



WHO

significant difference in the health and wellbeing of people living in the world's poorest communities.

The 0.7% Initiative provides an opportunity for Christians in high-income countries to critically assess individual, congregational and national response and responsibility towards a world increasingly polarized between rich and poor nations.

The initiative also provides an opportunity to demonstrate Christian concern and determination, as a community bonded by love for God and God's people, to improve the living conditions particularly of the poor and wellbeing for all human beings.

#### How does the 0.7% Initiative work?

Presbyterians are being asked to make a personal commitment to give 0.7% of their own income towards alleviating the burden of international poverty. They then find other groups of individuals within their congregation who are also interested in making this commitment and join together to learn more and support each other. In the congregation there are several groups which can provide leadership for the 0.7% Initiative.

Once interested individuals, groups and committees have made a commitment to the 0.7% Initiative they bring the 'Initiative' to the congregation as a whole to educate and encourage the congregation to adopt the 0.7% Initiative as a form of stewardship of its own resources. Interested members of the

congregation are challenged to develop creative ways to incorporate those who are not involved with any of the groups mentioned above and who may have little knowledge or interest in the issue of poverty. In some congregations this "uninterested" group may represent the majority of the church membership.

After the congregation has made a commitment to the 0.7% Initiative, they are encouraged to address their elected officials from the perspective of a body that is already giving 0.7% to international development and demand that their government keep its commitments and do likewise.

#### Conclusion

The health status and living conditions of people in poor countries today is in need of many changes. Christians, as congregations and as individual citizens of high income countries in the global economy, have it within their power to make a difference in supporting and walking with their brothers and sisters who live in poor countries and are working to improve their lives.

Dr Dorothy Brewster Lee is the Co-ordinator, International Health Ministries of the Presbyterian Church, USA E-mail: dblee@ctr.pcusa.org



Where there is no artist

# PEOPLE'S MOVEMENT AGAINST MALARIA

*Millions of World Bank dollars are being rolled out to combat malaria, but all the dollars/rupees in the world, all the insecticide-treated mosquito nets in the world, and all the 'gambusia fish in the world' will come to nothing, if the people do not rise up in support. Dr Johnny Oomen reports from Orissa.*

N. Wilmore/TDR/WHO

The incidence of malaria in the hill districts of western Orissa is grossly underestimated, under-stated and unreported. The National Malaria Eradication Programme (NMEP) reported that Orissa accounted for 25 per cent of the cases and 55 per cent of all deaths due to malaria. In the hill villages, for each person who tests positive, there are likely to be 99 untested, unrecorded and uncared for persons with malaria.

## Struggle with malaria

Decades ago, Dr Madsen, founder of the *Madsens Institute for Tribal and Rural Advancement* (MITRA), attempted mass chemoprophylaxis with sulfas, on a control trial basis. Then, and now through MITRA, village health workers have been trained to recognize and treat malaria, keeping stocks of chloroquine in each village. In 1994, when the new information system showed reasonably reliable data on the dimensions of the problem, the team decided to focus on malaria. Through interaction with resource organizations and involvement with the people, a clear-cut alternative strategy, as a supplement to the National Malaria Eradication Programme (NMEP), evolved.

The alternative, preventive and curative community-based malaria control strategy is village-level, people centred, health education-based, employs social mobilization and generates demand. Prevention is through deltamethrin-treated mosquito nets and neem oil-based repellents. Treatment includes early clinical diagnosis, prompt treatment and referral where needed.

**MITRA strategy** – a case study covering a population of 9,045,64

### Step I: Education

(January 1996) We shared information on malaria in all 38 villages.

### Step II: Demanded generation

Undertook a systematic malaria education campaign in villages. Demanded more information based on resolutions passed by the village as a whole.

(December 1996) – Thirty villages undertook campaigns.

### Step III: Malaria control

Villagers opted for malaria control through insecticide-treated mosquito nets (ITMN) Each village decided on a method to procure mosquito nets. Mutually acceptable dates were set. The village allocated responsibility for organization, keeping accounts and collection of dues. The payment was made in installments as decided by the village, in agreement with MITRA.

Village people impregnated the nets – an event that takes on a festive flavour!

December 31, 1996 –

Twenty-one villages confirmed using nets and others were waiting for nets.

### Immense demands

The demand for mosquito nets, even in the interior areas, had been immense and the willingness to pay, consistent. Payment in installments had been a great boon to the poorer families. The economic losses due to malaria out weigh the cost of the nets five or ten fold. Flies, mosquitoes, bed bugs

and head lice have decreased visibly – an advertisement in itself!

The response was unprecedented. On April 1, 1996, there were less than 15 nets in this 9,000 plus population; 75 per cent of the people had neither heard of nor seen a mosquito net. By January 1997, there were over 400 insecticide treated mosquito nets in use (in most families, members share the nets). And the demand for these nets is spiralling – contrary to the predictions of many local prophets of doom.

### Sustainability

All programme models run the risk of not being reproducible or sustainable. While insecticide-treated mosquito nets have significantly decreased malaria morbidity and mortality in many developing countries, its cost has been debated. Can the poor afford



Net check is essential

S. Lindsey/TDR/WHO

to buy nets? Our experience is that when presented with the facts, in a setting of trust and rapport, the poor realize they cannot afford not to have nets.

Dr Johnny Oomen: Head of Community Health Department, Christian Hospital, Bissamcuttack, Orissa, India E-mail: mercyj95@yahoo.com

## Background

There is great concern at the renewed outbreaks of malaria in Burundi. Malaria hit Burundi in the last quarter of 2000. The disease rose to epidemic levels in 9 of the country's 16 provinces. In November alone, 720,000 people fell ill countrywide even as mobile teams fanned out to bring care to malaria sufferers in isolated villages. Importantly, Burundi is not an exception. Africa bears the brunt of malaria and long term control is not possible unless supported by funds and drugs besides research.

The development of planting in marshland in which vector mosquitoes proliferate, the halting of vector control programmes and the probable resistance to Chloroquine may explain this epidemic.

## Causes

If the epidemic's direct causes were natural—the parasite-carrying mosquito and climatic factors—its indirect causes were man-made. Virtually all vector control programme were stopped in 1993, the year the country fell into war. Field studies also showed that the parasite prevalent in the outbreak was resistant to the standard Burundian treatment protocol for simple cases—Chloroquine/Fansidar—adding to the virulence of the epidemic.

## Treatment

Malaria treatment protocols include both first-line and second-line treatment. Patients with uncomplicated malaria are treated with first-line drugs and those who do not respond to this are treated with second-line drugs.

## Rigid Attitudes

In Africa, national treatment protocols have traditionally mandated the use of one anti-malarial drug—either Chloroquine or Fansidar as first-line treatment. But in recent years resistance to these drugs has increased dramatically and experts now strongly recommend changing protocols to include a combination of drugs.

But the government is often reluctant to change. It took months of persuasion

# BURUNDI'S NIGHTMARE

*Burundi's 6.5 million population have little respite from pain and death. First it was the war and now its malaria. Even in a 'normal' year, almost a third of the population is affected by malaria. Last year an epidemic ravaged the country and over 720,000 cases were reported in just one month. Excerpts from a report on the changing national treatment protocols in Africa.*

and an increase in the death toll to force the government to accept a more effective medicine as an alternative. In July 2001, Burundian authorities and the World Health Organization finally accepted the use of another drug, Coartem (artemether and lumefantrine combination) a more effective drug using artemisinin derivatives.

## Conclusion

- ✱ When considering changing national treatment protocols, it is essential that financial considerations do not lead to sub-optimal medical choices. When effective drugs that can save lives are available it must be included in national protocols.
- ✱ Developing countries should not be forced to cope with the financial burden of improving malaria treatment on their own. International aid should be forthcoming to help implement practical solutions.
- ✱ Antimalarials produced in Asia should be made available in Africa as soon as possible. WHO should expand the existing pre-qualification system for AIDS drugs cover to malaria too.
- ✱ If we are to succeed, then research and development for malarial treatment should be actively supported.

Source: Médecins Sans Frontières



S. Lindsay/TDR/WHO

# HOPE AND DESPAIR

## ON THE BANKS OF MEKONG

*Global efforts in their enthusiasm to cap diseases sometimes fail to understand the socio-economic ethos of the region. This myopic view often leads to problems that could have been avoided. **Karl Dorning**, cites the Mekong Region countries (Vietnam, Cambodia, Laos, Yunan in China and Burma/Myanmar) as an example. This area has been unsuccessfully struggling to combat HIV/AIDS for the past 10 years and is juggling between total denial and innovative prevention programmes.*



O. Martel/ITDR/WHO

The mighty Mekong River is the lifeblood of millions of people who live on and around its meandering path. It also has been a silent witness to the sadness brought on by decades of war. Today, it is witness to a new threat. Guns and mines, no longer kill — but a new killer — AIDS is taking the toll.

While world attention tends to focus on the African HIV situation and despite some remarkable success stories in the region (such as Thailand), the threat posed by HIV/AIDS to the many countries in the Mekong Region could be catastrophic.

### **A mistake**

In the past, programmes in the region focused only on education about the virus (how transmission takes place and how one can protect oneself from the virus). This was a mistake. HIV, perhaps more than any other epidemic in our history, has forced us to recognize that a disease of this sort and magnitude has far-reaching social, economic, political and spiritual dimensions. This socio-economic thrust can work both ways and can either fuel the epidemic or help to bring it under control.

### **Geographical compulsions**

It is important to recognize that, despite national boundaries in the region, cross-border movement of large numbers of people has played

a major role in fuelling the epidemic. There are many causes for this. Economic circumstances in Burma (Myanmar), for example, have forced more than 1 million people across the border into Thailand in search of employment.

Burmese women and girls in Thailand's sex industry is well-documented and needs no elaboration. But this is the tip of a far greater problem. Many young Burmese men and women working in the fishing industry, or working as labourers are easy victims. Distanced from their cultural values and their families, and with a steady, dispensable income and no savings facilities cannot be bothered about safe sex, let alone a relationship with a life-long partner. In addition, lack of access to health services by these predominantly illegal migrants further compounds the risk of transmission and the inability to provide care and support to those infected.

### **A vulnerable lot**

A second factor is the sharply increasing vulnerability of adolescents and young people across the region, particularly those who are out of school and who do not have access to education and health services.

Limited resources in many of these countries of the region severely curtails the development of appropriate programmes for the

young (and indeed all those vulnerable to infection). For example, it is estimated that last year a total of US\$5 million (including United Nations and non-governmental organization funding) was spent on combating the epidemic in Myanmar. By comparison, Thailand spent more than US\$200 million. Even basic options, such as the use of condoms to prevent transmission, are not available to the vast majority of people in the region because of cultural inhibitions.

### **Not easy to reach**

Restricted access to people engaged in high-risk behaviour, such as informal and formal sex workers, drug users (including injecting and non-injecting) and homosexual men, further compounds the complexity of response. This includes the continued difficulty of reaching people providing informal sex services and their clients. The associated epidemic of tuberculosis both complicates treatment and absorbs the meagre health resources of many countries in the region.

It is a tough road ahead, but like the mighty river itself, given the necessary supportive environment, it is not difficult to turn the tide from despair to hope.

Courtesy: Global Future, World Vision. Web: [www.wvi.org](http://www.wvi.org) E-mail: [global\\_future@wvi.org](mailto:global_future@wvi.org)

# THE ECUMENICAL RESPONSE

TO THE CHALLENGES OF HIV/AIDS IN AFRICA



*The Global Consultation met in Nairobi in the last week of November, 2001. The Plan of Action, an outcome of a dialogue between three groups of partners - churches, ecumenical and church-related organizations in Africa; churches, ecumenical and church-related organizations in Europe and North America; and the World Council of Churches – is intended as a guide map to knit together church leaders and their congregations to speak honestly about HIV and AIDS. Excerpts:*

## Vision

The ecumenical family envisions a transformed and life-giving church, embodying and thus proclaiming the abundant life to which we are called, and capable of meeting the many challenges presented by the epidemic. For the churches, the most powerful contribution we can make to combating HIV transmission is the eradication of stigma and discrimination: a key that will, we believe, open the door for all those who dream of a viable and achievable way of living with HIV/AIDS and preventing the spread of the virus.

## Commitments

◆ We will condemn discrimination and stigmatization of people living



with HIV/AIDS as a sin and as contrary to the will of God.

◆ We will urge our member churches to recognize and act on the urgent need to transform ourselves if we are to play a transforming role in the response to HIV/AIDS.

◆ We will launch a global effort to stimulate theological and ethical reflection, dialogue, and exchange on issues related to HIV/AIDS. Issues will include:

- Sin and sinner, stigma and stigmatized.
- Sexuality.
- Gender.
- Love, dignity and compassion.
- Confession and repentance.

This reflection will continue to challenge us to suggest guidelines for transformation of our churches, and support our search for an ecclesiology that will help us to address the issues raised by the response to HIV/AIDS.

In addition the plan includes guidelines on **advocacy, prevention, care and counselling, education, support and treatment and gender equality**. It also

recommends sensitivity to **local cultures** and about the language used in the **liturgy**.

## Mechanisms

The response, as defined in the Plan, will require a new level of cooperation and creativity as well as the strengthening of capacity and the developing of mechanisms at all levels.

These mechanisms will be set up in line with the following criteria:

- to create a central facilitating point in the WCC
- to put into place regional resource support and facilitation for churches, ecumenical organizations and church-related organizations
- to ensure national capacity for resource support and facilitation for churches, ecumenical organizations and church-related organizations
- to use existing structures of churches, ecumenical organizations, and church-related organizations (international, regional and national) wherever possible
- to provide technical resource support at key points
- to ensure creative communication and networking, making best use of electronic communication

● to establish an international reference group to accompany the implementation of the plan

● to ensure fund raising channels and mechanisms that maximize ease of access to funding and which take into consideration local limitations and realities.

These mechanisms are intended to operate in such a way that they support churches, ecumenical and church-related organizations, and strengthen their response to HIV/AIDS.

It is the responsibility of each church, ecumenical and church-related organization to own this plan and ensure that it is implemented.

Source: Excerpts from the Global Consultation

# WHY DO WE FAIL TO READ THE SIGNS OF THE TIME?

## JOHN 4: 1-42

*Disease and disappointment are an integral part of life, but there is a hidden message from God even in our illness. All one needs is to read the signs correctly.*

### Read the signs

Jesus also said to the multitudes: When you see a cloud rising in the west, you say at once "A shower is coming"; and so it happens. And when you see the south wind blowing, you say "There will be scorching heat"; and it happens. You hypocrites! You know how to interpret the appearance of earth and sky; but why do you not know how to interpret the present time? (Lk 12.54-56)

Even at the time of Jesus, people had developed a certain capacity to predict. Those who were able to read the signs properly were in a position to say about the next day. Jesus recognized this ability. But in his eyes the real challenge was elsewhere. What is required is "to read the signs of the time". What gain is it to be able to predict the future if we are unable to understand what is at stake in the present hour?

### Signs are opportunities

Signs play a decisive role in human life. Again and again we are confronted with the question as to how "signs", i.e. events that occur in our life, are to be interpreted - an illness, a victory or a defeat, a disappointment, or whatever else we may experience. Ultimately, in everything that we experience is hidden a message from God. As in a mirror we are shown who we are and where we stand. A secret voice addresses us, pointing to the way which we are to choose. Through signs we are given guidance. Signs

are opportunities. If we do not perceive them, they will become missed opportunities.

What is true for the life of each individual human being is also true for humanity as a whole. God speaks to humanity through signs. For years we have been warned that the climate system will lose its present equilibrium if we are not prepared to reduce drastically our emissions of greenhouse gases. It becomes ever more manifest that we are pursuing a suicidal course. But we continue to ignore the signs. As in Jesus' time, we are satisfied with forecasts for tomorrow's weather but close our eyes to the long-term danger. You hypocrites! Why is it so difficult to recognize the signs for what they are really saying? The answer is obvious: because God's voice is at first sight contrary to the dynamics of human life. Is it therefore not a normal first reaction to close one's eyes? The trouble is that in doing so we close our eyes to God's gift of life. Through the parable, Jesus urges us to overcome this first reaction and to listen to the secret voice of God's love.

### Questions for reflection

1. Are we ignoring the signs of our times?
2. In the challenges that we face are we closing our eyes?

Adapted from *Together On The Way To*, Volume 11, number 4 (December 2001) Lukas Vischer Federation of Swiss Protestant Churches

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17 Grove Lane  
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**Campaign for Access to Essential Medicines**

Medicins Sans Frontieres  
Website: <http://www.accessmed-msf.org>

**Dear reader please note:**

PHA is now known as PHM (movement) Website: [www.phamovement.org](http://www.phamovement.org)  
E-mail: [gksavar@citechco.net](mailto:gksavar@citechco.net)  
listserver is phaexchange@kabissa.org (moderator Claudio Schuftan: [aviva@netnam.vn](mailto:aviva@netnam.vn))

**Where Needs Meet Rights**

By Bas de Gaay Fortman and Berma Klein Goldewijk  
ISBN: 2-8254-1319-4

160pp. Price: Sfr 15.00 US\$ 9.95, 6.50 pounds, 9.90 euro

While most advocacy for human rights tends to emphasize people's civil rights rather than their economic and social rights, authors of this book call for

creative new approaches to economic and social rights, which must be rooted in human needs, human dignity and legitimacy even as it is underpinned by religious convictions.

**Christ for All People** Edited by Ron O'Grady.

This striking collection presented in full colour includes some of the best

contemporary Christian art from around the world and offers a journey through the life of Jesus. It is a testimony to the mission and talent of numerous artists worldwide. The short reflections accompany the images add to their relevance

ISBN 2-8254-1339-9 160pp  
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## WCC PUBLICATIONS

**The Clinical Use of Blood Handbook**

This book is designed to provide a quick but fairly detailed reference to transfusion, particularly when urgent. It has been prepared by an international team of clinical and blood transfusion specialists and reviewed by relevant WHO departments and critical readers from a range of specialties from all regions of the world.

Published in 2001, 219 pp, ISBN 92-4-154539-9 Price: Sfr. 15. (For developing countries Sfr. 10.50) Order no 1150485.

**WHO Model Prescribing Information-Drugs Used in Bacterial Infections**

This booklet is intended to provide up-to-date and independent clinical information on essential drugs, including dosage,

uses, contraindications and adverse effects.

It can be used as a source material for adaptation by national authorities, in particular in developing countries that wish to produce drug formularies, data sheets and teaching materials.

Published in 2001. 177 pp, ISBN 92-4-140107. Price: Sfr 35 (for developing countries Sfr. 24.50) Order no 1150483

**Health and Poverty Gender Analysis:**

Briefing prepared for the Swedish International Development Co-operation Agency published by Oxaal, Zoe; Cook, Sarah. 1998.

This report has five main parts: Debates on health and poverty; Debates on gender equality Gender perspective is important in linking health and poverty concerns; Implications for policy and

programmes of a gender perspective; New directions: Areas for further research policy development.

Although progress has been made in improving health indicators, this progress has been uneven, particularly in poor countries. Inequity in access to services for poor people and low quality care have been identified as problems in health services

provision. 22pp. report no. 46.

Source: BRIDGE (developing gender), Institute of Development Studies, University of Sussex, Brighton BN1 9RE, UK. Tel: (440 1273) 606261; Fax: (440 1273) 621202/691647; E-mail: [bridge@ids.ac.uk](mailto:bridge@ids.ac.uk); website: <http://www.ids.ac.uk/bridge>.

## OTHER PUBLICATIONS

## ANNOUNCEMENTS

Congratulations!!



We are pleased to announce that Dr Christoph Benn has been selected as the NGO representative from the developed nations to the board of the Global Fund to Fight AIDS, TB, Malaria (GFATM). Milly Katana is the representative from the South.

The GFATM is an independent, public-private partnership committed to sharing resources and expertise across the globe to fight AIDS, TB and malaria.

Dr Christoph Benn who is a medical doctor in tropical medicine and public health is the Head of the Department for Policy & Studies with the German Institute for Medical Mission. He has worked extensively in Asia & Africa and is passionate about fighting HIV. Christoph works with many national and international organizations including WCC, EAA, the German Network Covenants for Action Against AIDS and of course is an active participant in *Contact* editorial committee.

**Workshop on Transfection of Malaria** - from April 15-22, 2002 will be held at Parasites International Centre for Genetic Engineering and Biotechnology, New Delhi, India. Resource people include Alan Cowman, Brendan Crabb, Manoj Duraising, Jenny

Thompson (WEHI, Melbourne, Australia) and Vir Chauhan (ICGEB, New Delhi, India). Tel: +61-3-9905 4822. Fax +61-3-9905 4811 For further details please contact: Dr Alan F. Cowman E-mail: Cowman@wehi.edu.au.

Tribute



It is with grief that we have to inform our readers that Dr David B Larson passed away on March 5, 2002 at his residence.

Readers will recollect that the Faith and Healing issue (170) featured Dr Larson's interview 'The Search for Shalom'. His

contributions to the field of health and spirituality are renowned.

He is survived by his wife Susan and their two children Chad and Kristen.

We pray that the Lord will grant his family the strength and courage to bear this loss.

## LETTER

### TB control

Dear Editor

*I was very impressed by your coverage of the AIDS pandemic and your call for action to provide antiretroviral drugs for those in need in the latest edition of Contact. There is, however, one very important area of HIV management that could save thousands of years of human lives every year in a very cost-effective way; namely, tuberculosis control. The International Union Against Tuberculosis and other agencies are very concerned that so little attention is given to this major problem by the HIV agencies.*

**John M Grange**, Visiting Professor, Centre for Infectious Diseases and International Health University College London.

*Contact* deals with various aspects of the churches' and community's involvement in health, and seeks to report topical, innovative and courageous approaches to the promotion of health and healing.

*Contact*, magazine of the World Council of Churches is published quarterly in English, French, Spanish and Portuguese by a partnership of the World Council of Churches (WCC); Christian Medical Association of India (CMAI); German Institute for Medical Mission in Tübingen (DIFÄM), and Medical Coordination Secretariat of the Netherlands (MCS). Present circulation is approximately 15,000.

Articles may be freely reproduced, providing that acknowledgement is made to: *Contact*, the publication of the World Council of Churches. A complete list of back issues is published in the first annual issue of each language version.

Editorial Committee: Christoph Benn, Christina de Vries, Elizabeth Moran, Patricia Nickson, Sonia Covarrubias and Reena Mathai-Luke.

For this issue we acknowledge the contribution of Manoj Kurian, Nanda Chandrasekharan, Miriam Reidy-Prost, Catherine Alt, and Jenny Roske. Editor: Reena Mathai-Luke; Design: Indira Mark; Mailing List: Indira Mark. Printed by Impulsive Creations.

The average cost of producing and mailing each copy of *Contact* is US \$2.50, which totals US \$10 for four issues. Readers who can

afford it are strongly encouraged to subscribe to *Contact* to cover these costs.

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