improved quality of life;
3) health care that satisfied individuals, families and communities and in which they themselves participate; and
4) development and satisfaction of providers of care.

The HFA contract would impose certain constraints on each country. For example, a country might be expected to show evidence of preferential allocation of resources to underprivileged population groups.

Periodically, each country should monitor its own progress and its compliance with HFA aspirations. Supplementary audits might be carried out by an independent body at regional and global levels. This could be achieved through access to data from official country reports, non-governmental organizations, and commissioned studies.

Such audits may disclose glaring failings by countries in meeting their obligations to implement HFA. Disclosure of such evidence might exert powerful pressure on countries to intensify their efforts.

Dr Tarimo, speaking at a recent meeting at the World Council of Churches, said that the idea of a code of ethics for HFA had initially been proposed three years after the Alma-Ata international conference on primary health care in 1978. At that time, it was felt that such a process would create too much trouble for governments, especially those in eastern Europe. However, the need for a Global Advisory Council or a Global Commission to enhance the supervision of HFA remained, he said. "Today, governments were weaker and under pressure from international economic bodies. They needed partnership if they were to maintain their part in a social contract."

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MAKING ETHICAL CHOICES: WORKSHOPS ON HEALTH FOR ALL

Health care for the poor has been seriously damaged by the introduction of SAPs (Structural adjustment programmes) in Latin America, Asia and Africa, and by health care reforms introduced in the US, United Kingdom and other industrialised countries. During the first half of the 1990s, Church Women United introduced a programme which encouraged the middle class in the US to confront the impact that their silence on health issues was having on the poor. Programme coordinator, Sally Timmel, says that the approach taken is one that could be adapted by churches and groups in any part of the world and to other policy issues.

A survey of the local units of Church Women United within the US concluded that reforming the health care system was one of the top priorities for the organization during the 1992-1996 period. As in many parts of the world, health care reform is one of the major concerns of the American people as a whole. In 1993, opinion polls showed over 65% of respondents felt that the health care system needed fundamental change.

On this issue, the poor and exploited groups are usually fairly clear about which side they are on. Those who have no health care coverage know who would benefit and who would lose if health care reform were enacted. But the middle class is often torn by opposing interests. The key difference between the poor and the middle classes is that the middle class has choices. Yet, when middle class people reflect more deeply on what they believe, they are often surprised that they are more aligned with the poor.

Theory
The theory that informs the educational programme (entitled “Ethical choices: Reforming the health care system”) arose from the challenge of how to stimulate the middle class to think more critically about the issues that affect their lives and those of their neighbours. In developing this method, four main educational theories were adapted.

1. The process of coming to critical consciousness (Freire)
The Latin American educator, Paulo Freire, developed a method of education with peasants in Brazil called "conscientization”. His work in the 1960s was one of the key elements that stimulated the thinking behind liberation
theology and the building of base Christian communities throughout Latin America.

He spelled out six major principles that can be found in his books ("Pedagogy of the oppressed" and "Education for critical consciousness"). The principles include:

a The aim of education is radical transformation.

b Education needs to be relevant and empowering.

c Education must be built on dialogue.

d Problem-posing versus banking-up-knowledge education.

e Transformation happens through a process of reflection and action.

f Education is not neutral. Too often, education has been to "domesticate" people aimed at creating persons who will fit obediently into the roles required of them by the dominant culture. Education should rather enable critical, creative and active participation. The role of the animator (as opposed to teacher) should be non-directive, challenging and supportive of dialogue.

2. The particular place of the middle class in society (Gramsci)

Different from other theories of the role of the middle class in society, Gramsci (an Italian economist in the 1930s) noted that the middle class tends to be an "auxiliary" to the dominant class. He stated that the middle class aspires toward upward mobility and therefore takes on the dominant values of a culture. It is like a magnetic positive (+) pull towards the dominant values. Likewise, there is a negative (-) reaction against the poor or subordinate class.

As the disparity between rich and poor in our society grows, this reaction becomes a repulsion. The hope, however, is that most people have a spirit of generosity. Therein lies the dilemma – the conflict of values. On the one hand, there is the dominant cultural value of making more and more and upping one's standard of living. On the other hand, a good majority have been formed by some faith tradition which teaches to "love your neighbour as yourself".

3. Linking ethical dilemmas and public policy (Yankelovich)

Daniel Yankelovich, in his recent book "Coming to public judgment", states that there is a difference between "public opinion" and "public judgment". He says: "We are plagued by a fatal confusion between the two - as if information were a satisfactory substitute for judgment... There is an astonishing amount of confusion that exists about the relationship of information to judgment in policy making". People are flooded with information and come to quick opinions. They have little opportunity for serious reflection with others on the implications of the information or current opinions in light of the values they claim to support.

4. Methods of values clarification (Simon)

In the 1960s, Sid Simon, Howard Kirshenbaum and others developed a series of educational tools to help people clarify their values. Their approach was to give individuals time to reflect on choices. They set up various methods of getting people to make forced choices (either/or choices, rank ordering, etc) on particular aspects of their life. This method helped many people, particularly when they were in a transition in their lives. The individual choices we
make on ethical and moral issues is an essential step in developing critical awareness - a thinking public. At the same time, the spirit of "individualism" is deeply engrained in our culture. In order to break into the arena of searching for the common good, a method is necessary for people to reflect collectively.

**Workshop educational model**
During the workshop, not only does the individual wrestle with the ethical choices posed in the health care debate, but he or she faces the added component of finding a consensus within a small group. This is an important step: in the small groups, individuals are asked to work through their differences with their peers and to come to a consensus among themselves. Research has shown that people are more likely to change their minds because of what their peers think than because an "expert" has told them something. The consensus from the different small groups is then brought to the whole group to find a consensus there. In a spirit of listening to each other intently and openly (with the facilitator NOT acting as an expert), a collective decision becomes possible. This process of building consensus is therefore a critical step in enabling a movement towards awareness of the common good.

The model for the workshop programme was developed on the basis of the following six steps:

**Step A: Defining the ethical choices**
In June 1992, the Church Women United Washington Office staff held a health care reform consultation with 22 people from the public policy field, congressional offices, ethicists, religious advocates, health providers and consumers. We discussed what were the main ethical choices that were emerging from the health care debate.

In small groups, we developed "rank order" questions on each of these key ethical issues in reforming the health care system. The results from that consultation were 25 questions. A small group took those questions and pared them down to 13 questions. Participants would be asked first to answer the questions individually in silence. Then in groups of five people, they would discuss each question and try to come to consensus. They were also asked to discuss the consequences of their choices.

**Step B: Developing a user-friendly participatory educational tool**
Having refined the questions into an education tool, we knew that we would need ways to help the group focus on the issue and ensure an in-depth discussion on choices. We also needed to show the extent to which the group achieved consensus and to plan follow-up action. The design therefore followed Yankelovich's stages of: identifying the problems within the health care system; trying to understand the problem and then looking at several of the alternatives, and finally moving to the ethical choices.

The three-hour workshop design included:

- introduction to the aims of the workshop, and to each other including addressing two questions about the health care system;
- discussion on the major problems in small groups;
- seven-minute video to summarize the problems;
- one hour for individuals and then groups of five persons to wrestle with
ETHICAL CHOICES: REFORMING THE HEALTH CARE SYSTEM

The following is a shortened version of the participants' questionnaire for discussion. Not all eight questions have been included due to lack of space.

Introduction: The public debate has clearly identified that our nation has a health care crisis and that the system needs fundamental reform. This debate, however, is riddled with many ethical dilemmas and conflicts of values. These cannot be resolved easily by simply receiving more information. We all will need to wrestle with the "trade-offs" and come to some resolution on key issues. The aim of this questionnaire is to spark discussion, not to give "right or wrong" answers.

Instructions: For each of the following questions, rank order the choices presented to you. Place a number 1 beside your first choice, a number 2 by your second choice, and so on.

Individual ranking

1. Ultimately we all pay for our health care through some method. In rank order, what is your preference as to how you will pay for your health care?
   - a. your employer will help purchase insurance for you as an employee (with government assistance for the unemployed and small businesses)
   - b. you, as an individual, will make payment for your private insurance (with government assistance for the poor)
   - c. local, state or federal government will collect taxes, according to one's ability to pay, and set them aside in a health care fund (similar to the Social Security Fund)

2. The cost of medical treatment has more than doubled in recent years. Rank order who you prefer to make the decisions needed to contain health care costs.
   - a. everyone pays based on their health status, employment, age, or other criteria
   - b. everyone pays proportionately according to size of income
   - c. everyone pays a flat premium, with some subsidy for the poor.

3. Which of the following statements come closest to your belief about ideal health care? (Put in rank order)
   - a. Health care is a right of every person and it is the role of government to see that all persons have access to a basic package regardless of ability to pay.
   - b. Health care is a required benefit for those who are employed and government should ensure access to health care for those who are not employed.
   - c. Health care insurance is available for individuals/groups as a commodity to be purchased, with little government regulation.

4. On this issue of reforming the health care system, which do you most believe, next most believe, and least believe. (Put in rank order).
   - a. that this is a complex issue and it is best to leave it up to the insurance companies, doctors, and hospital administrators who know their business
   - b. that it is up to me, as an individual voter, to take responsibility to make my values known to policy-makers.
   - c. that our policy-makers (state legislators/US members of Congress/President) are informed on this issue and can be trusted to make the right decisions for us
   - d. that this issue is of such importance that we cannot leave it only to experts and policy makers. People of faith must get organized to make our voices heard.

For those from religious traditions: rank order the following statements which most closely guides your ethical choices.
   - a. "God helps those who help themselves." (source unknown)
   - b. "Do justice to the afflicted and the needy." (Psalm 82:3)
   - c. "The poor you always have with you ..." (John 12:8)
   - d. "... You shall love your neighbour as yourself ..." (Lev. 19:22)
   - e. "I came that they may have life and have it more abundantly." (John 10:10)
the ethical choices;

- 15-minute video of a panel discussing ethical choices;

- whole group discussion and consensus building on the three basic solutions that were being considered by the US Congress, and

- follow-up action planning in geographic area groups.

The alternatives to the existing health care payment system were defined in terms of the three solutions being discussed by US Congress, namely:

a) The Republican plan of making it easier for individuals to buy health insurance. Employers would be required to offer but not pay for health care coverage for workers.

b) The Clinton plan of moving to managed competition with all employers required to cover their workers by paying 80% of health care premiums.

c) The single payer plan based on the Canadian model. This solution allows for private delivery paid for out of a common public fund. It does not require the involvement of health insurance companies.

Built into the design were three major educational components:

- A programme for linking the ethical choices to the actual public policy choices being debated in Congress (see a, b and c above)

- A video as a back-up for the facilitator

- Detailed instructions for the facilitator on how to come to consensus.

**Step C: Testing the educational design**

From August to October 1992 the workshop design and the ethical choices' educational instrument were tested in seven focus groups. The groups involved varied in size from 16 to 95 and represented women from many different backgrounds. The same person facilitated each workshop. Through this process the workshop design was adapted and changed. The number of questions was reduced from 13 to eight (four of the questions and responses are shown in the box on page 8). The entire workshop design and the final questionnaire were then tested by a "cold" facilitator (someone who had not previously involved in the programme).

Six months after the focus groups had taken place, a short survey was sent to the 317 participants in order to find out what kind of effect the workshop had on their own attitudes, beliefs and behaviour on health care reform. The survey asked: "Since the Church Women United workshop on health care reform..." followed by eight different questions. Respondents could rank their response by checking (ticking) either: "yes indeed", "well sometimes" or "not really". The following are three of the questions with their response ratings.

"I have listened (watched) the news about health care much more carefully than before the workshop." 85% responded "yes indeed" and 12% responded "well sometimes".

"I have thought differently about health care in the United States since participating in the workshop." 66% responded "yes indeed" and 37% responded "well sometimes".

"I have found myself examining other issues, not just health care reform, with a more critical 'eye' on the ethical dilemmas."
51% responded "yes indeed" and 41% responded "well sometimes".

**Step D: Production of materials**

After testing the questionnaire and workshop design, 3,000 copies of the packet of material for facilitators were produced and sent to all Church Women United local and state units.

**Step E: Support and follow-up to local units**

Within less than nine months, 1,000 workshops had been held. Through the Church Women United structure, regional coordinators and state presidents were telephoned every month to encourage local units to use the workshop materials. Volunteers who were most comfortable with this methodology were encouraged to help other groups to run workshops. Getting response forms returned to the national office was a continual problem. Finally, the packet was revised to reflect suggestions from local experiences and changes in the health care debate.

**Step F: Target training**

States holding the largest number of workshops were provided with a two-phase training programme of two days each on how to further expand the programme. After the first phase, teams trained had developed plans to reach out to hundreds of congregations and secular groups with the workshop. After phase 2, teams had plans to do advocacy ranging from distributing door hangers (leaflets) in neighbourhoods, radio spots and talk shows to church bulletin inserts.

**Outcome**

Over 30,000 people participated in at least 1,500 three-hour study workshops on health care reform taking place in almost all of the states of America. In general, they found that they believed that a single payer system (i.e., a system in which payment for health was made via collection of taxation and which drastically reduced the role of the health insurance industry) most matched their fundamental values.

The extent of the consensus achieved in the workshops amazed even the organizers. Sally Timmel, national health care coordinator for Church Women United during the programme period 1992-1994, says: "We developed this workshop model to stimulate discussion at the local level so that people could become more informed about the choices involved in the health care reform debate. We didn't expect that the results would be as clear as they have been." Results in March 1994 showed 21% of participants were in complete agreement with a single payer plan, and 43% were "almost" in agreement with a single payer plan. Thirty-four percent could not reach agreement on any plan and 2% were in agreement with other approaches.

One of the conclusions drawn from this study is stated clearly by Marjorie Troeh from Independence, Missouri, who is chair of Church Women's United Health Care Project: "Legislators are again quite out of touch with their constituents. We keep wondering why our Senators and Representatives keep protecting the insurance companies when it is clear that fundamental reform is more cost effective and more fair to all of us, including small businesses. Perhaps we need to overhaul the way our members of Congress finance their campaigns before we can get a fair deal for consumers."

Church Women United is a movement of over half a million women, supported by 28 major denominations and found in 1,600 communities. The booklet "Ethical choices: Developing critical consciousness with the middle class", which describes the programme and provides an excellent guide for facilitators, is available from Church Women United, Washington Office, Box 46, 110 Maryland Avenue NE, Washington, DC 20022, USA. Tel: 202 544 8747, Fax: 202 543 1297. Readers requesting a copy are encouraged to send a donation of US$5 to cover handling and postage.

**Cartoon from "Health for the millions". July-August 1966**
THE IMPACT OF HIV/AIDS AND THE CHURCHES' RESPONSE

Introduction
1. Already in 1987 the Executive Committee of the World Council of Churches called the churches to address the urgent challenges posed by the spread of HIV/AIDS throughout the world. Appealing for an immediate and effective response in the areas of pastoral care, education for prevention, and social ministry, the Executive Committee noted that "The AIDS crisis challenges us profoundly to be the Church in deed and in truth: to be the Church as a healing community".

2. The spread of HIV infection and AIDS has continued at a relentless and frightening pace. The cumulative number of persons infected by the virus — women, men and children on all continents — is about 28 million by mid 1996 and it is estimated that 7000 new infections occur each day, including 1,400 babies born infected. Individuals, communities, countries and churches are highly affected by this pandemic.

3. Given the tragic impact of AIDS on persons, communities and societies all over the world; given its direct impact upon many Christians and churches; recognizing the need for careful reflection on a number of inter-related issues bearing on the churches' understanding of and response to AIDS; and believing it imperative that the churches address together this issue of global concern: the WCC Central Committee at its meeting in Johannesburg in 1994 commissioned a comprehensive study to be done by a Consultative Group on AIDS.

4. In its reflection the Group has focused on theological and ethical issues raised by the HIV/AIDS pandemic, on questions of human rights in relation to AIDS, and on pastoral care and counselling within the church as a healing community. As it draws its findings into a final report, the Consultative Group wishes to make available the present statement indicating some of the main concerns and implications of its work. We request that this Statement be adopted by the Central Committee, that the Report from the Study be welcomed by Central Committee, and that both be shared with the churches for their reflection and appropriate action.

"The AIDS crisis challenges us profoundly to be the Church as a healing community".

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The impact of HIV/AIDS
5. HIV is a virus and, medically speaking, AIDS is the consequence of viral infection; but the issues raised by the pandemic are far from purely medical or clinical. They touch on cultural norms and practices, socioeconomic conditions, issues of gender, economic development, human responsibility, sexuality and morality.

6. The HIV/AIDS pandemic is not just a matter of statistics. Its effects are impoverishing people, breaking their hearts, causing violations of their human rights, and wreaking havoc upon their bodies and spirits. Many who suffer do so in rejection and isolation. In a striking way HIV/AIDS has become a “spotlight” revealing many iniquitous conditions in our personal and community lives, revealing our inhumanity to one another, our broken relationships and unjust structures. It reveals the tragic consequences of personal actions which directly harm others, or of negligence which opens people to additional risk. The pandemic exposes any silence and indifference of the churches, challenging them to be better informed, more active, and more faithful witnesses to the gospel of reconciliation in their own lives and in their communities.

7. Almost every day there are new discoveries, new information, new hopes and accounts of how communities are affected by, and are dealing with, the challenge of HIV/AIDS. The reality of the pandemic seems increasingly complex, confounding the generalizations, stereotypes, and partial or false information which all too often dominate discussion of HIV/AIDS. We know, for example, that HIV/AIDS is not confined to particular groups within society, although in any given country particular groups may be more affected.

8. AIDS was first recognized in industrialized countries where, indeed, the vast majority of the funding for research, prevention and care has been concentrated. Now in its second decade, the pandemic is expanding fastest in countries with poor economies, where all the economic, political and social mechanisms that keep countries poor interact to produce a context in which AIDS thrives. Thus AIDS has become a development issue. The HIV/AIDS pandemic adds a heavy burden on health care systems. The cost of treatment is often completely disproportionate to the incomes of the affected families. In Thailand, for example, the cost of treatment for one person with AIDS absorbs up to 50% of an average annual household income.

9. AIDS impacts societies in many ways, challenging some traditional notions of the social order. In some places, the pandemic is raising questions about the meaning and role of the family; elsewhere it has focused attention on those using drugs, and their increased risk; still elsewhere it has raised questions about human sexuality and relationships. In the course of the pandemic the role of gay communities in compassionate care and effective prevention has been recognized. This perspective has challenged the churches to rethink their relation to gay persons.

10. The pandemic is also having profound consequences for family and community life. In addition to causing the illness and death of members of the most productive age groups, it severely restricts the opportunities for those - for the most part, women and girls - who care for persons suffering from the disease. In some societies whole communities are weakened by the pain and disruption HIV/AIDS brings to families and other basic social units. Grandparents find themselves caring for their sick children or orphaned grandchildren, and children and young people are forced to become the bread-winners for others.

The beginnings of a response
11. The challenges posed by AIDS require both a global and a local response. How can
we develop the will, knowledge, attitudes, values and skills required to prevent the spread of AIDS without the concerted efforts of governments, local communities, non-governmental organizations, research institutions, churches and other faith communities?

12. A full range of inter-related approaches is called for. Effective methods of prevention include sexual abstinence, mutual fidelity, condom use and safe practises in relation to blood and needles. Education, including education for responsible sexual practices, has been shown to be effective in helping to stop the spread of the infection. Other measures which inhibit its spread, or help deal with the suffering which it causes, include advocacy for justice and human rights, the empowerment of women, the training of counsellors, and the creation of "safe spaces" where persons can share their stories and testimonies. In addition all societies - whether "developed" or developing - need to address practices such as drug abuse and commercial sex activity, including the increasing incidence of child prostitution, as well as the root causes of destructive social conditions such as poverty, all of which favour the spread of HIV/AIDS.

13. Strategies for prevention and care may fail if those affected by HIV/AIDS play no part in designing or carrying them out. In the course of the current study, the Consultative Group noted the role played by the WCC in promoting participatory action research on "AIDS and the Community as a Source of Care and Healing" in three African countries. This process enabled village people to analyze the issues and problems raised by AIDS, and to develop actions which foster prevention and care.

14. From the beginning of the pandemic some Christians, churches and church-related institutions have been active in education and prevention programmes, and in caring for people living with HIV/AIDS. The Consultative Group was privileged to have worked with several of these during the study. The Group observes, however, that by and large the response of the churches has been inadequate and has, in some cases, even made the problem worse. As the WCC Executive Committee noted in 1987, "...through their silence, many churches share responsibility for the fear that has swept our world more quickly than the virus itself". Sometimes churches have "arm", ered the spread of accurate information, or created barriers to open discussion and understanding. Further, churches may reinforce racist attitudes if they neglect issues of HIV/AIDS because it occurs predominantly among certain ethnic or racial groups. These groups may be unjustly stigmatized as the most likely carriers of the infection.

15. The situation continues to call for "metanoia in faith", and a fresh resolve by the churches to address the situation directly. This must be done in a spirit of humility, knowing that we do not fully understand the scope and significance of the HIV/AIDS pandemic. It requires openness to new information, long discussion of sensitive issues, and readiness to learn from the experience of others, as we seek a more adequate response to the challenges posed by HIV/AIDS today.

Theological dimensions
16. The HIV/AIDS pandemic raises difficult theological issues in the areas of creation, human nature, the nature of sin and death, the Christian hope for eternal life, and the role of the church as Body of Christ. Furthermore the reality of AIDS raises issues, such as human sexuality, vulnerability and mortality, which stir and challenge us in a deeply personal way. Christians and the churches struggle with these theological and human issues and they differ, sometimes sharply, in their response to some of the challenges posed by HIV/AIDS. But it is imperative that they learn to face the issues together rather than separately, and that they work towards a common understanding of the fundamental questions - theological, anthropological and ecclesiastical - which are involved.

17. The church's response to the challenge of HIV/AIDS comes from its deepest theological convictions about the nature of
creation, the unshakeable fidelity of God's love, the nature of the body of Christ and the reality of Christian hope.

18. The creation in all its dimensions is held within the sphere of God's pervasive love, a love characterized by relationship, expressed in the vision of the Trinity as a model of intimate interaction, of mutual respect and sharing without domination. This inclusive love characteristic of the Trinity guides our understanding of the Christian claim that men and women are made in the "image of God". Because humanity is created in God's image, all human beings are beloved by God and all are held within the scope of God's concern and faithful care.

19. Within the fullness of creation we affirm the potential for goodness of the human body and of human sexuality. We do not completely comprehend the meaning of human sexuality. As with other aspects of creation, sexuality also can be misused when people do not recognize their personal responsibility; but it is to be affirmed strongly as one of God's good gifts, finding expression in many dimensions of human existence. The churches have recognized marriage as the primary place for the expression of sexuality in its various dimensions.

20. We live from God's promise that nothing can separate us from the love of God in Christ: no disasters, no illness or disease, nothing done by us and nothing done to us, not even death itself, can break God's solidarity with us and with all creation (Rom. 8:38-39). And yet the creation "groans in travail" (Rom. 8:22); we see in the world much suffering, injustice and waste. Some of this can be understood as the consequence, for ourselves and others, of the exercise of the freedom given by God to God's creatures; some of it, we sense, may be part of a larger pattern of which we now glimpse only a part; some of it defies understanding, leaving us to cry: "I believe; help my unbelief!" (Mark 9:24).

21. Finally we live by hope, holding our questions and doubts within the larger frame of God's love and final purpose for our lives and for all creation: life abundant, where justice reigns, where each is free to explore all the gifts God has given them. More particularly, we live by hope in Christ: Christ gone before us into glory is the basis for our hope. We share in the sufferings of Christ — Christ who is Immanuel, "God with us" — "that we may also be glorified with him" (Rom 8:17). And in our weakness we are sustained by the "Spirit who lives within us", interceding when we know not how to pray, and finally granting anew "life to our mortal bodies" (cf. Rom. 8:11, 26; cf. Eph. 3:16).

22. Strengthened by this hope, we wrestle with the profound questions put to us by suffering. We affirm that suffering does not come from God. We affirm that God is with us even in the midst of sickness and suffering, working for healing and salvation even in "the valley of the shadow of death" (Ps. 23:4). And we affirm that it is through bearing the suffering of the world on the cross that God, in Christ, has redeemed all of creation. Our hope is rooted, ultimately, in our experience of God's saving acts in Jesus Christ, in Christ's life, death and resurrection from the dead.

23. Remembering the suffering servant (Is. 42:1-9, 49:1-7, 50:4-11, 52:13-53:12), we are called to share the sufferings of persons living with HIV/AIDS, opening ourselves, in this encounter, to our own vulnerability and mortality. This is to walk with Christ, and, as Christ has gone before us through death to glory, we are called to receive "the sure and certain hope of the resurrection." This is God's promise that God's promise, for us and for all creation, is not destroyed by death: we are held within the love of God, claimed by Christ as his own, and sustained by the Spirit; and God will not forsake us nor leave us to oblivion.

24. We affirm that the church as the body of Christ is to be the place where God's healing love is experienced and shown forth. As the body of Christ the church is bound to enter into the suffering of others, to stand with them against all rejection and despair. Because it is the body of Christ — who died for all and who enters into the suffering of all humanity — the church cannot exclude anyone who needs Christ. As the church enters into solidarity with those affected by HIV/AIDS, our hope in God's promise comes alive and becomes visible to the world.

25. We celebrate the commitment of many Christians and churches to show Christ's love to those affected by HIV/AIDS. We confess that Christians and churches have also helped to stigmatize and discriminate against persons affected by HIV/AIDS, thus adding to their suffering. We recall with gratitude the advice of St. Basil the Great to those in leadership positions within the church, emphasizing their responsibility to create an environment — an ethos, a "disposition" — where the cultivation of love and goodness can prevail within the community.
and issue in the "good moral action" which is love.

26. We affirm that God calls us to live in right relationship with other human beings and with all of creation. As a reflection of God's embracing love, this relationship should be marked not just by mutual respect but by active concern for the other. Actions taken deliberately which harm oneself, others or the creation are sinful; and indeed we are challenged by the persistence of sin, which is the distortion of this right relationship with God, other persons, or the natural order. Yet sin does not have the last word; as we are "renewed by the Holy Spirit" (cf. Titus 3:5) and continue to grow in our communion with God, our lives will show forth more of God's love and care.

27. The World Council of Churches Executive Committee emphasized in a 1987 statement the need "...to affirm that God deals with us in love and mercy and that we are therefore freed from simplistic moralizing about those who are attacked by the virus." Furthermore we note how easily a moralistic approach can distort life within the Christian community, hampering the sharing of information and open discussion which are so important in facing the reality of HIV/AIDS, and in inhibiting its spread.

28. In the light of these reflections, and on the basis of our experience in this study, we wish to avoid any implication that HIV/AIDS, or indeed any disease or misfortune, is a direct "punishment" from God. We affirm that the response of Christians and the churches to those affected by HIV/AIDS should be one of love and solidarity, expressed both in care and support for those touched directly by the disease, and in efforts to prevent its spread.

**Ethical dimensions**

29. In responding to the challenge of HIV/AIDS, Christians are motivated by urgent imperatives, passionately felt: to show Christ's love for the neighbour, to save lives, to work for reconciliation, to see that justice is done. Making ethical decisions, however, requires a process of discernment which includes gathering the latest information, wrestling with deeply sensitive issues, and weighing differing, sometimes conflicting views and interests. This process needs to be undergirded by Bible study, prayer and theological reflection.

30. Christians make ethical choices following principles which derive from their understanding of the biblical witness and their faith convictions. These may be stated and developed differently in various traditions, but are likely to include the following points:

- because all human beings are created and beloved by God, Christians are called to treat every person as of infinite value;
- because Christ died to reconcile all to God, Christians are called to work for true reconciliation - which includes justice - among those alienated from one another;
- because we are "members one of
another", being built up by the Spirit into one body, Christians are called to responsible life within community.

31. Such principles -- the infinite value of each person, the gospel of reconciliation, the call to responsible life within community -- have to be applied to such questions as: How do churches respond to their members living with HIV/AIDS? How can churches promote responsible behaviour without being judgmental and moralistic? What public health measures to reduce HIV/AIDS transmission should churches advocate? How can resources for care and research be fairly shared? This means in each case exploring all available options, weighing the benefits (and difficulties) of each, and finally asking, "which of the possible courses of action best expresses Christ's love for all those involved?"

32. Such a process of "discernment" is often difficult: the options may not be fully clear; none of the options may be wholly satisfactory; the implications of some biblical or theological principles for specific problems today may not be clear. It is all the more important, then, that Christians and churches reflect and work on these ethical issues together. The challenge of HIV/AIDS demands nothing less than an ecumenical response.

33. Churches are expected to give both spiritual direction and moral guidance, and to play a responsible role in the discussion of these issues in the wider society, as well as in discussions of biomedical ethics. Witnessing to their own faith convictions, they enrich the wider debate and make common cause, where possible, with persons of goodwill who appeal to more general sets of ethical principles such as respect for persons, beneficence and non-maleficence, and justice.

34. The churches have crucial contributions to make to this wider debate. For example first, in accordance with their commitment to truth they can emphasize that the process of ethical discernment leaves no room for judgments based on superficial generalizations or stereotypes, on fear, of on incomplete or false information. The churches can do much to promote, both in their own lives and in the wider society, a climate of sensitive, factual and open exploration of the ethical issues posed by the pandemic.

35. Second, in accordance with their emphasis upon personal and communal responsibility the churches can promote conditions -- personal, cultural, and socioeconomic -- which support persons in making responsible choices. This requires a degree of personal freedom which is not always available: for example, women, even within marriage, may not have the power to say "no" or to insist on the practice of such effective preventive measures such as abstinence, mutual fidelity and condom use.

Human rights in relation to HIV/AIDS

36. The HIV/AIDS pandemic raises important issues relating to human rights. People living with HIV/AIDS generally encounter fear, rejection and discrimination, and often are denied basic rights (such as liberty, autonomy, security, and freedom of movement) enjoyed by the rest of the population. Because such reactions contradict the values of the gospel, the churches are called to formulate and advocate a clear policy of non-discrimination against persons living with HIV/AIDS.

37. One of the tasks of the WCC over the last three decades has been to be actively involved in human rights standard setting, and promotion and protection. The last decade has witnessed a significant trend in the development of international norms and standards in relation to people that are discriminated on grounds of race, gender, ethnicity and religion. There are other kinds of discrimination as well. Some of them arise because of lack of awareness and fear. People living with HIV/AIDS fall in this category. They are often denied their fundamental right to security, freedom of association, movement and adequate health care.

38. The issue of human rights also has important implications for the spread of HIV/AIDS. We note the alarming rise in sex tourism. Some men in societies in both the North and the South abuse the young and poor children for prostitution or in an effort to try to escape infection. This is also an issue of violence against children. We further note that men and women who are denied their fundamental human rights, whether on the grounds of social status, sexual orientation, or addiction to drugs, are thereby made especially vulnerable to the risk of HIV infection. Thus broadly-based strategies which advocate human rights are required to prevent the spread of HIV.

Pastoral care and counselling within the Church as healing community

39. By their very nature as communities of faith in Christ, churches are called to be healing communities. This call becomes the
more insistent as the AIDS pandemic continues to grow. Within the churches we are increasingly confronted with persons affected by HIV/AIDS, seeking support and solidarity and asking: are you willing to be my brother and sister within the one body of Christ? In this encounter our very credibility is at stake.

40. Many churches, indeed, have found that their own lives have been enhanced by the witness of persons living with HIV/AIDS. These have reminded us that it is possible to affirm life even when faced with severe, incurable illness and serious physical limitation, that sickness and death are not the standard by which life is measured, that it is the quality of life—whatever its length—that is most important. Such a witness invites the churches to respond with love and faithful caring.

41. Despite the extent and complexity of the problems, the churches can make an effective healing witness towards those affected by HIV/AIDS. The experience of love, acceptance and support within a community where God’s love is made manifest can be a powerful healing force. Healing is fostered where churches relate to daily life, and where people feel safe to share their stories and testimonies. Through sensitive worship, churches help persons enter the healing presence of God. The churches exercise a vital ministry through encouraging discussion and analysis of information, helping to identify problems, and supporting participation towards constructive change in the community.

42. Many trained and gifted members of the community, as well as some pastors, are already providing valuable pastoral care. Such care includes counselling as a process for empowerment of persons affected by HIV/AIDS, in order to help them deal with their situation and to prevent or reduce HIV transmission.

Conclusion: What the churches can do

43. This study has shown us the delicate, interwoven relationships of human beings and their connectedness to all of life. It has proved neither desirable nor possible to do a “one-dimensional” study of AIDS, describing only its dramatic spread and devastating impact on those who are directly affected. Rather, the AIDS pandemic requires the analysis of a cluster of inter-related factors. These include the theological and ethical perspectives that inform, or arise from, our understanding of AIDS; the effects of poverty on individuals and communities; issues of justice and human rights; the understanding of human relationships; and the understanding of human sexuality. Of these the factor of sexuality has received the least attention within the ecumenical community. We recognize that further study in this area is essential for a deeper understanding of the challenges posed by HIV/AIDS.

44. Our exploration of these themes has brought us face to face with issues, understandings, and attitudes of major consequence to the churches and their role in responding to the pandemic.

Are you willing to be my brother and sister within the one body of Christ? In this encounter our very credibility is at stake.
Through their witness to the gospel of reconciliation, the value of each person, and the importance of responsible life in community, the churches have a distinctive and crucial role to play in facing the challenges raised by HIV/AIDS. But their witness must be visible and active. Therefore we feel it essential to highlight the following concerns as points for common reflection and action by the churches:

A. The life of the churches: responses to the challenge of HIV/AIDS
1. We ask the churches to provide a climate of love, acceptance and support for those who are vulnerable to, or affected by, HIV/AIDS.
2. We ask the churches to reflect together on the theological basis for their response to the challenges posed by HIV/AIDS.
3. We ask the churches to reflect together on the ethical issues raised by the pandemic, interpret them in their local context and to offer guidance to those confronted by difficult choices.
4. We ask the churches to participate in the discussion in society at large of ethical issues posed by HIV/AIDS, and to support their own members who, as health care professionals, face difficult ethical choices in the areas of prevention and care.

B. The witness of the churches: in relation to immediate effects and causes of HIV/AIDS
1. We ask the churches to work for better care for persons affected by HIV/AIDS.
2. We ask the churches to give particular attention to the conditions of infants and children affected by the HIV/AIDS pandemic and seek ways to build a supportive environment.
3. We ask the churches to help safeguard the rights of persons affected by HIV/AIDS and to study, develop, promote the human rights of people living with HIV/AIDS through mechanisms at national and international levels.
4. We ask the churches to promote the sharing of accurate information about HIV/AIDS, to promote a climate of open discussion, and to work against the spread of misinformation and fear.
5. We ask the churches to advocate increased spending by governments and medical facilities to find solutions to the problems – both medical and social – raised by the pandemic.

C. The witness of the churches: in relation to long-term causes and factors encouraging the spread of HIV/AIDS
1. We ask the churches to recognize the linkage between AIDS and poverty, and to advocate measures to promote just and sustainable development.
2. We urge that special attention be focused on situations that increase the vulnerability to AIDS such as migrant labour, mass refugee movements and commercial sex activity.
3. In particular, we ask the churches to work with women as they seek to attain the full measure of their dignity and express the full range of their gifts.
4. We ask the churches to educate and involve youth and men in order to prevent the spread of HIV/AIDS.
5. We ask the churches to seek to understand more fully the gift of human sexuality in the contexts of personal responsibility, relationships, family and Christian faith.
6. We ask the churches to address the pandemic of drug use and the role this plays in the spread of HIV/AIDS and to develop locally relevant responses in terms of care, de-addiction, rehabilitation and prevention.

This statement, Document No 6.2B was accepted by WCC Central Committee, Geneva, Switzerland, 12-20 September 1996. It is reproduced in full with notes in the WCC study document entitled "The impact of HIV/AIDS and the churches' response", details on page 26.

We ask the churches to recognize the linkage between AIDS and poverty.

Forty-five church communicators from Asia met from 22-26 January 1996 in Chiang Mai, Thailand, for a workshop on communicating HIV/AIDS concerns.
This list consists of useful contacts and publications on the subject of ethics in health care. Unless otherwise stated, publications are only available in English. Addresses are provided in the Address box in the margin.

**USEFUL CONTACTS**

**Address box**

CIOMS  
C/o World Health Organization  
1211 Geneva 27  
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HAI-Europe  
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1053 NJ Amsterdam  
The Netherlands  
Fax: 31 20 685 50 02

IBFAN/GIFA  
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Switzerland  
Fax: 41 22 798 44 33

**USEFUL PUBLICATIONS**

- **WCC Publications**  
  World Council of Churches  
  PO Box 2100  
  1211 Geneva 2  
  Switzerland  
  Fax: 41 22 791 0361

- **Catholic Health Association of Canada**  
  1247 Kilborn Place  
  Ottawa, ON K1H 6K9  
  Canada  
  Fax: 613 731 7797

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**The church's mission to heal - Reflections on basic theology and ethical principles** is based on a presentation given at an international workshop on sustainable health care by Peter Henriot, a Roman Catholic priest based in Zambia. He describes the four ethical principles which he believes should guide social policy: 1) that providing health care is a form of service in and for the community before it is a form of economic activity, 2) that treatment should be for the whole person as part of a web of relationships, 3) that it is understood that health care is ineffective in poor societies unless it addresses the deeper, poverty-related forces that are the root causes of many of the serious diseases on the increase, such as TB, and 4) that health care is liberative not dependency-building. The six-page article was published in *Sedos Bulletin*, Vol 28 No 2, 15 February 1996. If you would like a copy of this six-page article, please write to *Contact*, World Council of Churches.

**Life and death: Moral implications of biotechnology** draws on discussions between biologists, theologians and ethicists and researchers, medical doctors and scientists from the Nordic Lutheran churches on reproductive technology, prenatal diagnosis, genetic engineering and euthanasia. As well as providing an ethical approach, it offers ethical reflections in a concrete and down-to earth form by providing responses to eight fictitious letters written by thoughtful Christians on issues such as childlessness, ageing, death and dying, the use of scarce medical resources, genetic testing in the workplace, and human gene research. The book is published for the Lutheran World Federation by WCC Publications. Price: Swiss francs 15, US$11.90, £7.95. ISBN 2 8255 1170 1.

**Health care ethics guide** is published by the Catholic Health Association of Canada and is proposed for the use of all health care institutions and individuals who share an orientation towards morality based on human reason, enlivened by Christian faith and taught by the Roman Catholic Church. Copies cost $15 (Canadian).
ONE AFRICA - ONE SOLUTION?

This year's Pharmaceutical Advisory Group at World Council of Churches looked at whether there was a single solution to Africa's problems. The meeting was entitled "One Africa— one solution: responses to macroeconomic change in Africa".

Speakers at the Pharmaceutical Advisory Group (PAG) meeting held in October 1996 in Geneva were all in agreement that the single worst influence on health in Africa was the impact of Structural Adjustment Programmes (SAPs).

In Nigeria, the combination of government mismanagement coupled with retrenchment following the introduction of SAPs had virtually destroyed the country's primary health care facilities. Dr Mrs Rakiya Booth who heads the primary health programme of the Christian Health Association of Nigeria (CHAN) said: "With SAPs, activity started to decline and to decline rapidly. Coverage is reversing, and the orientation of the health services is becoming more and more curative." She estimated that only 54% of the Nigerian population now had access to modern health care services.

Civil war
Mrs Marion Morgan, director of the Christian Health Association of Sierra Leone (CHASL), felt that SAPs were partly to blame for the civil war which began in 1991 in her country. She said that since SAPs were agreed in 1986, implementation might have led to improvements in macro-economic variables but had meant loss of jobs and increases in food prices at the micro-economic level. She said that during the adjustment period 29,000 people had been made poor. Two-thirds of the population were living in poverty, and 25% of children under five years were malnourished.

Former minister of health in Lesotho, Dr Deborah Raditapole, painted a similar picture of the experience of SAPs is her country. Macro-economic variables such as fiscal deficit and the debt servicing ratio had improved, but malnutrition in the under fives had increased dramatically, and overall, the policies had left people poorer.

Privatisation
Dr Raditapole was also concerned about the effects of the privatisation policies favoured by the World Bank and the International Monetary Fund (IMF). Throughout Africa, as elsewhere, privatisation was leading to fewer health services available to the poor and greater emphasis on curative care. Many hospitals, including many mission hospitals, were keenly experiencing the conflict demands of making services accessible, especially to the poor, and the need to make money. In Lesotho, Dr Raditapole, was worried about the effect of privatisation on the country's generic drugs manufacturing unit. Although the World Bank claims to be in favour of essential drugs programmes, she said that the Lesotho government was being forced into privatising the local generic drug operation. "How is this going to effect price and availability?" she asked. "When the primary motive for the operation becomes making profits, I can see that this change may have a negative effect on the availability of essential drugs in Lesotho."

Mr Philip Akazinge from the Christian Health Association of Ghana (CHAG) said some positive developments had resulted from decentralisation and the introduction of autonomous health districts. For example, he felt that there was now more communication between different levels of health services in

With SAPs, activity (in primary health care) started to decline and to decline rapidly.
Ghana and more doctors had acquired leadership and management skills. On the other hand, he felt that decentralization was allowing governments to "offload onto the private sector". He said that many of his colleagues were concerned that CHAG would be given the management of district hospitals in areas which were very difficult to reach. The worry was that the necessary resources required for effective management of these hospitals would not be available.

**Single solution**

Although no-one felt that there could be one solution to Africa's problems, Mrs Morgan suggested that there might be a process that could be shared. She re-echoed a statement made at the PAG gathering in 1995 by Professor Carl Taylor who felt that "in part... a universal process can be used to find appropriate solutions for every situation, but there can be no universal solution."

A forceful suggestion on process came from Dr Raditapole who was convinced that involving people in the issues that affected them was a key to success. She described how she had brought Lesotho's doctors together to discuss how to prevent a "brain drain" to South Africa. She said that it had worked well. "When you call in outside experts they are expensive and they often do not understand the local situation. Our own doctors know the capacity and the constraints."

Dr Raditapole also described a "Memorandum of Agreement" that she had developed while health minister. It aimed to coordinate the efforts of government and private health services in Lesotho. She said that it established ground rules so that government and private sectors set similar standards and paid equivalent salary rates to doctors. Dr Mrs Booth felt more coordination and collaboration was what was needed in Nigeria. She hoped that existing structures could be used in this initiative instead of creating new ones.

Dr Tarimo, a Tanzanian working at the World Health Organization, described what he felt to be a promising develop-
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Alcoholism and Drug Addiction - What is the Christian Response? - J. Granadason, BLESS, Priscillas Peter and Darlena David Titus, HAIN.
Reconstructing Peace: Together we can overcome Violence! - Salpy Eskidjian, Anthony Zwi, Elizabeth Sele Mulbah, Natasa Jovicic, Eduardo Campana.
Migration and Health: Caring for those in our Midst - Helene Moussa and Patrick Taran, Dr Paola Bollin and Dr Harald Siem, White Rakuba, Gabriela Rodriguez, Asian Migrant Centre, Rabia Chamoun and Aline Papazian, Mukami McCorm.
Health in the North: Learning from the South - Christopher Benn, Daisy Morris, Kofi Yamgnane, David Cowling, Eva Ombaka
Healing Traditions: Finding Answers in Gospel and Cultures - Guillermo Cook and Diana Smith, Eugenio Poma, Tara Tautari, Darlena David, Hakan Hellberg.
Healing Community: Caring is part of the Cure! - David Hilton, Erlinda Senturias, Ricus Duilaert, Paul-Hermann Zellfelder-Held, Pierre Strasse, Michael Lapsley, Marion Morgan.
USEFUL PUBLICATIONS

The impact of HIV/AIDS and the churches' response
This new study document grows out of two years of intensive international consultation. Its comprehensive, informed and insightful analysis calls the churches to both reflection and action. Successive chapters focus on the scientific facts and social, economic and cultural context; theological perspectives; ethical and medical-ethical issues; human rights and responsibilities, and pastoral care. Available from WCC at a price of Swiss francs 15, US$11.50 and £7.95 plus 20% for postage. ISBN 2 8254 1213 9.

The results of WCC's work in the regions and the subsequent meeting on Women and Health and the Challenge of HIV/AIDS in Vellore, India, in September 1995 were brought together as a special WCC Risk Book Series in June 1996. The book is entitled Love in a Time of AIDS: Women, Health and the Challenge of HIV by Gillian Paterson, former education secretary of the Churches’ Commission on Mission, Council of Churches for Britain and Ireland. With young women now accounting for two-thirds of the cases of new HIV infection among people between 15 and 24, it is becoming ever clearer that where women’s social, economic, and cultural status is low, they are more likely to become infected with HIV and pass the virus on to others. Vividly recounting the stories of women in churches and related groups in many countries, this book shows how the AIDS crisis makes improving the status of women not only a matter of theology and ethics but of health and survival. Price: Swiss francs 13.50, US$11.50, £7.25.

The French and Spanish editions of the revised “Learning About AIDS” were published in Geneva in November and December 1996 respectively. They are available free of charge to readers in developing countries.

Impunity: An ethical perspective
An increasingly critical issue on the international human rights agenda (and one which Contact hopes to give attention to in the near future) is impunity – the situation in which amnesty, pardon or deliberate inaction means that those accused of gross and systematic human rights violations or crimes against humanity are not charged, tried or published. Impunity: An ethical perspective, edited by former WCC staff member Charles Harper, has been developed on the basis of the recent discussions of impunity in international law which have exposed profound moral and ethical issues. For the churches, these questions are linked with theological convictions, pastoral concerns and often the experience of their own costly engagement in defence of human rights during periods of oppression and torture. The case studies in this book offer eloquent testimonies and penetrating insights into the issue. Available from World Council of Churches, this paperback is available at a price of Swiss francs 15, US$11.90 or £7.95 plus 20% for postage. Payment by Visa or Master Card is accepted. ISBN 2 8254 1203 1.

Medicine betrayed
This book, published several years ago, gives a detailed account of doctors' participation in abuses of human rights. The contents are based on the findings of a two-year study by a British Medical Association (BMA) working party, and cover topics ranging from illegal and outrageous torture through judicial and outrageous punishments, such as amputations, to the difficult and ethically perplexing hunger strikes and provision of evidence in capital punishment trials.

Unfortunately, the evidence that doctors examine and resuscitate victims of torture and issue false death certificates is irrefutable. While acknowledging that doctors may come under strong pressure to compromise their ethics, the report points out that some doctors collaborate willingly. The book provides extremely useful guidance for doctors (and others) in monitoring human rights. Its recommendations are unambiguous: "if the possibility of abuses of human rights comes to the attention of a medical practitioner, they have an ethical duty to take immediate action".

The international medical community is urged to "encourage effective opposition to torture in countries where the pressure for medical participation is considerable." The working party recommends that doctors should not participate in corporal punishment, either by certifying fitness or by performing amputations, and that professional associations and individual doctors should make clear their opposition to such punishments. Implementing its recom-
mendations is the responsibility of the international medical and human rights community. After publication of "Medicine Betrayed", doctors cannot remain silent. Review by Adriana van Es, President, Johannes Wier Foundation for Health and Human Rights, Netherlands (Fax: 31 33 726749). The book is published by Zed Books, 7 Cynthia Street, London N1 9JF, United Kingdom. Fax: 44 171 833 3960. Paperback price is £12.95, US$19.95 (plus £2/US$3.50 postage and handling) ISBN 1 85649 104 8 2

March 1995 on Financing Health Care you are sure to enjoy this new book by David Werner and David Sanders. The content addresses: the rise and fall of primary health care; oral rehydration therapy; What really determines the health of a population? Solutions that empower the poor, and an appendix-on the roles of Unicef and WHO. One reviewer describes the book like this: "Cuts like a precision laser beam through the self-serving myths and misguided policies propagated by official aid and by profit-seeking corporations from the food and pharmaceutical industries."


LETTERS

Urban wastes

National development entails finding solutions to problems of health, human settlement, educational and cultural upliftment. In the process of development to achieve these objectives, we have not always been sufficiently mindful of the need to strike a healthy balance between our development objectives and a wholesome environment. One phenomena associated with rapid urbanization is the rising volume of solid wastes generated by ever-increasing human population of cities. When the wastes are not properly managed, they become detrimental to health and life.

In Nigeria, our environment is polluted as never before by the accumulation of solid wastes. The urban centres are filthy as refuse litters the streets, gutters, main roads and areas around the market centres. Most Nigerians know that the state of the environment impinges on their health. However, what many do not seem to know is that they would spend much less on drugs and other medications if greater attention were paid to environmental sanitation by both the citizenry and government. I therefore propose to study this problem, and to make recommendations on the cheapest and most effective method of refuse disposal and preventive strategies with effective community participation.

Samuel Onwuchekwa
Abia State University
Nigeria

Breastfeeding Week celebrations

The community health department of the Malankara Orthodox Syrian Church Medical Mission Hospital celebrated Breastfeeding Week 1996 (1-7 August) with the help of members of the medical profession and about a hundred volunteers from the community.

Activities took place each day of the week and included classes on breastfeeding, essay competitions, cultural competitions and quizzes as well as a refresher programme for hospital staff in which all ward sisters participated. The pledge to promote and support breastfeeding in and outside the hospital was renewed.

Marina Joseph
Malankara Orthodox Syrian Church Medical Mission Hospital
Kerala State
India

Thank you for sending Contact to our Health and Environmental Club. We try to make all the information from Contact available to grassroots people by carrying out lectures, including on family planning and community-acquired infections. These lectures are

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provided to primary school children during school hours; secondary school children during weekends; youth associations in the churches in this area, and, at women’s groups and other meetings. We work in collaboration with some other sister health group and the local PHC committee.

Tabei Manfred Dahra
HEC Co-ordinator
Kumba, Cameroon

ANNOUNCEMENTS

Pharmaceutical programme
World Council of Churches’ pharmaceutical programme is moving to Nairobi, Kenya in June 1997. However, the Pharmaceutical Advisory Group will continue to meet at WCC, Geneva, each year.

CLAI health desk
After many years of fruitful collaboration, CMC welcomed the decision of CLAI (Latin American Council of Churches) to establish the Community Health and Ecology Programme. CLAI will be involved in the follow-up of the promotion of primary health care in the region.

Health and the media - Getting the message across
A four-day workshop on the promotion of health issues in the media was hosted jointly by Christian Medical Association of India (CMAI) and Appropriate Health Resources and Technology Action Group (AHRTAG) in New Delhi, 11-14 November 1996. Practical sessions focused on folk media, including a puppet show and a song in Hindi; newsletters; developing a dynamic resource centre; finding ideas and catchy headlines for stories about community health and primary health care; writing a press release and experiencing a trial press conference in which two participants answered questions from journalists.

In the final session of the seminar, all those who said that they intended to use their new skills were asked to write to CMAI about their experiences. Dr Cherian Thomas, CMAI general secretary, said that he wanted to hear about the difficulties as well as the successes in promoting health in the media. Contact will follow-up on the information CMAI receives with the intention of featuring the experiences during the course of next year. For more details about the seminar, including a package of materials, please write to Ms Darlena David, Christian Medical Association of India, Plot No 2, A-3, Local Shopping Centre, Janakpuri, New Delhi 110 058, India. Fax: 91 11 559 8150.

More little announcements, taken from Church bulletins!
"The rosebud on the altar this morning is to announce the birth of David Alan Belzer, the son of Rev and Mrs Julius Belzer.
"This being Easter Sunday, we will ask Mrs Lewis to come forward and lay an egg on the altar."

Contact is a periodical publication of "CMC-Churches' Action for Health" of Unit II, Churches in Mission: Health, Education, Witness, of the World Council of Churches (WCC). It is published six times a year in English, French, Spanish and Portuguese. Selected issues are also published in Kiswahili in Kenya. Following our recent mailing list review, present circulation is approximately 15,000.

Contact deals with varied aspects of the community’s involvement in health and seeks to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first annual issue of each language version. Articles may be freely reproduced, providing that acknowledgement is made to: Contact, the publication of CMC-Churches’ Action for Health, WCC.

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