DIS 2 N.1

Use of Indian Traditional Drugs in HIV/AIDS – A Scientific and Clinical Study

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Human immunodeficiency virus (HIV) has been conclusively known to be the causative agent for AIDS which is a major killer disease of the modern times affecting almost 50 million people around the world. The fact that the majority of the affected individuals are from Asia and Africa and that India is highly vulnerable to the disease make it very important in the national priority in the medical strategy of the coming decade. Even after the intensive research of the last decade, there are no effective remedies for the disease and the available one are highly costly and is not affordable to the affected persons in India.

It has been known that CD_4 lymphocytes are mainly affected by the HIV when this class of lymphocytes are destroyed, it produces an immunological imbalance in the body and weakens the resistance to several opportunistic infections, consequently leading to death. The medicines available at present produce a decrease of the viral load, but as they are immunosuppresents they can produce a deterioration of the patients immunity. Hence a search for non-toxic drugs that can stimulate immunity and there by increase the body's ability to fight the HIV infection are being sought.

Indigenous medicines in India are known for their action of stimulating the immune system. Rasayanas which are preparations made either from a single plant or a combination of several plants are known for their immunomodulatory properties. The immunostimulating activity of plants such as *Tinospora cordifolia, Withania Somnifera, Viscum album, Emblica officinalis, Semicarpus anacardium Asparagus racemoses* and *Pueraria tuberosa* have been studied in detail and some of them are being used in immunodeficient conditions such as cancer.

In Ayurveda a similar condition to HIV/AIDS has been mentioned which is known as "Ojakshaya", in which the fall in immunity may be due to other pathological condition for which medicines have been prescribed. Charaka Samhita, Susrutha Samhita and Ashtanga Hrudaya explain the function of 'Ojas' its symptoms, and the diseases caused by its depletion. 'Ojas' is otherwise explained as 'Bala' (strength) and 'Dhatusara'. "Ojas" is of two types namely, 'para ojas' and 'Apara ojas'. The 'ojas' of para (excellent) type is eight drops in quantity and death occurs when this get depleted. The other type 'Apara ojas' is also known as 'sleshmaka ojas", the quantity of which is described as "Ardha Anjali". When this ojas is not affected the bodily functions will be normal. 'Bala or immunity prevents in the body. 'Ojas' depletion occurs due to the physical and mental causes such as a blow, a persistent wasting disease, anger, grief, anxiety, fantigue and hunger. "Jeevanceya oushadhas" - (certain groups of herbal drugs described in

ancient Ayurvedic texts as Jeevaneeya oushadhas) along with milk, meat soup can counteract 'ojakshaya'.

HIV infection leads to break of immunity of the body. But this immunological breakdown doses not occurs in every person in the same manner. According to the body strength, an infected person may be free of symptoms upto 15 years. So it can be ascertained that one may not get AIDS when the immune mechanism is intact even if he is infected. 'Ojas' is the abstract part of seven dhatus. Dhatus are the vital tissues of the human body. They are Rasa (Chycle), Raktha (blood), Mamsa (flesh), Meda (fat), Asthi (bone), Majja (bone marrow) and Sukra (semen). So, when there is adequate poshana (nourishment) of Dhatus the 'ojas' is maintained in the body. For the proper nourishment of Dhatus, Dhatwagnies have an important role. As Dhatwagnies are the nourishing enzymes of Dhatus. Each Dhatu is being nourished by the help of Dhatwagni. We have selected the drugs for HIV/AIDS keeping the above points in mind. Three types of drugs are selected for this study. They are Jeevaneeya, Bramhaneeys (maintaining or improving body wt.) and Panchaneeya (or nourishing).

AIDS research was started by Amala Ayurvedic Hospital using in collaboration with Amala cancer Research Centre in December 1992. A total no. of 700 HIV/AIDS cases were seen till 2-4-2002. On the basis of the known literature we have formulated 3 types of Ayurvedic herbal preparations to counteract the 'Ojakshaya' seen in HIV/AIDS cases.

In the present study, we have evaluated the efficacy of the medicines in improving the immune status of the HIV patients with AIDS related syndrome.

Materials and Methods

The study was conducted on patients in whom the HIV infection was confirmed through ELISA and Western blot tests. For the clinical evaluation of medication 700 patients were studied. For detailed study these patients were again classified into three groups. In the first group all the 700 patients were included. In the second group 45 AIDS symptoms patients were selected. In the third group 11 AIDS patients were selected and their CD_4, CD_8 ratio and other immunological parameters before and after treatment were done at CMC Medical College, Vellore and its details will be presented by Dr. Ramadasan Kuttan.

Initial weight of the patient as well as the history, duration of contact and prior medication were recorded.

Medication

Patient were given three types of medications formulated in our centre which are coded as NCV-I, AC II and S.G.-III.

TABLE 1.

EFFECT OF AYURVEDIC DRUGS ON HIV-INFECTED (ARC) PATIENTS

Patients 45 Total patient 45

Symptoms	No.of. Patients with symptoms	Relief after treatment		
		Complete	Partial	No.of relief
Fever	45	33(79%)	7 (16%)	5 (5%)
Diarrhoea	11	9 (82%)	2 (18%)	-
Cough	17	11 (65%)	6 (35%)	-
Lymphadenopathy	49	45 (56%)	4 (44%)	-
Glossitis	13	4 (31%)	9 (69%)	-
Loss of appetite	20	13 (65%)	5 (25%)	2 (10%)
General weakness	18	15 (83%)	3 (17%)	-
Joint pain	12	10 (83%)	2 (17%)	-
Insomnia	10	7 (70%)	3 (30%)	-
Tuberculosis	14	9 (65%)	4 (28%)	1 (7%)
Itching	12	9 (75%)	3 (25%)	-
Anorexia	6	4 (67%)	2 (33%)	-
Herpes exbaster	2	2(100%)	-	
U Icer penis/vegina	4	3 (75%()	1 (25%)	-

NCV I and AC II are herbal powders while SG II is ghee based formulation. SG-III formulation was avoided in patients who are having very low appetite and diarrhoea. Dosage of the drugs are as follows.

1. NCV-I : 5 gm - twice a day with milk
2. AC-II : 5 gm - twice a day with milk
3. SG-III : 10 gm - morning and bed time.

Clinical details of group I patients

The total no. of cases studied were 700 out of this 530 were male, 162 were female and 8 were children.

Group II - Total patients - 45.

Clinical findings

Medication produced satisfactory relief of opportunistic infection and physical ailments in patients. A summary of the relief of clinical symptoms is shown in the table 1. The drug produced satisfactory relief of fever, diarrhoea, joint pain, itching and produced partial

relief to lymphadenopathy, glossitis etc. Moreover the drug produced a weight gain in most of the patients and with feeling of well being.

In summary medication found to be useful in improving the immunological status in many HIV patients with ARC with subsequent improvement in health. The drug also increased the life span in many patients.

Conclusion

1. The total number of patients studied were 700.
2. Among the 700 patients 313 were HIV carriers, 294 were AIDS symptoms patients and 93 were feel blown cases.
3. It was seen that this disease mainly gets infected through sexual contact.
4. Medication was found to be useful in improving the immunological status in HIV patients and as well as early stages of AIDS.
5. The drugs produced a weight gain in most of the patients and with a feeling of well being.
6. Drugs also increased the life span in many patients.
7. None of the patients become sero negative during the treatment.
8. Our drugs did not produce any adverse toxicity to the patients.

Body Weight of 30 HIV patients before and after treatment

		Years of Treatment								
No.	Before treatment	1	2	3	4	5	6	7	8	9
1.	57									61
2.	52									52
3.	50							47		
4.	82			90						
5.	87									102
6.	78								78	
7.	46								42	
8.	52							55		
9.	49									51
10.	48								41	
11.	39									44
12.	42								42	
13.	68							65		
14.	47			44						
15.	37				41					

16.	48			51	
17.	68				64
18.	56		51		
19.	39	43			
20.	63			56	
21.	55			55	
22.	43		45		
23.	63			55	
24.	11	14			
25.	43			41	
26.	50		54		
27.	40			41	
28.	21			34	
29.	45		44		
30.	48	59			

Clinical Evaluation

For the clinical evaluation of the medication against HIV/AIDS, eleven patients were studied. All the patients were positive to HIV-ELISA (Gene labs, USA) supplied by Ranbaxi, India and were confirmed for positively using Western Blot (Gene Labs, USA) supplied by Modi Biotec, India and done in our laboratory.

The patients were examined by an Ayurvedic Physician and a medical doctor. All the patients selected in the study have contacted with HIV either through sexual contact or through accidentally using a contaminated blood product. Duration of the disease varied but the minimum was 5 years. All patients selected in the study were symptomatic with AIDS related complex and the symptoms varied from fever, lymphadenopathy, diarrhorea, skin rashes etc. and tuberculosis. None of the patients selected had taken any other medication either Ayurvedic, homeopathic or modern medicine specifically for HIV.

Initial weight of the patient as well as the history, duration of the contact, prior medication were recorded. Patients were informed about the merits and demerits of the treatment given and individual written consent was obtained.

Medication

Patients were given three types of medication formulated in our centre which are coded as NCV I, AC II and SG III. NCV I and AC II are herbal powders while SG III is ghee based drug (this formulation was avoided in patients who are complaining gastrointestinal problems.) Dosage of the drugs are given below:

NCV I : 5 gms twice daily with milk
AC II : 5gms twice daily with milk
SG III : 10 gms morning and evening

All the drugs and tests were given free of charge. Before starting the medication patients were asked to undergo cell phenotype analysis at Dept. of Virology, CMC Hospital, Vellore. This was done using FACS Scan, Becton Dickenson, USA using BD Simultest Reagent.

The patients were seen in the clinic every two weeks initially and every one month thereafter. They were asked to report any physical problems immediately to clinic and they are recorded.

Medications continued for one year and they were asked to undergo cellular phenotyping at 9th month and a few patients after 12 months. Western blot of the patients were repeated after 12 months.

Results

The evaluation of 11 patients for the effect of medication for HIV and AIDS are given in Tables given **below.**

Body Weight

In most cases the body weight was positively increased during the first six months. (Table2) There after the body weight was found to remain same or showed a slight decrease which may be due to the increased activity of the patient as they are professional workers. A few cases where the body weight was decreased drastically (P6) was due to the decreased food intake.

TABLE 2
EFFECT OF MEDICATION ON BODY WEIGHT OF PATIENTS

Name	Before	3 Months	6 Months	9 Months
PI	50 Kg	59 Kg	65 Kg	60 Kg
P2	40	46	50	43
P3	54	55	53	53
P4	44	46.5	43	-
P5	45	48	47	47
P6	50	51	49	41
P7	40	41	36	-
P8	57	59	-	-
P9	50	65	68	68
P10	59	60	62	63
P11	38	42	47	45

Life Span

Medication improved the life span of the patients considerably. Patient like P/11 in fact was discharged from the Medical college Hospital without further treatment. Even this patient showed positive improvement during the medication.

Two of the patients died (P4 & P7) during the project period. P4 died of acute diarrhoea and stocmach candidiasis, and decreased food intake while P7 died of stomach candidiasis. In fact upon administration of antifungals to this patient at this stage worsened the condition of the patient.

Lymphocytes

Total lymphocytes (cmm) was normal in all the patients expect P4 which was 690. (Table-3) The value did not alter significantly change after the treatment.

TABLE 3
EFFECT OF MEDICINES ON LYMPHOCYTES

Patient	Age	Lymphocytes (cmm)	
		Before	After (1 Year)
P1	42	610	2716
P2	22	4170	2070
P3	29	3310	1920
P4	29	690	(expired)
P5	32	4500	1500
P6	30	4500	sick
P7	28	3810	(expired)
P8	31	1750	(discontinued)
P9	25	1450	sick
P10	30	2810	1650
P11	38	2830	3350

Normal > 1500 cmm

CD^{+}_{3} CD^{+}_{19} Lymphocytes

CD^{+}_{3} (Total T + B) were almost normal in most of the patients except P4, and the values were found to be increased after the treatment period. (Table 4)

TABLE 4

EFFECT OF MEDICATION ON T AND B LYMPHOCYTES

Name	CD^+_3 Before	CD^+_{19} Before	CD^+_3 After	CD^+_{19} After
P1	1100	180	1793	291
P2	3590	130	1660	170
P3	2610	430	1210	461
P4	380	90	---	---
P5	3550	300	930	60
P6	2017	442	---	---
P7	2970	270	---	---
P8	770	90	---	---
P9	750	370	---	---
P10	2130	230	930	180
P11	2180	110	2180	200

Normal range CD^+_3 cells/cmm > 1200

CD^+_{19} cells/cm 250-750

But B cells count (CD^+_{19}) was found to be low in many patients and in case P2 and P22 B cell count was fond to be increased after treatment.

CD^+_4 and CD^+_8 lymphocytes

CD^+_4 lyphocytes was found to be low in most of the patients and it was well below normal in P4, P1, P6, P8 and P9. Table 5. The ratio of CD^+_4 and CD^+_8 was 0.1 - 0.2 in all the patients. Administration of medicine increased the CD^+_4 in most of the evaluated cases with subsequent improvement in CD^+_4 and CD^+_8 ratio.

Percent of CD^+_4 in lymphocytes

There was an increased in the ratio of CD^+_4 in lymphocytes in several patients after treatment which at times was almost similar to normal. (Table 6).

TABLE 5
EFFECT OF MEDICATION ON CD4, CD8 CELLS

Patient	CD^+_4/cmm	CD^+_8/cmm	Ratio	CD^+_4/cmm	CD^+_8/cmm	Ratio
	Before			(after)		
P1	100	980	0.1	163	1521	0.10
P2	290	3290	0.1	290	1125	0.25
P3	200	2380	0.1	326	787	0.41
P4	100	280	0.4	---	---	---
P5	300	3200	0.1	240	690	0.34
P6	50	1953	0.1	60	310	0.02
P7	270	2700	0.1	---	---	---
P8	110	600	0.2	---	---	---
P9	120	640	0.2	---	---	---
P10	290	1840	0.2	130	790	0.2
P11	200	1970	0.1	200	1850	0.1

Normal range CD^+_4 - 500 - 1500

CD^+_8 - 277 - 1728

TABLE 6
EFFECT OF MEDICATION ON CD4/LYMPHOCYTES RATIO

Patient	CD^+_4 cells	lymphocytes	% CD^+_4	CD^+_4 cells	Lymphocytes	% CD^+_4
	Before			(after)		
P1	100	1610	6.2	163	2716	6.0
P2	290	4170	4.8	290	2070	14.0
P3	200	3310	6.0	326	1920	16.9
P5	300	4500	6.6	240	1500	16.0
P10	290	2810	10.3	130	1650	7.8
P11	200	2830	7.0	200	3150	6.3

CD^+_4 normal range 500-1500
(Cells/cmm)

NK cell and activated T cells

NK cell and activated T cell indicate the state of infection. NK cell was very high in P6 and activated T cell in P4. Both of them became sick later and P4 expired. Increased activated T cell in P2 was found to be decreased after medication. (Table 7)

Western Blot Analysis

Western Blot analysis of the patients before and after treatment did not significantly produce any change, and all patients were sero positive after the treatment period.

TABLE 7

EFFECT OF MEDICATION ON NK CELL & ACTIVATED T CELL (DR+) CELLS

Patient	NK cell (before)	Activated T (DR+) (before)	NK cell (after)	Activated T cell (after)
P1	433	110	435	1439
P2	420	790	230	190
P3	170	170	192	442
P4	210	790	---	---
P5	590	150	345	555
P6	1980	293	---	---
P7	530	190	---	---
P8	850	50	---	---
P9	250	90	---	---
P10	440	150	550	310
P11	530	250	900	180

Normal range - NK cells - 200-750; Activated T cells **50-300**

TABLE 8

EFFECT OF AYURVEDIC DRUGS ON HIV-INFECTED-SYMPTOMATIC RELIEF

(Total patients -10)

Symptoms	No. of cases with Symptoms	Relief		No Relief
		Complete	Partial	
Fever	7	87 (100%)	1 (20%)	
Diarrhoea	5	4 (80%)	1 (50%)	
Lymphadenopathy	2	1 (50%)		
Joint pain	2	2 (100%)		
Itchimg	2	2 (100%)		
Glossitis	5	2 (40%)	3 (60%)	
Tuberculosis	5	2 (40%)	3 (60%)	
Penis ulcer	1		1 (100%)	
Disturbed sleep	4	4 (100%)		
Cough	2	1 (50%)	1 (50%)	
Loss of appetite	5	5 (100%)		
Headache	1	1 (100%)		
Throat Pain	1	1 (100%)		
Herpes xoaster	1	1 (100%)		
Weight loss	10	Weight gain 7	Weight maintained-2	Weight loss 1

In summary, medication was found to be useful in improving the immunological status in many HIV patients with ARC with subsequent improvement in health. This could be seen from their weight gain. CD^{+}_{4} count and other immunological parameters discussed above. Drug also improved the life span in many patients. However the following observation were also made.

Other general observation

1. The financial status of many patients were very bad and a proper nutritious food along with medication could have improved the status better.
2. Many patients have to work hard in order to make their living in spite of the disease. This might have adversely affected the usefulness of the medication which advocates more rest to the sick patients.
3. Oral and stomach candidiasis may product lot of harm to the patient as they are not be able to swallow food and medicine. This needed to be taken care of properly.
4. Patients with TB need take anti-TB drugs.

DIS 2N.2

Value-based University Pogrammes of Study on HIV and Family Education

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The Indira Gandhi National Open University (IGNOU) is the largest Open University in the World today with an annual enrollment of over three hundred, thousand, (300,000) students and over one million students on role. The University has a wide network not only within the country, but also in as many as 23 other countries. It is offering 80 programmes and has been declared as 'Centre of Excellence' by the Commonwealth of Learning. Among the nearly 300 Universities and Deemed to be Universities in India, IGNOU is the first and the only university in the country offering programmes of study in the area of HIV/AIDS currently.

The Catholic Bishops Conference of India (CBCI) and the Indira Gandhi National Open University (IGNOU) signed a Memorandum of Understanding (MoU) on February 29, 2000 and established the IGNOU-CBCI Chair on 'Health and Social Welfare' at **IGNOU**.

One of the objectives of establishing this Chair was to develop and launch programmes of study in the areas of HIV/AIDS and Family Education to address the unabated spread of HIV/AIDS in the country. This much needed and timely intervention of the Health Commission of the CBCI saw the launching of the first programme namely; "Certificate in HIV and Family Education" of 6 months duration from January 2002. Within one year (in January 2003) the Chair also developed and launched a one year Diploma on "HIV and Family Education".

The main target groups for these programmes are the school teachers, NGO functionaries, para-medicals and parents of adolescents. Already over 2000 students are enrolled in these programmes.

Among the Indians, sexual norms are still to abide by the life-long rule of monogamy, while, in most societies severely hit by the HIV/AIDS epidemic, the norms have been 'change of partners'. Virginity before marriage is still highly valued among most Indians and families have by and large greater control over the behaviors of children at least until they are married and settled.

However, with India's shift from a predominantly agricultural, low subsistence and low consumption economy and a community based social structure, to an industrially developing nation with urbanization, globalization, migration and break down of rural economies, joint family system and communities, there have been shifts in social values and world views. The degree and nature of this impact has been various across different sections. The weakening controls have allowed greater individual freedom and releasing the stifling controls on young people. Much of the publicity materials used in HIV/AIDS awareness in India are copied from literature prepared in foreign countries meant for a

society having different cultural setting. There is much resistance from school teachers and parents in using these materials in schools and in training program for various target groups in India.

Considering the need of the society, CBCI-IGNOU Chair on 'Health and Social Welfare' has developed a set of academically sound and socially acceptable quality materials-print, audio and video-which form part of the educational package. These are value based materials prepared keeping in view the social, cultural, family, religions and moral values dear to the Indian Society. The seven courses which form part of the Certificate and Diploma programmes are:

- Basics on HIV/AIDS (4 credits)
- Elective on HIV/AIDS (4 credits)
- Basics of Family Education (4 credits)
- Elective on Family Education (4 credits)
- Alcohol, Drugs and HIV (4 credits)
- Communication and Counselling in HIV (4 credits)
- Project Work (8 credits)

Anyone with a 10 + 2 qualification from any part of India can enroll for these programmes. The University has kept the fee very low in order to make this programme accessible to almost anyone interested. For a certificate one needs to pay Rs. 800/- while for the Diploma the fee is Rs. 1600/- inclusive of examination fee, registration fee as well as the print package. These programmes are available both in English and Hindi.

The humble beginning that the CBCI initiated in collaboration with IGNOU to prevent and control HIV/AIDS has attracted people from various walks of life. Today over two thousand learners from all over country are doing these programmes through distance learning mode. It is a matter of satisfaction to report that these value based programmes have attracted world attention. Already the Kenyatha University from Kenya has sought license to adapt this value based programme in that country. IGNOU has also started offering these programmes in Namibia. Apart from these formal programmes of study, this small initiative of the Church has motivated IGNOU to use other strategies to reach out to millions across the country with HIV/AIDS prevention messages.

Currently IGNOU is involved in a massive HIV/AIDS Awareness Campaign all over the country. As a part of the campaign the University is reaching out to all its students through an HIV/AIDS folder: 'HIV Prevention Guide' for students which is being mailed to over 300,000 fresh students and its readership every year is estimated to be over one million. Apart from this IGNOU has produced over a dozen video films and audio programmes which are being telecast/broadcast over Doordarshan/Gyan Darshan and All India Radio as well as Gyanvani. Besides this, IGNOU also regularly conduct teleconferencing as well as interactive radio counseling on this subject. Above all the University also conducts awareness/publicity seminar in various states through IGNOU Regional Centres located in state capitals.

HIV/AIDS' Patient and His or Her Rights

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HIV/AIDS is the most dangerous disease the world faces today. There is no certainty about the origin of this disease, however, it is believed that its virus first surfaced in Africa. Later, somehow it moved to the United States, where it was first detected decades later. After its first detection, the Disease has remained in existence for more than twenty years now, without a foolproof medical response in terms of vaccination against it or its cure. The Disease, in absence of effective and easily available/accessible treatment troubles not only the individual sufferer but also society at large. The number of patients suffering from this disease is quite daunting. The total number of HIV-positive people in the world rose from 10 million in 1990 to 28 million in 1996, 34 million in 2000, and to as many as 40 million in 2002.

There are several dimensions of the Disease including moral and legal. The legal dimension of this Disease is about at least three basic questions. First, what are the rights of the patient suffering from HIV/AIDS? Secondly, what are the rights of people in general to protect and prevent themselves from being affected by the Disease? Thirdly, what are the duties of various stakeholders, patients, public and the State?

The present article discusses some important rights of patients suffering from the Disease. These are the Right to Privacy, the Right to Marry and the Right to Employment. In order to trace these rights, the provisions of various relevant international instruments, the provisions of the Indian Constitution and some judicial pronouncements are considered in the article.

There are several instances of cruel and inhuman treatment meted out by society to the HIV/AIDS patients on grounds of morality etc. The Law, however, has no such provisions permitting discriminatory, inhuman, degrading or cruel behaviour against them. Though suffering from this dangerous disease, the patients have certain rights provided for by different instruments at the international as well as domestic level. There has also been an attempt to clear some ambiguity pertaining to these rights through judicial pronouncements.

(i) Right to Privacy

Some of the fundamental provisions entailing the right to privacy are as under:

The Universal Declaration of Human Rights (UDHR) Article 12:

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, or to attack upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

The International Covenant on Civil and Political Rights (ICCPR) Article 17:

1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, or to unlawful attacks on his honour and reputation.
2. Everyone has the right to the protection of the law against such interference or attacks.

Similarly, the Constitution of India provides for the Right to Life under Article 21. Which means the right to a decent and dignified life including the right to privacy. As is the case, rights are always subject to certain conditions. The exercise of various rights within the purview of the Right to Life under Article 21 of the Constitution is also subject to certain conditions like public health, safety, public order, public interest etc.

A difficult situation arises when a patient asserts his/her right to privacy or confidentiality and it comes in conflict with the question of public health, order, safety etc. In the event of such a conflict the Roman Law principle, '*Salus populi est suprema*' (regard for the public welfare is the highest law) should apply. In *Mohan Patnaik v. Government of A.P., 1 Andh LT 504*, it was held that in case of conflict between individual fundamental rights and larger interest of the society, the latter right would prevail. The Supreme Court of India, in Mr. 'X' v. Hospital 'Y', AIR 1999 SC 495, held that Article 21 includes right to privacy, but the same is not absolute. The Court further said that disclosure by Doctor that patient who was to get married has tested HIV+ve, is not violative of patient's right to privacy.

The position of the right to privacy, therefore, is as follows:

(1) Everyone, including the HIV/AIDS patient, has the right to privacy.
(2) Such a right may be curtailed in the larger public interest.

(ii) Right to Marry

The Right to Marry is another fundamental right which every human being has. The Universal Declaration of Human Rights providing for this right states in Article 16 (1):

Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and its dissolution.

Also, this right finds a place in the International Covenant on Civil and Political Rights. Article 23 (2) of the Covenant provides:

The right of men and women of marriageable age to marry and to found a family shall be recognised.

The Right to Marry is inherent in the Right to Life as provided for in the Article 21 of the Constitution of India. However, the Supreme Court made it clear that it is not an absolute right. Person suffering from venereal disease has a suspended right to marry till he is cured of the disease. The Court held:

> The emphasis, therefore, in practically all systems of marriage is on a healthy body with moral ethics. Once the law provides the "venereal disease" as a ground for divorce to either husband or wife, such a person who was suffering from that disease, even prior to the marriage cannot be said to have any right to marry so long as he is not fully cured of the disease. If the disease, with which he was suffering, would constitute a valid ground for divorce, was conceaded by him and he entered into marital ties with a woman who did not know that the person with whom she was being married was suffering from a virulent venereal disease, that person must be injuncted from entering into marital ties so as to prevent him from spoiling the health and, consequently, the life of an innocent woman. (Mr. 'X' v. Hospital 'Z', AIR 1999 SC 495).

In the same case, dwelling on the right of a person to lead a healthy life, and therefore to be informed of the health condition of his/her prospective spouse, the Court further held:

> As a human being, Ms. Y must also enjoy, as she, obviously, is entitled to, all the Human Rights available to any other human being. This is apart from, and, in addition to, the Fundamental Rights available to her under Article 21, which, as we have seen, guarantees "Right to Life" to every citizen of this country. This right would positively include the right to be told that a person, with whom she was proposed to be married, was a victim of a deadly disease, which was sexually communicable. Since "Right to Life" includes right to lead a healthy life so as to enjoy all faculties of the human body in their prime condition, the respondents, by their disclosure that the appellant was HIV(+), cannot be said to have, in any way, either violated the rule of confidentiality or the right of privacy.
>
> Moreover, where there is a clash of two Fundamental Rights, as in the instant case, namely the appellant's right to privacy as part of right to life and and Ms. 'Y's' right to lead a healthy life which is her Fundamental Right under Article 21, the RIGHT which would advance the public morality or public interest, would alone be enforced through the process of Court, for the reason that moral consideartions cannot be kept at bay and the Judges are not expected to sit as mute spectators of clay in the Hall, known as Court Room, but have to be sensitive, "in the sense that they must keep their fingers firmly upon the pulse of the accepted morality of the day."

Further, the Court, considering Sections 269 and 270 of the Indian Penal Code, held that these statutory provisions impose a duty upon the appellant not to marry as the marriage would have the effect of spreading the infection of his own disease, which obviously is dangerous to life, to the woman whom he marries. The said Sections provide:

> "269. Negligent act likely to spread infection of disease dangerous to life – Whoeve unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both.
>
> 270. Malignant act likely to spread infection of disease dangerous to life – Whoever malignantly does any act which is, and which he knows or has reason to believe to be likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both."

(iii) The Right to Employment

The Right to Employment is also a very important human right. Some provisions pertaining to this right which form a part of the International Bill of Human Rights are:

Article 23 (1) of the Universal Declaration of Human Rights –

> Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

Article 6 (1) of the International Covenant on Economic, Social and Cultural Rights –

> The States Parties to the present Covenant recognise the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and will take appropriate steps to safeguard this right.

The Constitution of India, in its chapter on the Directive Principles of State Policy, directs the State to make effective provision for securing the right to work. The chapter on Fundamental Rights provides for non-discrimination with regard to opportunity in public employment. The Constitutional provisions to this effect are:

Article 16 (1). There shall be equality of opportunity for all citizens in matters relating to employment or appointment to any office under the State.
Article 16 (2). No citizen shall, on grounds only of religion, race, caste, sex, descent, place of birth, residence or any of them, be ineligible for, or discriminated against in respect of, any employment or office under the State."

The Bombay High Court, in *MX of Bombay Indian Inhabitant v. M/s. Z.Y, AIR 1997 Bombay 406*, addressing a question as to whether it is permissible for the State under our

Constitution to condemn a person infected with HIV to virtual economic death by denying him employment, held:

> "... The rule providing that person must be medically fit before he is employed or to be continued while in employment is, obviously, with the object of ensuring that the person is capable of performing his normal job requirements and that he does not pose a threat or health hazard to the persons or property at the work place. The persons who are rendered incapable, due to the ailment, to perform their normal job functions or who pose a risk to the other persons at the work place, say like due to having infected with some contagious disease which can be transmitted through the normal activities at the work place, can be reasonably and justifiably denied employment or discontinued from the employment inasmuch as such classification has an intelligible differentia which has clear nexus with the object to be achieved, viz., to ensure the capacity of such persons to perform normal job functions as also to safeguard the interests of other persons at the workplace. But the person who, though has some ailment, does not cease to be capable of performing the normal job functions and who does not pose any threat to the interests of other personsat the work place during his normal activities cannot be included in the aforesaid class. Such inclusion in the said class merely on the ground of having an ailment is, obviously, arbitrary and unreasonable. ... the impugned rule which denies employment to the HIV infected person merely on the ground of his HIV status irrespective of his ability to perform the job requirements and irrespective of the fact that he does not pose any threat to others at the work place is clearly arbitrary and unreasonable and infringes the wholesome requirement of Article 14 as well as Article 21 of the Constitution of India."

The Supreme Court of India, in Mr. 'X' v. Hospital 'Y' AIR 1999 SC 495, held:

> The patients suffering from the dreadful disease "AIDS" deserve full sympathy. They are entitled to all respects as human beings. Their society cannot, and should not be avoided, which otherwise, would have bad psychological impact upon them. They have to have their avocation. Government jobs or service cannot be denied to them as has been laid down in some American decisions.

Subject to certain reasonable restrictions, which are expedient in the larger public interest, the HIV/AIDS patient has all the rights. These include the right to life, the right to health, the right to education, the right to freedom of expression, the right to movement, the right to equality etc. Merely on the ground that a particular person is suffering from HIV/AIDS, he/she cannot be denied any of the rights available to human beings.

DIS 2N.4

HIV/AIDS in India – Church's Responsibility

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Introduction:

The first case of HIV was detected in India in 1987. In the last 15 years, the epidemic has spread rapidly all over the country. Today India has about 4 million HIV positive people. If this trend continues, India will be the leading country with HIV infection in the world in the near future.

Impact of HIV/AIDS

HIV/AIDS increases the mortality and morbidity rates of the affected communities. It will increase the infant and under five mortality. The number of orphans will increase. It also produces emotional trauma and discrimination among the infected individuals.

HIV/AIDS also has an economic impact. The work force of the country will be affected as young adults are affected. National budget on Health care is likely to increase as the demand for care of HIV infected individual's increases. It is likely that the country will loose all the economic gains that it has achieved and slide back in development. Poverty worsens inequality and increases human rights abuses.

Trends in HIV spread:

89% of infections occur among the sexually active and economically productive age group of 18-40 years. 25% of HIV positive patients are women. The disease has not spared children. The virus infects about 30,000 newborn children. At least 120,000 children rendered orphans by the epidemic.

There are certain differences between the epidemic in India and in the Western world. The HIV virus seen in India belongs to clade type C, in the west it is clade

B. In contrast to the West, heterosexual transmission is the commonest mode of infection. Incidence of HIV associated with blood transfusions is decreasing. The incidence of HIV transmission from Mother to child is increasing in the country. Intravenous drug abusers are one of the sources of HIV transmission in the Northeastern regions of the country. From being, a disease of the urban areas and of groups that indulged in high-risk behaviours it has now become a disease that is seen among the rural areas as well as the general population

Factors that Influence the spread of the disease in India:

The behaviour of people puts them at the risk for developing disease. General awareness of the disease and its mode of spread are low in the community. Incidence of reproductive tract infections as well as sexually transmitted disease is high. Changing social behaviours patterns due to the influence of the media and the peer pressures leads to risky sexual behaviour.

Gender inequality and poverty also contribute to the spread of the infection. Large population of migrant workers tend to have high-risk behaviour when they are away from their families. Economic necessity and gender inequality render sex workers vulnerable to acquire the infection. In the Northeastern regions of our country intravenous drug abuse also contributes. In a study conducted by NIMHANS at Bangalore, alcohol abuse was one of the factors that increased the risk for acquiring the **infection.**

Abuse of blood and blood products as well as unsafe blood banking practices also contributes. Similarly, poor antenatal facilities also contribute to spread of infection.

Efforts by the Government to combat the spread of the infection in India:

Governmental efforts in prevention

With the advent of the infection, the central Government set up a National AIDS Committee in 1986 and launched the National AIDS control programme in 1987. In 1992, the Government formulated a new programme and changed the committee into a National AIDS control organisation (NACO). It also formulated a policy that involved a multi sectoral approach and with the involvement of Non-governmental organisations (NGO) to control HIV/AIDS in the country.

NACO implements its policies as well as its activities through the different State AIDS Cells/societies in the states. Its activities involve programme management, surveillance, research, information, education and counselling activities. It also undertakes initiatives to ensure safe use of blood, reduction of Sexually transmitted disease (STD's), condom promotion and undertakes interventions that can reduce the impact of the disease.

Efforts by the Catholic Institutions:

The Catholic Hospital Association formulated an HIV/AIDS policy in 1997. It has been conducting various training programmes and interventions through its members. Catholic hospitals have been in the forefront of providing care for the HIV/AIDS patients in the country. Catholic colleges have actively taken part in the University programmes on AIDS control. Some schools have made HIV/AIDS classes as part of the curriculum. These efforts have not been coordinated and consistent to have an impact on the epidemic in the country.

Preventive measures and Catholic Institutions role:

Measures to prevent the spread of HIV involve both medical as well as social interventions. Combination preventive strategies that involve multiple

interventions that work synergistically will reduce the incidence of the disease. Hence, there is a need to have inter sectoral collaboration within the church.

Medical interventions

Medical interventions like voluntary testing and counselling will increase the awareness of the need to reduce high-risk behaviour as well as bring the disease into open. Catholic hospitals with their holistic approach to health care are in a better position to implement this intervention. There is a need to strengthen personnel in the hospital by conducting training programmes.

Provision of safe blood transfusions has reduced the incidence of HIV transmission through this route. Implementation of strict laws by the Government has ensured this achievement. Catholic Hospitals working in rural areas may not have access to a safe blood transfusion. We need to look at this problem pragmatically and find solutions.

Providing treatment for opportunistic infections as well as for the HIV patients in the institutions will reduce the stigma as well as provide care for the patients. Though catholic Hospitals are doing a wonderful job on this front, there are still some institutions that do not provide care. The major hurdle has been the attitude of the staff. To change this attitude, there is a need to provide training programmes for all categories of the staff. The administration also needs to be strict to combat the attitude.

Control of sexually transmitted disease by prompt treatment of STDs can lead to risk reduction. Prompt reporting of the cases to the governmental authorities will ensure better statistics as well implementations of preventive measures in the community.

Catholic hospitals are renowned for Mother and Child health services. We should build on these strengths. Provision of HIV counselling, testing antenatal mothers and providing antiretroviral therapy will definitely reduce the transmission as well as the impact of the disease. There is an urgent need to explore this intervention so that we can make a definite dent on the disease.

Programmes that reduce alcohol as well as intravenous drug addiction will definitely make an impact. Many hospitals have de-addiction programmes in place. Provision of needle exchange programme in these de-addiction programmes will go a long way in reducing the spread of the disease.

Provision of universal precaution and safe disposal of wastes will not only protect our staff but also help the environment.

Social Interventions

Social interventions involve general interventions as well as interventions that target specific vulnerable groups in the community. Knowledge is power and an individual should have the knowledge about the disease so that she can protect herself. Our educational institutions can play a vital role. The knowledge about HIV/AIDS should be incorporated in the school curriculum. It must begin in lower classes (3rd or 4^{th} STD) and the content must be increased gradually. The theme in the lower classes must be that we have to protect our body against all sorts of harm. In the higher classes, sex education should be made a part of the curriculum. To implement this type of curriculum, teachers need to be trained to handle issues with sensitivity. Colleges can introduce seminars and awareness programmes.

At the parish level, youth groups can take up awareness programmes. To reduce the stigma as well as increase awareness churches can celebrate an 'AIDS day'. Awareness of HIV and its prevention should be a part of every marriage counselling. Family education and support services need to be strengthened at the parish level.

Social welfare schemes that are run by the church can help to reduce the spread of the disease. Increasing the economic capacity and local employment can prevent migrations. These schemes can also be used to spread awareness in the community. Targeted intervention programmes may be a little difficult to implement by the church institutions. There are groups that work in the prisons, among street children and among marginalised people. They can have AIDS prevention activities.

Working with certain high risk groups can lead to moral and ethical dilemmas in catholic institutions e.g. AIDS prevention work among sex workers. We are comfortable in providing rehabilitative measures for sex workers but AIDS prevention has to be conducted with active sex workers. Similarly, dilemmas arise when working with drug addicts and gay men. We need guidance from the church authorities.

Impediments to effective prevention work:

The attitude of the institutions is a major impediment for implementing AIDS awareness programmes. That needs changing. We need training programmes to train health personnel as well as teachers. Institutions that can offer this type of training need to be identified.

Drugs are essential to prevent mother to child transmission as well as to treat HIV infected patients. Intervention programmes need dedicated staff and there must be provisions to provide for salaries. All of these need money.

The church institutions get support form internal resources. Huge amounts are available through external funding for AIDS awareness programmes. Institutions need to tap these resources. Catholic institutions do not tap Governmental resources. We should shed our inhibitions and approach the government for funding. We need a resource centre that can help our institutions to write good proposals. This centre should also inform institutions about the sources of funding that are available.

Ethical dilemmas that arise in the course of AIDS awareness programmes need to be addressed. At present, people grapple with these dilemmas privately as well as approach local resources. We need a body that will address these issues from an all India perspective. The CBCI should take an initiative in this regard.

Advocacy has been one of the important aspects of HIV/AIDS epidemic. Bringing Human rights abuses to notice as well as empowering the marginalised members of the society needs a powerful advocacy at all levels. Church with its social organisations is eminently suited to take up these issues.

In the states that have a high prevalence of HIV a large number of catholic institutions are present. Catholic institutions can definitely make an impact on the HIV epidemic in India.

HIV/AIDS Surveillance in India
(as reported to NACO)
As on 30th June, 2003

AIDS CASES IN INDIA	Cumulative	This Month
MALES	39466	329
FEMALES	13705	87
Total	53171	416

RISK/TRANSMISSION CATEGORIES

	No. of cases	Percentage
Sexual	45435	85.45
Perinatal transmission	1455	2.74
Blood and blood products	1409	2.65
Injectable Drug Users	1309	2.46
History not available	3563	6.70
Total:	**53171**	**100.00**

Age group	Male	Female	Total
0 - 14 yrs	1252	777	2029
15 - 29 yrs.	12231	6289	18520
30 - 44 yrs.	22957	5880	28837
> 45 yrs.	3026	759	3785
Total	39466	13705	53171

S. No.	State/UT	AIDS Cases
1	Andhra Pradesh	3707
2	Assam	171
3	Arunachal Pradesh	0
4	A & N Islands	27
5	Bihar	152
6	Chandigarh (UT)	733
7	Delhi	807
8	Daman & Diu	1
9	Dadra & Nagar Haveli	0
10	Goa	194
11	Gujarat	2660
12	Haryana	271
13	Himachal Pradesh	112
14	Jammu & Kashmir	2
15	Karnataka	1707
16	Kerala	267
17	Lakshadweep	0
18	Madhya Pradesh	996
19	Maharashtra	9234
20	Orissa	82
21	Nagaland	331
22	Manipur	1238
23	Mizoram	50
24	Meghalaya	8
25	Pondicherry	157
26	Punjab	248
27	Rajasthan	751
28	Sikkim	8
29	Tamilnadu	24667
30	Tripura	6
31	Uttar Pradesh	983
32	West Bengal	930
33	Ahmedabad M.C	267
34	Mumbai M.C	2404
	Total:	**53171**

DIS 2N.5

HIV/AIDS: ETHICAL RESPONSE OF THE CHURCH

Thomas P. Kalam, CMI, St. John's National Academy of Health Sciences, Bangalore

1. Christ's View of Illness: Basis for Christian Ethical Response to HIV/AIDS

Christ's view on illness as expressed in two *loci* in St. John's Gospel can form the basis for a Christian ethics of HIV/AIDS:

> John 11:4: "This illness does not lead to death; *rather it is for God's glory*, so that the Son of God may be glorified through it;" and,
> John 9:3: "Neither this man nor his parents sinned; he was born *blind so that God's works might be revealed in him*.

In the same vein, HIV/AIDS can be considered from a Christian perspective as, "for God's glory, so that the Son of God may be glorified through it" and "so that God's works might be revealed."

The central question should be how God's power and compassion might be seen at work in this pandemic.

So many millions being HIV positive is a tragedy; so many billions not being positive about HIV is a greater tragedy.

It was St. Iranaeus who pointed out long ago: "The glory of God is a human being who is fully human and fully alive." The human being seems to be God's proudest boast in the whole of creation. HIV/AIDS seems to be yet another occasion and call to live the human to its fullest possible realisation.

It is in this context that one must appreciate the response that the Church gave to the HIV/AIDS pandemic by helping to institute a Chair at IGNOU for "Family Life Education" in the context of HIV/AIDS. The Health Commission of CBCI and Dr. Gracious Thomas of IGNOU deserve the all the appreciation for this wonderful gesture.

2. Ethics of HIV/AIDS: Casuistry vs. Life affirming

Ethics of HIV/AIDS cannot afford to be confined to casuistry, though as Enda McDonagh rightly points out that it is a useful instrument in detailing Christian moral response to a range of difficulties.

- Clean needles for recovering drug addicts
- condom for protecting the non-infected partner
- obtaining consent before testing for HIV/AIDS, the right to refuse treatment
- Physician's duty to treat HIV/AIDS patients
- Patient's right to confidentiality with regard to HIV status

may all be important issues that must be addressed. They however should not be allowed to dominate the ethics of HIV/AIDS.

Ethics, as the science of what a human being ought to be on the basis of what he/she is (Marc Oraison) promotes the art of living the fullness of human life. Ethics of HIV/AIDS must be developed with reference to this ultimate aim of achieving the fullness of life and thus the glory of God. All those principles, which enable people who live with HIV/AIDS and all others to achieve greater fullness of life, should form the ethics of HIV/AIDS. Therefore HIV/AIDS must be considered as

a "moral booster!" For, HIV/AIDS touches all the important existential variables of human life:

> "The AIDS epidemic has rolled back a big rotting log and revealed all the squirming life underneath it, since it involves, all at once, the main themes of our existence: sex, death, power, money, love, hate, disease and panic" (Edmund White, U.S. author. *States of Desire: Travels in Gay America* (1980; "Afterword— AIDS: An American Epidemic," added to 1986 ed.)

3. HIV/AIDS: not God's Punishment for Sin

In our effort to formulate a Christian ethics of HIV/AIDS, one conjecture that must be ruled out at the very outset is the view that HIV/AIDS was sent by God to punish people for their violations of Christian moral values. This theological conjecture seems to be blatantly unscientific, blasphemous and self-righteous. *Unscientific*, because there is no decisive proof that any moral depravity was at the source of HIV being introduced to human organism. This virus can be transmitted in different ways, moral, immoral and amoral. It is primarily an epidemiological issue rather than a moral one. *Blasphemous*, because, the God whom Jesus of Nazareth revealed, is a God of mercy and compassion, not of condemnation. His main interest lies in the conversion and healing of human beings and not in their destruction and punishment. The God whom Jesus reveals is diametrically the opposite to such a God of vindictiveness. Sadly such a revengeful God is still presented at times under the guise of the 'Good News' preached by the Catholic Church. As Kevin T. Kelly says: "We cannot present such a God of condemnation and then dare to claim 'This is the Gospel of the Lord'." *Self-righteous*, because it is doubtful that all who are not infected with this virus can honestly claim that they have been upholding the Christian values they would like to assume that those HIV positive human beings have supposedly violated. Moreover, it is a fact that many people living with AIDS can be more accurately described as the *victims* of the injustice and oppression of others rather than as people whose immoral life-style has brought this tragedy upon themselves (e.g. women and children). The most despicable sin that Jesus abhors in the pages of the Gospels is not adultery or prostitution; it is self-righteousness.

The Church has been blamed for lack of enthusiasm in these preventive and educative measures regarding AIDS, especially because of moralisation due to the prejudice at the initial stage that it was the violations of the moral teaching of the Church that brought about this scourge. "The slow-witted approach to the HIV epidemic was the result of a thousand years of Christian malpractice and the childlike approach of the Church to sexuality," wrote Derek Jarman, British filmmaker, artist, author, in his *At Your Own Risk: A Saint's Testament,* "1980's" **(1992).**

The society at large has been blamed of politicisation of this disease, and the efforts at prevention and education have become handicapped through this politicisation.

As Dennis Altman, Australian sociologist wrote: "Both the Moral Majority, who are recycling medieval language to explain AIDS, and those ultra-leftists who attribute AIDS to some sort of conspiracy, have a clearly political analysis of the epidemic. But even if one attributes its cause to a micro-organism rather than the wrath of God, or the workings of the CIA, it is clear that the way in which AIDS has been perceived, conceptualised, imagined, researched and financed makes this the most political of diseases." *AIDS in the Mind of America,* Ch. 2 (1986).

It is time that the Church stops moralising HIV/AIDS and sees it as a human problem. It is time for the society to de-politicize HIV/AIDS and accord it all the urgency it deserves.

4. Different ways in which HIV/AIDS becomes an occasion for the promotion of fullness of life:

a. **By celebrating life when it is disrupted by HIV/AIDS:** HIV/AIDS presents a situation the actual nature of fullness of life is related to the concrete context its ultimate brokenness. This was the message of Calvary where, when human life was overcome with pain, desperation and hopelessness, Jesus continued the celebration of life: ""It is completed" (John 19:30). The cross on Calvary remains the symbol of the ultimate hope in a hopeless human life.

b. **In the positive living of people with HIV/AIDS:** Often people get healed through their diseases. It is true also in the case of HIV/AIDS. At a conference on AIDS in Bangkok a certain Krishna, comparing 32 years of his life as HIV negative and 6 years of his life as HIV positive, stated confidently that it was like night and day: 32 years of night and 6 years of day in his life.

Anthony Perkins, (1932–92), U.S. screen actor made this statement published posthumously in *Independent on Sunday* (London, Sept. 20, 1992): "I have learned more about love, selflessness and human understanding in this great adventure in the world of AIDS than I ever did in the cut-throat, competitive world in which I spent my life."

To illustrate what it means to 'live positively with HIV/AIDS', let me quote from a book by Noerine from Uganda entitled *We Miss You All* where she is explaining its meaning:

> "Living positively with AIDS. The public health messages were saying: "Beware of AIDS. AIDS kills", "You catch it and you are as good as dead." There were no messages for those people who were already infected. What was implied was that people who were already infected should die and get it over. People with HIV and AIDS were seen as dying. We adopted the slogan of "living positively with AIDS. For us it was the quality rather than quantity of life which was important. Once infected with a deadly virus like HIV people need to take definite steps to enhance the quality of whatever life they have left. They must develop a positive attitude to life.
>
> Having a positive attitude to life means:
>
> - knowing and accepting that they are infected
> - knowing and understanding the facts about AIDS
> - taking steps to protect others from their infection
> - taking care not to expose themselves to further HIV infection or other infections
> - taking special care of their physical health and treating symptoms of ill health as soon as possible.
> - having access to emotional support
> - continued participation in social life
> - eating well and avoiding or learning to cope with stressful situations.
>
> This seemingly complex philosophy is attainable. Achieving positive living is a process, with ups and downs, in which we all need support. It is part of working through the various feelings that having HIV may bring: shock, denial, anger, bargaining, acceptance and hope. Counsellors, carers, and friends should learn to recognise this instability, and not be frustrated when progression through the stages

seems erratic, and we regress to former emotional reactions. We need to be accompanied through these stages by a sensitive, understanding friend who pledges to be there for us.

The question is whether as a Church we manage to 'live positively with AIDS.' The insistence here is on the giftedness and preciousness of time as appreciated by people who are living positively with AIDS and the deep sense of responsibility this engenders in them, as well as the desire to live the present as fully as possible.

c. <u>In the Cry of those with HIV/AIDS:</u>

The ability to cry for help is part and parcel of a life lived to its fullest. Life means not only the ability to give, but also the ability to receive gracefully. It is this cry which bonds together different lives. Ultimately, whatever is important in the life of a person are those gifts of life that were freely given to him/her. Human beings' ability to be open to the Grace that is bursting into life freely is one of the clues of fullness of life.

d. <u>In the Care given to people living with HIV/AIDS</u>

"One does not live by bread alone" (Matt 4:4). Human beings are sustained by fulfillment of needs which transcend the mere physiologial and security needs. People living with HIV/AIDS proclaim this truth loud and clear:

> As Amanda Heggs, AIDS sufferer said: ""Sometimes I have a terrible feeling that I am dying not from the virus, but from being untouchable." Quoted in: *Guardian* (London, 12 June 1989).
>
> Derek Jarman (b. 1942), British filmmaker, artist, author wrote: "I'm not afraid of death but I am afraid of dying. Pain can be alleviated by morphine but the pain of social ostracism cannot be taken away.." *At Your Own Risk: A Saint's Testament,* "1980's" **(1992).**

e. <u>In the efforts for positive action for prevention and education:</u>

It is evident that a response to HIV/AIDS in terms of practical charity demands effective action in the field of prevention and education. Prevention is not only better than cure, it a pre-emptive cure itself. Gratitude for the gift of life should not be limited to occasions when cure of diseases is experienced. Health itself is the most miraculous healing in life. Preventive measures, including education, are here seen as part of the ongoing celebration of the fullness of life.

5. <u>Ethical Conflicts regarding HIV/AIDS</u>

Ethical conflicts that arise in dealing with HIV/AIDS can be grouped under three areas:

1. IN DEALING WITH PEOPLE AFFECTED BY HIV/AIDS: This ethics should promote the care and treatment persons affected by HIV/AIDS should get; it should guarantee strong action to protect individuals against discriminatory treatment or any form of persecution or ill treatment; it should protect the dignity of the affected as human beings.

2. IN DEALING WITH THE GENERAL PUBLIC NOT AFFECTED: it should positively address the need to protect public health by helping to promote ways of preventing the spread of HIV/AIDS.

3. IN DEALING WITH ENHANCEMENT OF QUALITY OF HUMAN LIFE: it should enable everyone, both the infected and the non-infected to 'live positively' with this pandemic of HIV/AIDS. The quality of human life should be enhanced in the way we deal with HIV/AIDS.

In the matter of HIV/AIDS, the poles of ethical conflict are:

Public health	vs. Fundamental rights of an individual;
Utility (for many)	vs. Liberty (for the few).

On the one hand, there is for the affected individual the possibility of discrimination – of loss of employment or residence, a risk of public shunning, a possibility of psychological distress acute enough to lead to suicide.

On the other hand there is the concern for public safety: the right of the public to be protected against the disease.

Therefore, one has to strike a balance which, while protecting public health, will also protect individuals so that they will feel free to come forward for available treatment. Any one-sided and divisive approach that sets fundamental rights of individuals in opposition to public health, or vice versa, or which does not give hope to both the affected and non-affected cannot be considered as constructively ethical.

5. 1. Rights of Persons Living with HIV/AIDS to care and treatment:

Often persons living with HIV/AIDS face difficulty in obtaining access to quality care and treatment. Some health care professionals refuse to treat persons living with HIV/AIDS for their HIV-related illnesses; others refuse to treat patients with HIV/AIDS who consult them in connection with medical problems that are unrelated to HIV. At times they betray an attitude that HIV-positive persons are just not worth receiving quality, expensive medical care. Often there are prejudices within the medical profession, in particular against prostitutes, homosexuals, injection-drug users, and women.

The ethical questions here are: Do health-care professionals have a duty to treat patients with HIV/AIDS? Do people affected by HIV/AIDS have a right to have access to care and treatment?

Generally speaking the doctor has a moral duty to treat all patients, including patients with HIV/AIDS. This duty comes from the doctor's professional ethics which obliges a medical practitioner to treat all patients they are competent to help. This duty is also involved in the oath that every doctor takes at the beginning of his practice.

People with HIV/AIDS have the same right to health care and respectful treatment as any other person. The right to health is a fundamental right. HIV/AIDS patients are in no way excluded from this fundamental right. Health-care providers therefore have the obligation to provide that care, and it is unethical for any health provider:

(1) To refuse to care for any person who is HIV-positive or who has AIDS, or

(2) To make the care of any person contingent on that person having an HIV test.

Though the physicians have an obligation to treat patients with HIV/AIDS, this obligation does not seem to be unlimited. There are factors which might limit the

obligation. Some of such factors are, for example, excessive risks, questionable benefits, obligations to other patients, or obligations to self and family.

Another important issue is that, while one can assert a duty to treat, one cannot argue that the medical professionals or the general public have a duty to be not afraid. Similarly, one cannot coerce empathy or any other feelings or attitudes that are essential to the development of caring relationships between physicians and patients. It should come from an attitudinal change on the part of the health care professional. Therefore there is a need to stress the importance of education of health-care workers and institutions about:

- ☐ how to treat HIV,
- ☐ the risk (or absence thereof) of patient-doctor contact,
- ☐ and the methods of preventing transmission,
- ☐ their ethical and legal duties to provide care, and
- ☐ the existence of significant legal penalties.

5. 2. Futility of Discrimination Against People Living with HIV/AIDS

The core of the Universal Declaration of Human Rights is the postulate that all human beings have equal rights. Denying human rights to people affected by HIV/AIDS is denial of this fundamental right and thus discrimination.

How a government - local, regional, or national - chooses to confront the AIDS epidemic reflects its underlying interests, values, and systems, as well as those of the society it claims to serve. How a country treats its own people with AIDS and HIV - or those at risk for HIV - thus would reflect its general approach to human rights. HIV/AIDS thus becomes an acid test for a country and its government regarding its respect for human rights.

One of the tragedies of HIV/AIDS phenomenon is that persons living with it have to face death and discrimination at the same time. This discrimination is manifested in all areas of life - health care, housing, education, work, travel, etc. Often ignorance and prejudice are the sources of this discrimination. It is expressed in particularly harsh forms against the most vulnerable sections of the society: the poor, women, children, prisoners, and prostitutes among them , who are often identified with HIV epidemics. Whereas most illnesses produce sympathy and support from family, friends and neighbours, persons with AIDS are frequently feared and shunned by others. Prejudice, stigmatisation and even violence against those living with HIV/AIDS seem to be a world-wide phenomenon. As Amanda Heggs, AIDS sufferer said: "Sometimes I have a terrible feeling that I am dying not from the virus, but from being untouchable."[1] The late Derek Jarman, British filmmaker, artist and author wrote: "I'm not afraid of death but I am afraid of dying. Pain can be alleviated by morphine but the pain of social ostracism cannot be taken away."[2] The net result of this discriminative feeling is that it hinders our efforts to minimise pain of the patients and the transmission of HIV.

In the context of AIDS, respect for human rights and dignity of those affected by this malaise is not only an ethical and legal imperative, but the basis for our efforts to prevent the spread of HIV. If HIV infection leads to stigmatisation and discrimination, those affected will actively avoid detection and contact with health

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[1] Quoted in: *Guardian* (London, 12 June 1989).

[2] *At Your Own Risk: A Saint's Testament,* (1992).

and social services. The result will be that those most needing information, education and counselling will be "driven underground." There can no longer be any doubt that respect for human rights saves lives. Indeed, there has been a realisation that protection of human rights is a necessary component of HIV/AIDS prevention and care, and that health and human rights are inextricably linked. Discrimination hurts the fight against AIDS. Therefore the protection of the rights and dignity of HIV-infected persons is an integral part of the Global AIDS Strategy. In short, human rights of HIV/AIDS patients must be protected for the following reasons:

(1) because it is their fundamental right;

(2) because preventing discrimination helps ensure a more effective HIV prevention programme;

(3) because social marginalisation intensifies the risk of HIV infection; and

(4) because a society can only respond effectively to HIV/AIDS by expressing the basic right of people to participate in decisions which affect them.

The protection of the uninfected majority depends upon and is inextricably bound with the protection of the rights and dignity of the infected persons. As mentioned earlier: "If our society cannot take care of a few who are HIV/AIDS affected, it may not be able to save the many who are healthy."

Three different possible types of discrimination can be listed below in order to point out how it is counterproductive:

1. Against high-risk groups:

   It is meaningless, because, persons who do not belong to this category place themselves at risk through the sexual behaviour that they choose. On the other hand, others in the so-called 'risk groups' may well have chosen to behave in ways which do not place them at risk, whether abstinence or faithfulness.

2. Against HIV positive people:

   The ethical basis for non-discrimination is the ancient principle that equals should be treated equally - that distinctions should be made between people only on grounds which are morally relevant. The significant thing about someone who is HIV-positive is that, as a carrier of the AIDS virus, in specific situations, that person may be instrumental in bringing about the illness and death of another person. So if, for instance, within the closed and impcsed context of a prison, people are located in different places solely on grounds hat they are HIV positive or negative, it may be morally justified. It is, however, not a relevant ground for offering less exercise or worse facilities to them. In addition, since it would rightly be considered a breach of fundamental rights to make a person's medical condition a matter of public knowledge, it might be practically impossible to achieve such segregation without breaching this ethical principle, unless someone is proved to be intentionally trying to infect others.

   Within society at large, however, where people may choose their associates, such separation is in most cases unnecessary. HIV is not transmitted through social contacts. This means that discrimination in housing or employment against those who are HIV positive is unjustifiable.

3. Against people with AIDS

They must be protected from arbitrary shunning in work or housing as HIV/AIDS does not spread through social contacts. Therefore social discrimination towards them people is unjustifiable.

Some suggestions for combating HIV/AIDS-related discrimination:

- ☐ making changes in the area of human rights legislation and enforcement,
- ☐ creating a more supportive environment for persons living with HIV/AIDS as well as the groups most affected by the disease,
- ☐ strengthening anti-discrimination laws,
- ☐ expanding legal services,
- ☐ developing more rational insurance practices,
- ☐ educating health-care providers.

The importance of proactive responses that seek to identify the causes of discrimination and to deal with these before conflict arises, rather than reactive responses that depend upon those who are discriminated against seeking redress after the event, is to be stressed, including legislative responses, advocacy, public declarations by influential individuals or groups, proactive ethical approaches, educational responses.

The Question of HIV/AIDS and Insurance: Since a level of discrimination is the essence of insurance policy, especially of health insurance, it may be difficult to exclude testing and consequent exclusion of HIV-positive people from life insurance. Some sort of arrangements for the care of the AIDS patients should be one of the priorities of the government. Let us again remember what the Father of our Nation Mahatma Gandhi used to say (as mentioned earlier): "any legislation or government policy should first and foremost think about how it is going to affect the well being of the poorest and the most marginalised of citizen."

5. 3. The Right to Autonomy of HIV/AIDS Patients

HIV/AIDS patients, in so far as they are competent human persons, enjoy this basic right of autonomy:

- ☐ "The right to knowledge" and "the right to ignorance": with regard to understand what is happening to them: the right to knowledge about their condition, if they so desire; the right not to know what is happening to them, if they do not want to know.
- ☐ The right to know and accept what is being done to them with regard to the diagnostic and therapeutic procedures.
- ☐ The right to give informed consent
- ☐ The right to enjoy confidentiality

It is quite evident that this right is not an absolute right. The limit of a person's rights and freedom is another person's rights and freedom. In the context of the special nature of HIV/AIDS, let us see how the right to autonomy applies to the questions of testing for HIV, right to confidentiality, etc.

5. 4. The Question of **Testing**

The Ethical Advantages of Testing:

a. Testing can tell the person tested whether he or she is carrying the virus or not. This itself may be useful to the individual in two ways: first it informs the individual of whether or not to expect the onset of a serious illness, and second, it tells the person whether or not he or she is likely to transmit a lethal virus to another person by intimate contact.

Those who oppose testing tend to ignore this second extremely important function. As regards the first, they speak of a 'right to ignorance'. It is true that the news that one is suffering from something that may lead to fatal illness is bound to be unwelcome. Nevertheless the second function of this knowledge should override the right a person might otherwise be considered to have to maintain peace of mind through ignorance. This right becomes relevant in relation to proposals for testing the blood supply, or for conducting anonymous surveys designed simply to establish the extent of the spread of the virus in the population.

b. Testing can enable a medical professional to treat a person whose condition might otherwise be misunderstood. It can enable medical professionals to take appropriate measures to guard against infection in operating on or otherwise treating the person. It can also enable the medical professional to discover whether others are involved who might be at risk, in particular the spouse of a patient and to consider whether they are adequately protected.

c. Thus it is hard to justify a right to remain ignorant, unless indeed the desire to remain ignorant is combined with a willingness to behave as if one had been tested and the result was positive.

5. 5. Principle of Autonomy and Testing:

The principle of autonomy of the patient demands, however, that HIV testing should generally be undertaken only with the informed consent of the person being tested. This for two reasons: potential harms from testing, and respect for the autonomy of patients.

This, however, does not apply to the testing of donors of blood, organs, semen, or similar bodily products. In all cases of donations, ethical approach is that prospective donors should be informed before the performance of the test that an HIV-related test will be conducted, and given adequate information about the nature and purpose of the test.

This does not apply to testing performed as part of an anonymous HIV screening programme for epidemiological or research purposes, though.

5.6. General Principles for Testing: voluntary or mandatory:

There are several general principles that should guide consideration of all testing proposals:

- ☐ First, the purpose of testing must be ethically acceptable. Protecting public health and preventing transmission of HIV are acceptable purposes, while denying needed services and expressing disapproval of certain groups are not.

- ☐ Second, the proposed use of test results must contribute to the programme's goal.

- ☐ Third, the test programme must be the least restrictive or intrusive means for attaining the programme's purpose.

- ☐ Fourth, the benefit to public health must warrant the extent of intrusion into personal liberties. This principle does not suggest that

public health should be sacrificed in order to protect civil liberties, but only that an uncertain or minimal public health benefit should not be used to justify gross invasion of personal rights.

5. 7. The Question of compulsory Testing:

There have been repeated calls, however, for mandatory or compulsory testing of the entire population or of certain groups of the population, such as: pregnant women, new-borns, prisoners, persons accused or convicted of sexual assault, prostitutes, health-care workers and patients, and immigrants. Is it acceptable ethically?

It is true that compulsory testing can be justified ethically in some situations. For example, when a health care provider is at risk for HIV infection because of the occurrence of puncture injury or mucosal contact with potentially infected bodily fluids, it is acceptable to test the patient for HIV infection even if the patient refuses consent. When testing without consent is performed in accordance with the law, the patient should be given the customary pre-test counselling, though.

Mandatory testing programmes have been used in combating other communicable and sexually transmitted diseases, such as tuberculosis and syphilis. The conditions under which a mandatory testing programme is acceptable were defined by the World Health Organisation in 1968.

Though not all of these ten conditions are fulfilled in the case of HIV/AIDS. Nevertheless, world-wide, opinion about HIV-antibody testing has varied widely.

- ☐ There are those who recommend screening for all the population: their arguments seem to be irrational and are not based on scientific fact.
- ☐ Others show interest in screening targeted groups: the problem then lies in the choice of the groups and in the motives of that choice, which are often subjective.
- ☐ Last, there are those who recommend voluntary screening: they defend both human rights and scientific inquiry.

Which of these approach can be considered to be ethical by the Church?

We must remember that in the outbreak of HIV/AIDS, policy makers had to face a public health crisis of catastrophic proportions: the disease is fatal; no cure or vaccine exists. The number of infected people has been increasing at an alarming rate. These chilling facts and the public reaction to them made legislators want to do something, anything that can make a difference.

Initially, in the face of the HIV/AIDS epidemic, proposals for mandatory or compulsory testing were easy to understand. People naturally searched for concrete solutions, and the notion of mandatory testing – coupled perhaps with forced segregation of persons living with HIV or AIDS – had obvious superficial appeal. Calls for mandatory or compulsory testing became a common political response to HIV/AIDS, partly because they create the appearance of taking a strong stand against the threats of AIDS. Moreover, there were nagging doubts about the credibility of those who denounce forced testing. For example, how can it be better *not* to know who harbours the virus? Are those who reject forced testing trying to protect the individual rights of AIDS carriers at the expense of the public health?

Over the years, calls for mandatory HIV testing have never stopped. Motivated by a mix of emotions and ideologies, they have re-echoed, citing new research findings and targeting different populations. Let us examine the question of mandatory testing and its merits and demerits further.

5. 8. Screening the Entire Population:

Early in the epidemic, some even recommended that the entire population be mandatorily tested for antibodies to HIV. A popular misconception was that widespread or even universal HIV testing could identify all who carry the virus so that they could be isolated and the uninfected majority could be secure from any risk of transmission. However, wide consensus emerged that it would be a mistake to enact laws requiring the entire population to submit to testing: Concerns for protecting public health support this conclusion, just as concerns for protecting fundamental rights do; each goal independently militates against mandatory testing. In particular, it was pointed out that:

- ☐ even if universal testing could be carried out, it could not contain HIV: false negatives and persons still in the latency period ("window period") when testing was performed would not be detected; repeat testing would be necessary to remedy those errors, and in the meantime those undetected might continue to spread the disease;
- ☐ there is a danger that the "uninfected" population would feel a sense of security and not pursue precautions against infection, even though that population could not be entirely secure from HIV-positive persons;
- ☐ a universal or widespread testing programme does not represent a practicable approach because of the costs it would entail; and,
- ☐ the HIV-negative persons in the population are not in fact at risk from HIV-positive persons living in their midst: they can protect themselves against becoming HIV-positive by taking appropriate precautions.

5. 9. Testing of so-called "High-Risk Groups"

Recognising the problems raised by universal testing of the entire population, some have recommended that mandatory or compulsory testing be limited to members of the so-called "high-risk groups," in particular homosexuals, injection-drug users, and haemophiliacs and prostitutes.

However, such proposals were rejected on the basis that HIV is an indiscriminate virus that does not infect people along group lines: it is a high-risk activity, not identification with a group that is decisive in the transmission of the virus. In addition, it was recognised that a mandatory testing programme aimed at the so-called "high-risk groups" would face obvious problems in identifying members of the targeted groups: testing would be associated with stigma, and members of "high-risk groups" would be encouraged to go underground. Finally, mandatory testing of these groups would have intensified the sense polarisation of "us" and "them" – therefore increasing discrimination towards "them" and giving "us" a false and potentially dangerous sense of **security.**

5. 10. Testing Specific Populations

There is increasingly broad realisation that proposals for mandatory testing generally are political rather than health policy proposals. As more persons come to realise these facts and also become dedicated to taking AIDS seriously, they reject most of the proposals for testing for HIV by specific groups.

Because there are problems both with forced testing of the entire population and with testing of "high-risk groups," some have called for more targeted mandatory testing programmes. One or more of the following four factors seem to underlie the proposals for testing of certain groups:

- ☐ A perceived high risk of being HIV-positive;
- ☐ A perceived high risk of infecting others with HIV;
- ☐ Attribution of culpability due to involvement in criminal activity, so that being required to undergo the test can be considered a just component of punishment;
- ☐ Perception of some use that can be made of test results.

For example, some argued that testing should be required among prisoners, arrested prostitutes and drug users, and those who attend sexually transmitted disease- and drug-abuse clinics. In this view, these groups are not only at a high risk of infection, but they also pose a serious risk to the health of the community and are likely to transmit the disease to innocent, healthy members of society.

Each type of testing proposal raises a unique set of policy issues, and therefore it will be considered separately in section 6. 8. below. For example, proposals to test all pregnant women raise different concerns and implications from proposals to test all prisoners.

Mandatory or compulsory testing, whether of the entire population or of specific groups, is generally opposed because of the following reasons:

- ☐ Because of the potential for invasion of privacy and discrimination.
- ☐ Because of the stigmatisation and discrimination directed at HIV-infected people, individuals who believe they might be infected tend to go "underground" to escape mandatory testing. As a result, those at highest risk for HIV infection may not hear or heed education messages about AIDS prevention.
- ☐ Testing without informed consent damages the credibility of the health services and may discourage those needing services from obtaining them.
- ☐ In any testing programme, there will be people who falsely test negative – for example, because of laboratory error or because they are infected but have not yet developed detectable antibodies to HIV. Thus, mandatory testing can never identify all HIV-infected people.
- ☐ Mandatory testing can create a false sense of security especially among people who are outside its scope and who use it as an excuse for not following more effective measures for protecting themselves and others from infection. Examples are health care workers who do not follow universal precautions when all hospital patients are tested, and clients of sex workers who do not use precautions when they believe that all prostitutes are being tested.
- ☐ Mandatory testing programmes are expensive, and divert resources from effective prevention measures.

Other international organisations have made similar statements. For example, the Council of Europe adopted a recommendation stating that "in the absence of curative treatment, and in the view of the impossibility of imposing behaviour modification and the impracticability of restrictive measures, compulsory screening is unethical, ineffective, unnecessarily intrusive,

discriminatory and counter-productive."[3] The Joint United Nations Programme on HIV/AIDS (UNAIDS), in its 1997 Policy on HIV Testing and Counselling, also expressed its opposition to mandatory testing stating that "HIV testing without informed consent and confidentiality is a violation of human rights."

Finally, the International Guidelines on HIV/AIDS and Human Rights recommend that HIV testing only be performed with the specific informed consent of the individual tested, and that "exceptions to voluntary testing would need specific judicial authorisation, granted only after due evaluation of the important considerations involved in terms of privacy and liberty."[4]

This conclusion is consistent with WHO's Statement from the 1992 Consultation on Testing and Counselling for HIV Infection, which emphasises that "mandatory testing and other testing without informed consent has no place in an AIDS prevention and control programmes."[5] The Statement continues by saying:

> There are no benefits either to the individual or for public health arising from testing without informed consent that cannot be achieved by less intrusive means, such as voluntary testing and counselling.

Public health experience demonstrates that programmes that do not respect the rights and dignity of individuals are not effective. It is essential, therefore, to promote the voluntary co-operation of individuals rather than impose coercive measures upon them.

The following are the specific groups which are often referred to as useful candidates for testing:

i) Pregnant Women:

The legal and ethical background for HIV testing requires respect for the conditions of informed consent, pre- and post-test counselling, and confidentiality. As with any other patient, pregnant women and women who are intending to conceive need to fully understand the advantages and disadvantages of HIV testing before deciding to undergo the test. The discovery of a HIV -positive status has important implications for decisions to interrupt pregnancy, to take antiretroviral therapy should pregnancy continue, and to breastfeed – decisions which themselves are mostly voluntary in nature. Help must be given to meet the challenge of ensuring that all HIV-infected women who desire to continue a pregnancy are offered effective means to reduce the risk of HIV transmission to their babies while respecting the rights of all pregnant women, the majority of whom will not have HIV infection, to decide for themselves whether or not to be tested for HIV. Ever since the discovery was made that administration anti-retroviral therapy, such as Zidovudine (AZT), significantly reduces the danger of HIV transmission from the mother to the child, the clamour for compulsory testing of pregnant women has increased. Ethically, however, the importance must be stressed of allowing women to make decisions about testing as well as AZT use in a non-coercive atmosphere and based on the balance of the benefits and potential risks of the regimen to herself and her child.

ii) New-borns:

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[3] Recommendation No. R (89) 14 of the Committee of Ministers to Member States on the Ethical Issues of HIV Infection in the Health Care and Social Settings.

[4] HIV/AIDS and Human Rights – International Guidelines, recommendation 28(b).

[5] WHO, resolution WHA 45.35, 14 May 1992.

Unlike programmes directed at offering voluntary HIV testing and counselling to all pregnant women – coupled with voluntary treatment, if necessary – testing of new-borns does not have the benefit of substantially reducing the risk of transmission from mother to baby, except to the extent that a positive test might indicate a need to discontinue breastfeeding in order to prevent any further risk of transmission, assuming transmission has not already occurred. Therefore, it can been said that mandatory new-born testing is the wrong answer to the wrong question.

The right question is: How can we offer appropriate counselling to all women and engage them voluntarily to learn their HIV status? If they are HIV-positive, how do we ensure that they receive needed care for themselves and potential interventions to prevent transmission to their foetus and, finally, that they provide care for their infants? With appropriate resources given to education and health care, the desired goal of early identification and treatment of HIV-infected infants can be accomplished without mandatory new-born screening.

Women who tested positive during pregnancy (or before), as well as women who refused HIV testing during pregnancy, but are considered to be at risk by their health-care provider, should be asked to consent to testing of their new-borns. Refusals should generally be respected. Testing of an infant without the parent's consent may, however, exceptionally be justified in a few circumstances, when a court decides that it is necessary, effective and the least invasive and restrictive means available to achieve the aim of benefiting the infant. This could be the case, for example, when a physician has reason to suspect that a child suffers from an HIV-related illness, the parents' and the child's HIV status are unknown, the parents refuse to give consent to testing, and knowing the child's HIV status would be necessary to decide how the child's illness could best be treated.

iii) Prisoners:

It does not seem that their exists any public health or security justification for compulsory or mandatory HIV testing of prisoners, or for denying inmates with HIV/AIDS access to all activities available to the rest of the population. Rather, prisoners should be encouraged to voluntarily test for HIV, with their informed, specific consent, with pre- and post-test counselling, and with assurance of the confidentiality of test results. As do people outside prison, they should have access to a variety of voluntary, high-quality, bias-free testing options, including anonymous testing. Ensuring that HIV-related medical information remains confidential is particularly important in prisons because potential harms from testing for prisoners may be especially great because of the higher potential for stigmatisation and discrimination.

iv) Sexual Offenders:

Testing sexual offenders like rapists, by itself, may not best serve to assist victims of these offenders. It may provide some relief to victims, but programmes that include counselling, monitoring of victims' own health status, and emphasis on their own well-being may generate greater long-term benefits.

The issue of compulsory testing of persons accused and/or convicted of sexual assault has often been characterised as being one of choosing between the accused's rights and victims' rights. However, to attempt to characterise the choice whether or not to require HIV antibody testing of accused persons as being either pro-woman or pro-criminal tends to obscure the real complexity of the issue and the tangible needs of the survivor. In so doing there is a danger of manipulating the survivor's understandable feelings of

anger, frustration and fear in order to advance a position that ultimately will not help her.

There can be no question that persons convicted of sexual assault have committed a serious criminal offence – if compulsory testing could further some useful objective for the survivor of the assault, it might be appropriate to regard the convicted person's claim to autonomy as appropriately of less weight.

However, as demonstrated above, compulsory testing and disclosure of the test result to the survivor of a sexual assault provide little if any benefit to the survivor. Testing a person convicted of sexual assault cannot provide the survivor with useful information. At the time of conviction, she can find out whether she herself is HIV-positive by undergoing testing. In contrast, testing the offender would only provide her with information about the offender's HIV-status.

In contrast to persons convicted of sexual assault, persons *accused* of sexual assault are innocent until proven guilty. Therefore, it is not at all clear how compulsory testing could even be legally performed on them. Not having been convicted, testing could not be imposed as part of the punishment of the accused person. Merely having been accused of sexual assault is unlikely sufficient grounds to establish such a threat.

v) Commercial Sex Workers:

Laws under which prostitutes may be required to refrain from specific conduct, undergo specified treatment or counselling, submit to supervision, undergo treatment while detained, or, if infected with HIV, be detained, may be counterproductive. These compulsory measures will dissuade prostitutes to come forward for public testing for HIV infection. Moreover, clients are absolved of any responsibility for using precautions because the effect of the legislation leads them to assume that working prostitutes will be 'clean'.

Rather than such measures, interventions are necessary that would give sex workers the means to protect themselves against HIV transmission and would empower them to use them. This will also necessitate an analysis of the impact of laws regulating and/or penalising prostitution on efforts to prevent HIV infection.

The use of condoms must be evaluated in this context. The truth is that condoms are not considered to be sure means of prevention of the spread of HIV/AIDS. In the context of commercial sex workers continuing in their life style, however, it can be considered as part of harm reduction efforts.

vi) Health Care Workers:

Should health-care providers be required to undergo compulsory testing for antibodies to HIV; if positive, should they be excluded from practising, or required to disclose their HIV status to their patients?

The general opinion is against a position that would require testing for antibodies to HIV and restrictions on a wide range of health-care professionals, but equally against a position that would set no limits on health-care workers living with HIV/AIDS. The most appropriate way to frame the question is to ask how best can patients be protected against real risks, while not overreacting and excluding competent and safe practitioners. In order to best protect physicians as well as patients, the emphasis needs to be on strict adherence to infection-control practices rather than on efforts to detect who is infected. The emphasis given by political figures to protecting the patient from the HIV-infected health-care provider seems to misdirect

efforts and resources away from activities that would do the most to protect the health of the public - namely the procedures that emphasise good infection-control practice. HIV-positive health-care providers have saved and continue to save thousands of lives every year, and that excluding them from exercising their profession would endanger their patients' lives, and ruin the lives of thousands of dedicated medical professionals.

vii) Visiting foreigners:

It does not seem to be befitting human dignity and international etiquette to screen all the foreign visitors to our country for HIV status. For one thing, their 'foreigness' does not pose any health hazard to any one as far as HIV is concerned. Regarding visitors who are proven to be HIV positive the individual circumstances of each case should be taken into account, weighing the costs against the benefits of allowing a particular person to immigrate or to visit, and take humanitarian concerns into account.

Regarding foreign students who are going to be on scholarships, it is a different matter. Conditions can and should exist for qualifying for such privileges and people remain free to apply for them or not.

5. 11. Confidentiality:

The right to confidentiality is one of the important rights of the patient. The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.

The obligation to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities. Also, communicable diseases, suspected medico-legal cases, should be reported as required by law. If a physician knows that a HIV-positive individual is endangering a third party, the physician should, within the constraints of the law, (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third **party.**

These principles regarding confidentiality in general applies to HIV-related information as well.

The confidentiality of the results of HIV testing must be maintained as much as possible and the limits of a patient's confidentiality should be known to the patient before consent is given.

5. 12. Obligation to Report HIV status

Generally speaking, when reporting of both HIV and AIDS is necessitated by law, it should be done anonymously: nominal reporting is not warranted either for surveillance or for partner notification purposes.

Test providers, ethicists, public health professionals, technical experts and others have to develop a system that collects only the information necessary,

using unique or coded identifiers that ensure privacy and confidentiality of the individual. If it is not done in a way that the confidentiality is protected, the studies are going to totally biased because of the non-co-operation of the general public.

Also the communication media have to exercise a lot of self-discipline in this matter. The inhuman persecution that followed careless reporting by the communication media of some HIV/AIDS patients in our Country is well known. 'Do to others, as you would have them to do to you' has been the golden rule of ethics down the **ages.**

5. 12. 1. Partner Notification

When a married person is tested positive for HIV, should the medical professionals or authorities inform the partner about it? If the person is likely to infect the partner, certainly there is an obligation on the part of the medical professionals to divulge the information to the partner. Convincing the person to share this information with the partner would be much more effective and conducive to prevent the spread of the contagion.

It would be a better policy to inform each person who requests HIV testing and counselling, under which circumstances the partner will have to be notified in case the test proves to be positive.

While most agree that there are situations in which breaching confidentiality would be justified ethically, such breaches raise difficult questions: What will occur if it becomes generally known that clinicians breach confidentiality to protect third parties? Will patients cease to speak with candour about their behaviour? Will the public health suffer as a consequence?

Here we are facing an extraordinary irony: the ethics of the clinical relationship, which usually favours strict confidentiality, appear to dictate a breach of confidentiality in the matter of partner notification, while the ethics of public health, which are usually less concerned with confidentiality, may dictate a stricter adherence to it.

It would be more beneficial to analyse the reasons why a client refuses to tell his or her sexual partner about his or her HIV-positivity. Working through of deep-rooted issues of rejection, abandonment, loneliness, and infidelity may be more effective for prevention of the spread of AIDS rather than police–like reporting practices.

5. 12. 2. Confidentiality of HIV Status on Autopsy (post mortem) Reports

In the same vein, it is clear that health care professionals have a serious duty to maintain the confidentiality of HIV status on post-mortem reports. Physicians who perform autopsies or who have access to autopsy information regarding a patient's HIV status should be familiar with state law governing (a) the reporting of HIV and AIDS to public health authorities; (b) obligations to inform third parties who may be at risk for HIV infection through contact with an HIV-infected dead person; (c) other parties to whom reporting may be required like funeral directors, embalmers, etc. This includes reporting to organ or tissue procurement agencies if any parts of the decedent's body were taken for use in transplantation.

5. 13. Ethics of Legislation about HIV/AIDS

One of the responses to HIV/AIDS has been an "epidemic" of laws and policies enacted by many countries all over the world. These laws relate to public health, civil liability for HIV transmission, discrimination, homosexuals, sex workers and their clients, employment, injecting-drug-use, therapeutic and preventive goods (including

condoms, HIV test kits and injection equipment), the media, broadcasting, censorship, and privacy, etc. As early as May 1991, the World Health Organisation listed 583 laws and regulations concerning HIV infection and AIDS from different countries. To this, more than 170 laws from the United States had to be added.

The effectiveness of this legal response, however, has to be evaluated. In the words of one legal expert, this "juridical outburst," while it may have solved some problems, has caused the appearance of "a new virus, 'HUL' (=for Highly Useless Laws)."[6] It is generally agreed that many of the legal or policy responses to HIV/AIDS are useless and often can be harmful and counterproductive because, instead of being based on an understanding of the medical issues, medical research and its findings, they are driven more by fear and the resulting public demand for action. Some law makers, who show a willingness to practice demagoguery by placating or stimulating false and irrational fears through proposed enactments or decisions, often ignore established medical evidence.[7]

We know that the legal response to HIV/AIDS is important, but what should the legal response actually be? Legislation in this matter should be able to assist in strategies for the care and treatment of people with HIV and help to reduce the spread of HIV. The approach of the law in responding to AIDS should encourage the cooperation, confidence and trust of those infected and at risk by protecting their dignity and integrity.

There could be three main models through which the law can be incorporated into HIV/AIDS policy:

(1) The traditional proscriptive model that penalizes certain forms of conduct;

(2) The model that focuses on the protective function of the law and the need to uphold the rights and interests of persons living with HIV/AIDS; and

(3) A third model that seeks to use the law actively to promote the changes in values and patterns of social interaction that lead to susceptibility to HIV infection.

(1) A large number of countries have adopted provisions for compulsory reporting of HIV and AIDS, provided penal sanctions for knowingly spreading HIV, established procedures for mandatory testing for HIV, or enacted other proscriptive laws directed specifically at HIV/AIDS. The coercive nature of such laws, far from encouraging conduct that will reduce the spread of HIV, may actively impede prevention efforts by alienating those people who are at risk of HIV and making it less likely that they will cooperate in prevention measures. Lawmakers must be sensitive to not only the direct but also the indirect impact of legal sanctions. The particular dynamics of AIDS and HIV infection suggest that proscriptive laws will rarely be an appropriate policy response if they seek merely to target the conduct of people with HIV or activities that give rise to HIV infection risks. In this guise, the role of the law is a negative rather than a positive one, and the challenges of HIV/AIDS are such that an effective policy requires more than negative prohibition. Of all the different models the law can follow, the proscriptive model has the least scope for a creative application to policy formulation.

(2) The second model for the role of law in HIV/AIDS policy focuses upon how the law can protect people from discrimination, breaches of confidentiality, and other harmful and undesirable occurrences. This model has been of central importance in

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[6] Justice Kirby, at the Symposium international de réflexion sur le SIDA, Paris 22-23 October 1987; see also Kirby M. The New AIDS Virus - Ineffective and Unjust Laws. *Journal of Acquired Immune Deficiency Syndromes* 1988; 1: 304-312).

[7] see Hermann DHJ. AIDS and the Law. In: Reamer FG (ed). *AIDS & Ethics*. New York: Columbia University Press, 1991, 277-309

the context of the legal response to HIV/AIDS because of the proliferation of discrimination against people with HIV and because of the increasing recognition, both nationally and internationally, of the interplay between AIDS and human rights. Protective laws may help to enlist the support and cooperation of people at risk of HIV in prevention strategies. Decisive and firm legal intervention may be what is required in the context of measures to protect the rights of people with HIV.

(3) The third model for legal intervention mentioned above is the most controversial, but arguably may also be the most important. It operates on a broader and more far-reaching level and suggests that the law can play a proactive role not merely in mediating rights and obligations as between individuals but also in seeking to change underlying values and patterns of social interaction that create vulnerability to the threat of HIV infection. The challenge for HIV/AIDS policy is to recognise the need to address not only what might be called the 'HIV/AIDS-specific' issues, such as HIV education programmes and research into new barrier methods to prevent HIV transmission, but also the underlying social and economic factors that deprive individuals of the power to protect themselves against HIV infection. The law can be used as an instrument to provoke or reinforce the required changes, "as a sword rather than a mere shield." These interventions will require a creative approach to the law, which recognises that the law can play more than just a direct proscriptive or protective role. With such an approach, there is a real potential to use the law proactively and constructively in the response to HIV/AIDS.5.

5. 14. Criminalization of HIV Transmission

Whether or not the criminal law should be used to deal with the behaviour of persons living with HIV/AIDS who put others at risk of contracting HIV is one of the most hotly debated topics.

Any person who engages in any high risk behaviour knowing that he or she has been infected with the human immunodeficiency virus is certainly committing a criminal offence.

In attempting to "criminalize" certain behaviour by people infected with HIV, the criminal justice system at times tends to ignore the conclusions of public health officials. The strategy of some prosecutors of charging people with serious crimes for committing certain acts while knowing they are infected, discourages people from learning their HIV status and seeking diagnosis and treatment. Further, by attempting to charge people with serious crimes for actions that cannot transmit the virus, criminal justice system is undermining efforts to educate people about the real risk of transmission. There is a real risk that judges and juries will punish people not because they have committed dangerous acts, but because they are homosexuals or prostitutes or use drugs. These prosecutions also permit judges to punish people for being infected with HIV.

Amending the Criminal Code to create an HIV-specific offence should be done very cautiously. In particular this can send out a message that all persons living with HIV/AIDS are potential criminals, that the uninfected are potential innocent victims; and that one need not protect him/herself because the law is there to protect. The question is whether public health laws would not be better suited than criminal law to deal with those individuals who, knowing that they are infected, engage in behaviours likely to transmit HIV without using precautions and without previously informing their partners about their HIV status.

Many argue that traditional criminal laws are ill-suited to the context. They seem to be ineffective and inappropriate in dealing with conduct likely to transmit HIV. Unlike traditional penal laws, statutes made in many countries regarding HIV do not require proof of either "harm," "causation," or "state of mind": it is sufficient that the accused engaged in the forbidden behaviour - persons would commit a criminal offence if, knowing that they are HIV-infected, they engage in sexual intercourse **or**

other activities that could potentially transmit HIV, without previously informing their partner about their positive HIV status.

Some argue that that the threat posed by HIV is such as to require all reasonable measures of containment to be seriously examined, including the use of the criminal law. Anyone who knowingly engages in high-risk conduct and does not inform the other participant deserves condemnation, and the strongest way to express that condemnation is through the criminal law.

However, it must be pointed out that in this matter use of criminal law serves only a limited purpose. For example, in a case where individuals knowing they are infected choose to engage in behaviour that will likely lead to the infection of others, criminal prosecution for the purpose of punishment and deterrence can be justified . However, the use of the criminal sanction to punish and deter conduct likely to result in transmission of HIV may not lead to achieving the purposes of the criminal law and its efficacy in dealing with problems such as HIV transmission. Also, creating a provision that would deal only with HIV/AIDS, thereby singling out HIV/AIDS from other serious communicable diseases is blatantly unfair to HIV/AIDS patients. The principle concern here must be prevention through education and adequate information rather than the possibility of imposing penalties whenever they might appear necessary. The criminal justice system may not be an inappropriate mechanism through which to combat the AIDS crisis. Criminalisation of HIV transmission would encourage people to avoid testing, threaten the privacy of sexual relationships and encounters, and raise a risk of official harassment and abuse.

Even those who argue in favour of using the criminal law often concede that it has only a minor role to play in preventing the spread of HIV and that ultimately the major role will be played by education rather than coercion

5. 15.Ethics of Developing Drugs Against HIV/AIDS

In 1980s, when AIDS broke out, the system regulating the approval of new drugs underwent some changes, partly as a result of AIDS activism. There certainly was a conflict between the anxiety and urgency perceived by those seeking access to new drugs and treatments on the one hand, and scientific method, on the other hand. Both had their justifications and both sets of demands must be seen as legitimate. However, it is ethically very important to conserve the central points of the philosophy of drug regulation. Generally speaking drugs should not be licensed for marketing until they have proved safe and effective under proposed conditions of use. Any change in the process regulating drug approval should be at least consistent with, if not positively enhancing of, the ability to speedily conclude sound scientific evaluations of any new treatments. On the other hand, it can be said that people with life-threatening illnesses like AIDS or cancer have exceptional rights, and should be allowed access to experimental drugs before these have been formally approved.

Often the medical profession and patients become pawns in the hands of manipulative drug industry. As Barbara Ehrenreich, the US author wrote: "From the point of view of the pharmaceutical industry, the AIDS problem has already been solved. After all, we already have a drug which can be sold at the incredible price of $8,000 an annual dose, and which has the added virtue of not diminishing the market by actually curing anyone."[8]

[8] *The Worst Year s of Our Lives,* "Phallic Science" (1991; first published 1988).

The important tenets of a healthy drug-policy should prevail in order to remedy potential manipulations and exploitation by the drug industry of both the medical profession and the patients

5. 16. Drug Addicts and HIV/AIDS

Until the outbreak of HIV/AIDS, drug-addiction was considered in general as law and order problem, or a crime. The advent of the AIDS pandemic has fortunately turned out attention to the real nature of drug-addiction as a public health concern. A sensible strategy in dealing with drug-addiction would be to aim at harm minimisation, rather than total legal **prohibition.**

Instead of reaching out to the drug addicts with the healing touch that they require, often they were discriminated against and ostracised. A group that was often most in need of services was denied access or actively discouraged from accessing these services. Even more disturbing is that this treatment of drug-addicts seems so acceptable to society.

The existing drug laws in many countries negatively affect efforts to prevent HIV infection and to care for HIV-positive drug users. The drug users, rather than being offered easy access to treatment for both their drug use and HIV/AIDS, are being "driven underground." Existing laws and policies in many countries make it difficult to reach and educate them. It is because drug use is treated as a criminal activity rather than a health issue. They create a culture of marginalised people, driving them away from traditional social support networks. They foster a reluctance to educate about safe drug-use practices, for fear of condoning or encouraging the use of illegal drugs. They foster public attitudes that are vehemently anti-drug user, creating a climate in which it is difficult to persuade people to care about what happens to their fellow citizens who use drugs. They focus too much attention on punishing people who use drugs, thereby downplaying critically important issues such as why people use drugs and what can be done to help stop unsafe drug-use practices.

There can be no question that concern about HIV/AIDS, especially about the connection between the sharing of contaminated needles and the spread of HIV, is having an important impact on the course of drug-prevention policy. Many are officially embracing the so-called "harm-reduction approach" to drug use. Under this approach, the first priority is to decrease the negative consequences of drug use rather than its prevalence. Harm reduction "establishes a hierarchy of goals, with the more immediate and realistic ones to be achieved as first steps toward risk-free use or, if appropriate, abstinence". Some people fail to make a distinction between harm-reduction approaches and approaches advocating decriminalisation of drugs. But the difference is clear: a harm-reduction approach may or may not include the goal of decriminalisation of drug use, but, even if it does, this will only be one of many components of a strategy to reduce the harms from drug use, rather than its primary goal. Supply of clean needles should be seen in this context, and not in the context of promoting a permissive attitude towards drug use.

5. 17. Homosexuals and HIV/AIDS

Human Immunodeficiency Virus can spread through any intimate sexual contact, whether it is heterosexual or homosexual. The routes of contagion are usually used as a norm to demarcate HIV/AIDS population into two categories: *the guilty majority* and *the innocent minority.* Gay men, injection drug users and promiscuous men and women are supposed to belong to the first category, and haemophiliacs or transfusion cases to the second category.

The fact is that human immunodeficiency virus is the same whichever way it enters a human body. Its effects are also more or less the same for everyone. We may have

different moral or ethical convictions regarding different sexual orientations or addictions. Once a person is affected by HIV, it is unethical, though, to discriminate against him/her on the basis of our moral convictions about various sexual orientations and moral aversion towards addictions. The ethical duty of everyone is to reach out to those unfortunate fellow human beings with compassion and care.

Statements like *"All gay men have AIDS and are infectious,"* or *"Gay men are to blame for AIDS,"* or *"All drug addicts have AIDS and are infectious,"* are as absurd like statements like *"All heterosexuals have AIDS"* because AIDS can spread through heterosexual contacts too.

Often people with HIV infection or AIDS are not referred to as members of a single community or society to which we all belong, but as "them." This process of creating "Us" and "them" is called a process of "disidentification." This process of "disidentification" is inherent in all forms of discrimination. The truth is that one cannot discriminate against others and treat them in a way that one would find seriously harmful to oneself unless one can "disidentify" from them and consider them as somehow "different" from "us." HIV/AIDS is a good example of this. Most citizens are not involved in the AIDS fight: they are uninvolved because they do not perceive themselves to be at risk of infection; others are - they are different. Gay and bisexual men and intravenous drug users represent the "them" to a large majority of the population. Persons infected, or perceived to be infected, with HIV are regarded as alien and threatening. This is one of the most unethical attitudes that is condemned in the Sacred Writings of all the religions in our country, and this attitude can be described as one of **"self-righteousness."**

5. 18. Prostitution and HIV/AIDS

Usually public health initiatives and media accounts emphasise the role of prostitutes as people who infect others rather than people who are infected by others. People do not seem to be concerned about whether prostitutes themselves get infected from their clients and die. The only discussion is whether they transmit the virus to their male customers, who then pass it on to their 'innocent' wives and children. All over the world, prostitutes are being made the scapegoats for heterosexual infection. This scapegoating is taking place in the context of a general viewing of women as vectors for transmission of the disease to their male sex partners ... and their babies. Laws were introduced to protect the interests of prostitutes' clients, considered to be potentially innocent victims of AIDS, at the expense of prostitutes, on whose side guilt is deemed to lie.

Certainly, there is a legitimate community interest in regulating, and in some places controlling and prohibiting, prostitution.

Earlier we have dealt with the question of mandatory testing directed prostitutes, and suggested alternative ways of reducing the spread of HIV among prostitutes and to their clients. The main reason against targeting prostitutes for forced testing is that it simply won't work as a prevention strategy, because it will drive them underground. The attitude of compulsory measures, which focus exclusively on prostitutes, but not on clients, is evidently unjust and unethical.

Rather than coercive measures, as it was pointed out earlier in this Unit, interventions are proposed that would give prostitutes the means to protect themselves against HIV transmission and would empower them to use them, like the development of educational strategies for reaching prostitutes, giving them accurate information about the ways of preventing transmission, and supporting them in their efforts to utilise these measures consistently, provision of income and job training alternatives for those who wish stop working in the sex business, welfare payments, so that women aren't forced into prostitution by economic need, and for women who want to get off prostitution.

The importance of examining existing laws on prostitution was also recognised by the World Health Organisation, which held a consultation on HIV epidemiology and prostitution in 1989. One of the recommendations put forward by the consultation was to organise a meeting "with appropriate representation from the international legal and civil rights communities" to address issues such as "laws which impinge on social, economic, and legal rights of prostitutes and therefore impede HIV prevention efforts."[9]

5. 19. Women and HIV/AIDS

The HIV/AIDS pandemic highlights plight of human beings who are victims of the world's most pervasive inequality - women. The HIV epidemic seems to have taken the age old the sexual, economic and cultural subordination of women and translated it into a death sentence for women. The virus exposes the vulnerability of women, leaving them powerless to protect themselves against infection. The response to the epidemic should not fail to recognise that the disadvantaged status of women is the cause of their vulnerability to HIV and should not refuse to permit the rights and needs of women to play a part in shaping HIV strategies.

The most striking feature in dealing with women and HIV/AIDS is that it deals with women as mothers or as future mothers, and comparatively rarely about women as women and the many problems they face in dealing with HIV/AIDS.

As pointed out earlier, ever since the finding that administration of AZT to pregnant HIV-positive women can reduce transmission of HIV from mother to child, many people are advocating compulsory testing of pregnant women, women of childbearing age, and/or new-borns. The concern was and is the reduction of HIV transmission from mother to child, and the early detection of HIV infection in new-borns. Before the discovery of the effectiveness of AZT, the fear was that a compulsory screening programme among pregnant women would lead to advocacy for abortion, and would take women's reproductive choices away from them. We have dealt with the issue of testing pregnant women for HIV earlier in section.

The ethical issue here is that women who are not pregnant or of childbearing age find it difficult to access HIV testing. This raises the issue of whether there is less concern about the welfare of women than for that of their children or potential children. Provisions must be made that testing of women should always be accompanied by concurrent legal protection for them, such as anti-discrimination and informed consent laws, and it must be linked to the availability of early clinical intervention programmes to them.

Attempt to address the needs of women and children with HIV must, for reasons both ethical and pragmatic, be broadened to encompass more of the women's own health and support needs. Women must not only receive the message that health systems are interested in them only or primarily because of their children.

Woman's varying life situations should be systematically taken into consideration in the formulation of responses to the epidemic.

5. 20. Poverty and HIV/AIDS

Even poverty becomes a reality in relation to HIV infection - some people become poor because they have AIDS and people who are poor can be more at risk. When informed about the fatal nature of HIV infection, the statement that a poor man living below poverty line in India made was: "I prefer to die of AIDS than of poverty and famine." Especially in developing countries poverty seems to play a central causal role in AIDS epidemic. Therefore many see the relief of poverty as a key to prevention of HIV/AIDS, especially in these countries. It is true that programmes to

[9] Global Programme on AIDS and Programme of STD, 1989.

combat AIDS in the developing countries are inevitably drawn into the wider economic and social problems of the people with whom they are involved

It is true that AIDS has become a major political issue. It is good to an extent because action in national and international level can be promoted to combat the disease in the context of eradicating poverty. The unacceptable side effect of politicisation of HIV/AIDS, however, is that it tends to divide human beings some as privileged and others as underprivileged. The disease is often seen by many people, as an affliction of marginal groups. As a result, they tend to see the ethical and legal issues generated as essentially matters of fundamental rights: the marginal groups have to be protected against the discrimination that is prompted by their assumed connection with a lethal and incurable infectious disease. Here the responsibility to guard against the spread of infection here is considered to be the responsibility of everybody else, not of the victims. Others, perceiving the issue in terms of guilt and innocence, of morality and immorality, seeks solutions in legislation directed against the target groups. What is needed here is the necessity is to be united and have the fellow-feeling and a common sense of human vulnerability in dealing with **HIV/AIDS.**

DIS 2N.6

The Global Epidemiology of HIV/AIDS: Current and Future Trends

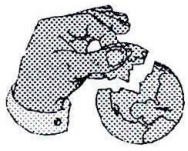
Presentation by Rev. Robert J. Vitillo
At Special Consultation of Bishops and Leaders of Major Health Organisations
Bangalore, India
August 8-9, 2003

Pandemic vs. Epidemic

- Pandemic: Global, encompassing.

*Global AIDS is a pandemic

*Epidemic: Occurs in one locale for a limited time.



*Specific countries and local areas have distinct epidemics of HIV.

Historical Lessons

- AIDS is comparable in magnitude to the worst and most tragic pandemics in human history, which have tended to infect 20%-50% of certain populations.
- Scarlet fever, plague, smallpox and typhus were respectively held responsible for the military loss of the Athenians, the destruction of the Roman Empire, the defeat of the Aztecs and Incas in the Americas, and the defeat of Napoleon at Waterloo.

Source: Steven Forsythe, "*Infectious Disease: historical lessons for the age of AIDS*," AIDS Analysis Africa 10(3) Oct/Nov 1999.

HIV/AIDS, malaria and TB: disease burden and mortality, 2000

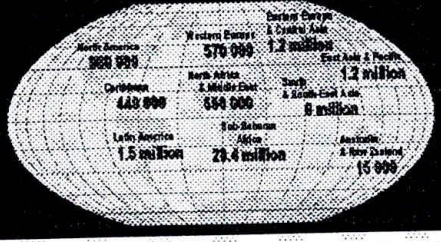
	Lost Healthy Life Years [HLYs] (millions)	Deaths (millions)
• HIV/AIDS	90.4 (54%)	2.9 (52%)
• Malaria	40.2 (24%)	1.1 (19%)
• TB	35.8 (22%)	1.7 (29%)

Global estimates for adults and children end 2002

People living with HIV/AIDS	42 million
New HIV infections in 2002	5 million
Deaths due to HIV/AIDS in 2002	3.1 million

UNAIDS

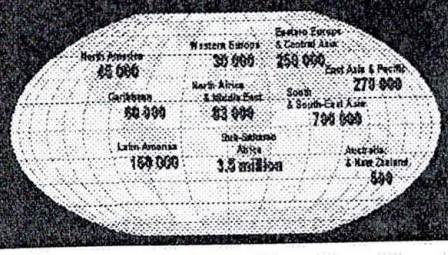
Adults and children estimated to be living with HIV/AIDS as of end 2002



Total: 42 million

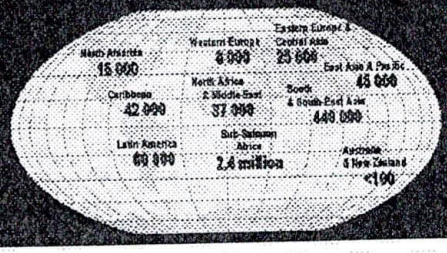
UNAIDS

Estimated number of adults and children newly infected with HIV during 2002



Total: 5 million

Estimated adult and child deaths from HIV/AIDS during 2002



Total: 3.1 million

About 14 000 new HIV infections a day in 2002

More than 95% are in developing countries

2000 are in children under 15 years of age

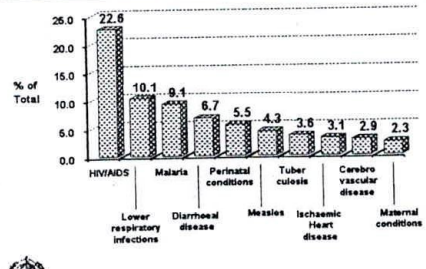
About 12 000 are in persons aged 15 to 49 years, of whom:

- almost 50% are women
- about 50% are 15–24 year olds

HIV in Sub-Saharan Africa

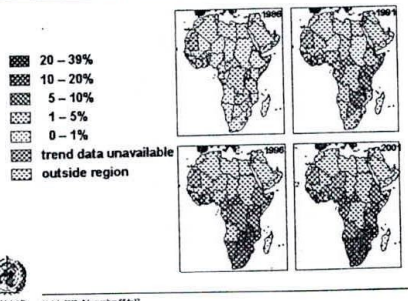
- By far the worst-affected region, sub-Saharan Africa is now home to 29.4 million people living with HIV/AIDS.
- Approximately 3.5 million new infections occurred in 2002, and 2.4 million died during that same time period.
- In 4 southern African countries, national adult HIV prevalence has risen higher than though possible, exceeding 30%
  - Botswana (38.8%), Lesotho (31%), Swaziland (33.4%), and Zimbabwe (33.7%)
- Food crises in the latter 3 countries are linked to the toll of HIV.

Leading causes of death in Africa, 2000



Source: *The World Health Report 2001*, WHO

HIV prevalence in adults in sub-Saharan Africa, 1986-2001



Historical Stages of HIV Spread in Asia and Pacific

- During the early to mid-1980s, there was extensive spread among men who engage in same-sex contact, especially in Australia, Japan, Malaysia, New Zealand, Singapore and Hong Kong
- During the mid- to late 1980s, high HIV prevalence was documented among other populations with high risk behavior (50% or more among female sex workers in Thailand and in parts of India, notably Mumbai)
- In addition, at the same time, there was HIV spread among Injecting Drug Users (IDUs) in Thailand, Northeast India, and the "Golden Triangle" area of China, Myanmar, and Thailand

Source: HIV/AIDS in Asia and the Pacific Region, World Health Organization, 2001

Historical Stages of HIV Spread in Asia and Pacific

- During the 1990s, in several South and South-east Asian countries (Cambodia, parts of India, Myanmar and Thailand), significant heterosexual transmission continued or was first noticed.
- An explosive spread of HIV occurred within IDU populations (levels of more than 50% within 1-2 years in several provinces of China, north-east India, Malaysia, Myanmar, Pakistan, Thailand, and Vietnam, Indonesia, and Nepal.

Source: HIV/AIDS in Asia and the Pacific Region, World Health Organization, 2001

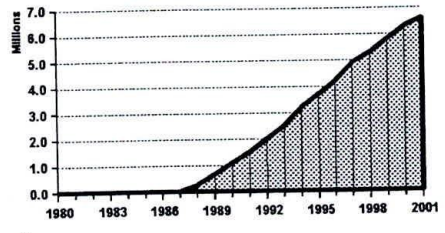
HIV/AIDS in Asia and the Pacific

- Almost 1 million people in this region acquired HIV during 2002 – a 10% increase since 2001 – bringing the estimated number of people living with HIV there to 7.2 million.
- China and India are experiencing serious, localized epidemics that are affecting millions of people.
- Although India's national adult HIV prevalence rate remains at less than 1%, it has an estimated 3.97 million living with HIV – the largest number in a single country with the exception of South Africa.

HIV/AIDS in Asia and the Pacific

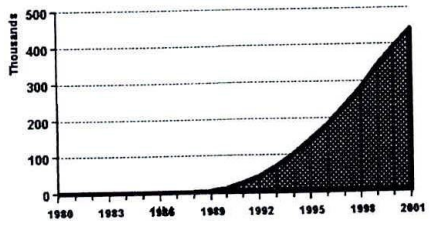
- The epidemic in China shows no signs of abating.
- Official estimates put the number of HIV-infected people there at 1 million; there was a 17% increase in new infections in the first six months of 2002.
- The country is marked by widening socioeconomic disparities and extensive migration (more than 100 million Chinese living outside their home regions) – these factors have strong influences on the spread of the epidemic.

Number of people living with HIV/AIDS in Asia: 1980-2001



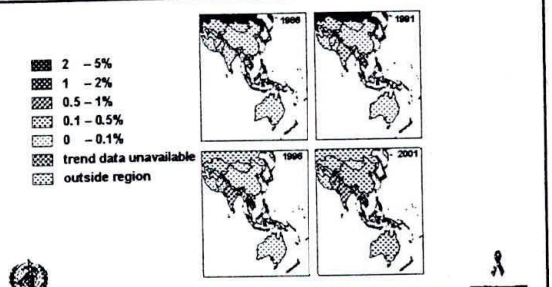
Source: UNAIDS/WHO, 2002

Number of people who died from HIV/AIDS in Asia: 1980-2001

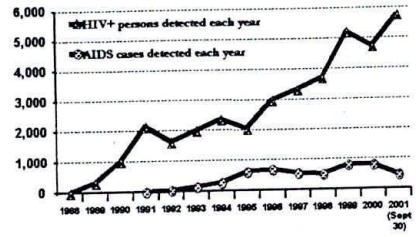


Source: UNAIDS/WHO, 2002

HIV prevalence in adults in Asia: 1986-2001

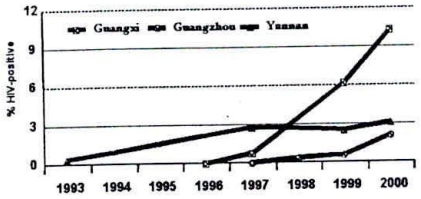


Annual number of persons diagnosed with HIV and AIDS in Myanmar : 1988 - end Sept 2001



Source: National AIDS Programme, Myanmar

HIV prevalence among sex workers in selected provinces in China: 1993-2000



National AIDS Programme, China (1993-2000). Data compiled by the US Census Bureau

Knowledge about HIV in China

- **One in every five Chinese does not know what AIDS is, according to the government of China.**
- **The State Commission for Family Planning conducted a survey of 7,000 people in different regions.**
- **71% of those interviewed did not know how HIV is transmitted.**
- **According to the Health Ministry there, some 22,500 people are reported to be HIV-infected in China, but this number is thought by some to be as high as 600,000. The government recorded 466 deaths due to AIDS since 1985.**

Potential for Increasing HIV Burden in Asia

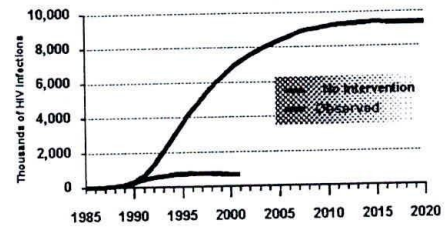
	% of World's Population	Distribution of Adult HIV Infection
Asia and Pacific	60%	18%
Sub-Saharan Africa	8%	70%

Some Causes for Grave Concern about HIV vulnerability in South Asia

- 54% of its population is under the age of 25 – the age of vulnerability for risk taking behavior
- There is ample evidence of sexual activity and of injecting drug use among young people
  - in Maharashtra, a study of adolescent, married people indicated that 48% of boys had engaged in premarital sex
  - in Nepal, HIV prevalence among IDUs increased from 2.2% in 1995 to nearly 50% in 1998
  - Thousands of children live and work on the streets – many abused, marginalised, unaware of HIV risk

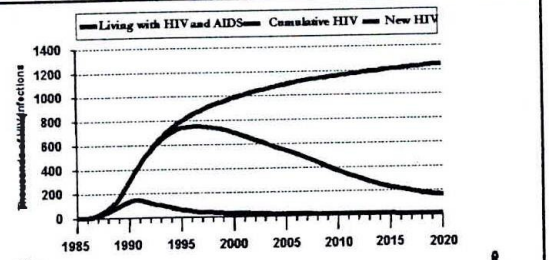
Success Stories

Scenario of the epidemic in Thailand had there been no intervention through 2020, and observed epidemic curve



Source: Division of AIDS, Ministry of Public Health in Thailand; Thai Working Group on HIV/AIDS Projection (2001)HIV/AIDS Projections for Thailand: 2000-2020

HIV infection in Thailand: 1985-2000



Source: Ministry of Health, Thailand

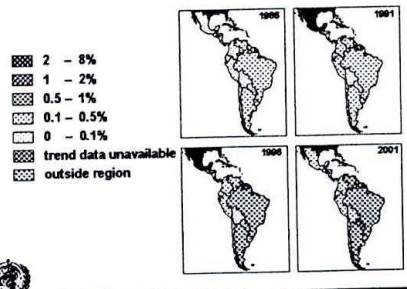
HIV/AIDS in Eastern Europe and Central Asia

- This region has the unfortunate distinction of having the fastest-growing HIV/AIDS epidemic. In 2002, there were 250,000 new infections, bringing to 1.2 million the number of people living with HIV/AIDS in this area.
- The Russian Federation has experienced an exceptionally steep rise in new infections, mostly due to transmission through injecting drug use among young people.
- Knowledge and awareness remains dismal among the wider population, the epidemic is beginning to spread more extensively.

HIV/AIDS in Latin America and the Caribbean

- An estimated 1.9 million adults and children are living with HIV in this region – this includes the estimated 210,000 people who acquired the virus in 2002.
- Among pregnant women, in twelve countries of the region, there is an estimated HIV prevalence rate of 1% or higher.
- In several Caribbean countries, adult HIV prevalence rates are surpassed only by the rates in sub-Saharan Africa – making this the second-most affected region in the world. Haiti is the worst affected in the region (est. 6% sero-prevalence) and Bahamas has a 3.5% sero-prevalence rate.

HIV prevalence in adults in Latin America and the Caribbean, 1986-2001



HIV/AIDS in the Middle East and North Africa

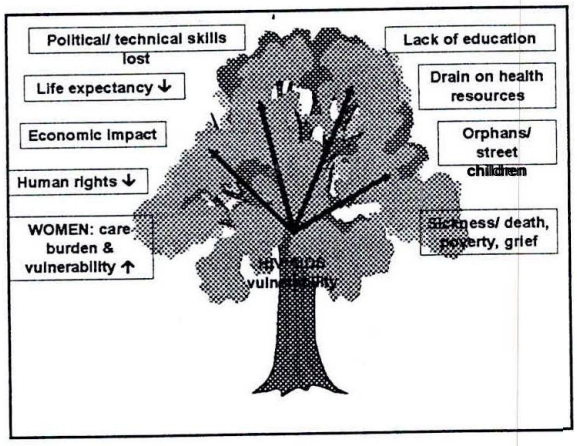
- Systematic surveillance is inadequate in this region, so it is difficult to deduce trends in HIV infection for the area.
- It is estimated that 83,000 acquired the infection in 2002 – bringing to 550,000 the estimated number of people living with HIV/AIDS.
- Significant outbreaks of HIV infection occurred among drug users in half of the countries of the region, notably in North Africa and the Islamic Republic of Iran.
- Other affected groups include men who have sex with men and sex workers and their clients.

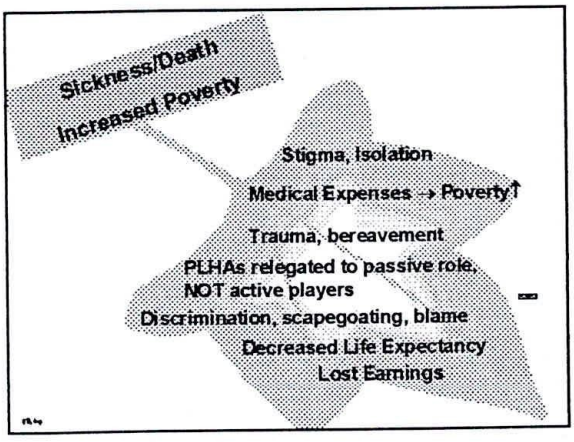
HIV/AIDS in High-Income Countries

- Approximately 76,000 people became infected during 2002, bringing to 1.6 million the number of people living with HIV/AIDS in these countries.
- The introduction of antiretroviral therapy since 1995/1996 has dramatically reduced HIV/AIDS mortality in these countries. About 500,000 people were receiving this therapy by the end of 2002.
- A larger proportion of new HIV diagnoses (59% between 1997 and 2001) in several Western European countries has been traced to heterosexual intercourse.
- Sex between men remains a prominent transmission root; the behavior change previously accomplished in this population is now a thing of the past.

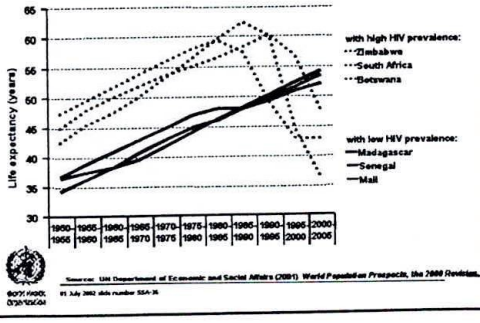
Predictions for the "Second Wave" of HIV

- Five countries – Nigeria, Ethiopia, Russia, India, and China – will be burdened with some 50 to 75 million people living with HIV.
- In Nigeria, life expectancy is expected to decrease to age 47, compared with 61 before the arrival of AIDS; and in Ethiopia, to 40, from 53 before the onset of disease.
- In addition to the increased health care costs, the burgeoning number of orphans due to the death to AIDS of one or both parents, other catastrophes forecast for these countries by 2010 include:
  - famines,
  - civil wars
  - economic reversals
  - collapse of social and political institutions



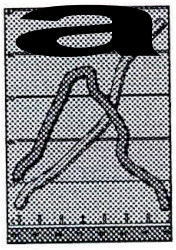


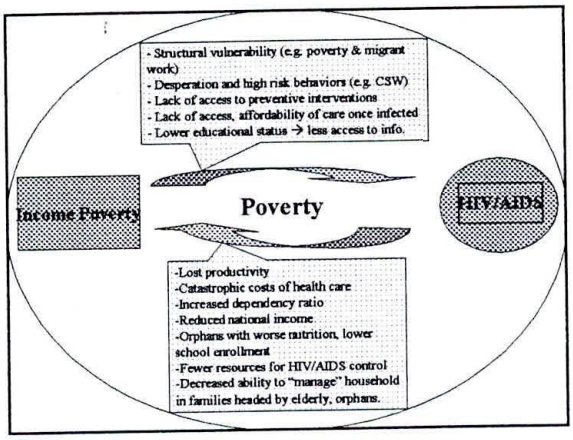
Changes in life expectancy in selected African countries with high and low HIV prevalence: 1950 - 2005



Impact on Population & Life Expectancy

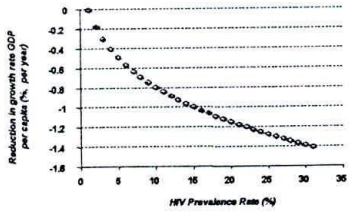
- U.N. Population Division estimates that the population of the 45 most affected countries will be 97 million smaller in 2015 and that the world population will be 480 million smaller by 2050.
- India alone will account for 47 million additional AIDS-related deaths and China will account for an additional 40 million such deaths.
- Life expectancy in Sub-Saharan Africa is the same as it was in tenth century Europe.





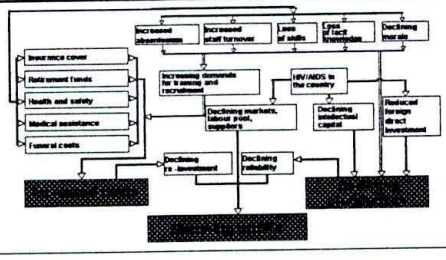
Economic Growth Impact of HIV (1990-97)

Figure 2: Growth Impact of HIV (1990-97) (80 developing countries)



Source: R. Bonnel (2000) Economic Analysis of HIV/AIDS, ADF 2000 Background paper, World Bank

The impact of HIV/AIDS on industries: an overview

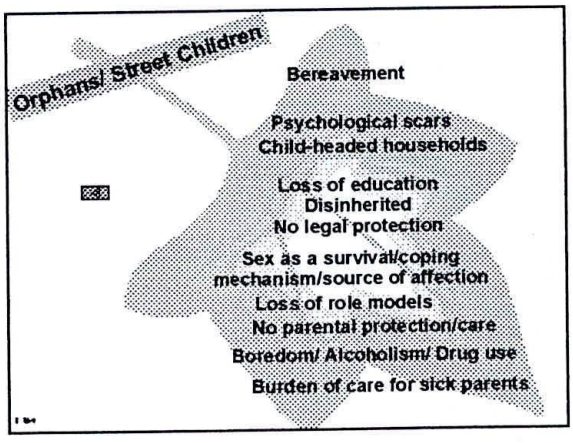


Source: UNAIDS (2000) Adapted from *The Business Response to HIV/AIDS: Impact and lessons learned*

AIDS in the family means increased costs, greater poverty

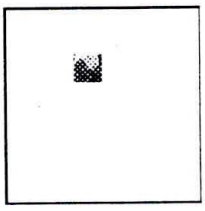
- **A study in Côte d'Ivoire indicated that health-care costs rose by up to 400% when a family member had AIDS.**
- **Households in both Thailand and Tanzania reported spending up to 50% more on funerals than on medical care.**
- **Research in Tanzania showed that individuals' food consumption dropped by 15% in the poorest households after the death of an adult to HIV/AIDS.**

Source: UNAIDS Barcelona Report, 2002.

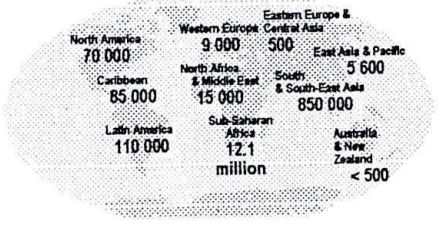


Orphans: A Lost Generation

- Numbers are large and growing
- Social support systems are overwhelmed
- Risk of a lost generation:
  - little or no education
  - poor socialization
  - social upheaval
  - economic underclass



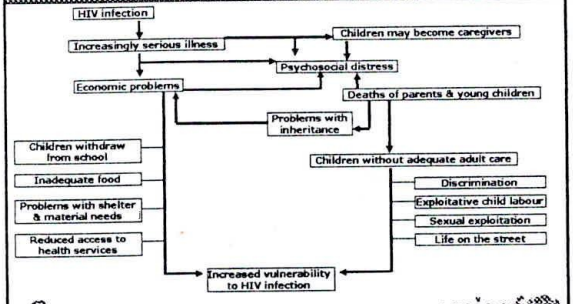
Cumulative number of children estimated to have been orphaned by AIDS* at age 14 or younger at the end of 1999



Total: 13.2 million

* HIV-negative children who have lost their mother or both parents to AIDS before the age of 15 years

Problems Among Children and Families Affected by HIV/AIDS

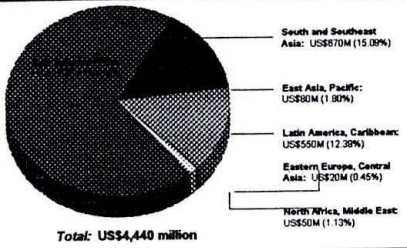


unicef

Drain on Health Resources

- Sexual health services (education, prevention, care, treatment, FGM, MTC, STDs, condoms)
- Screened blood/ transfusions
- Sterile equipment / needles
- Voluntary testing & counselling
- TB treatment & control
- Care of people with AIDS (Basic drugs, ARVs, MTC)
- Withholding routine treatments for people with HIV/AIDS

Projected annual expenditure requirements for HIV/AIDS care and support by 2005, by region



Total: **US$4,440 million**

UNAIDS

Source: Schwartländer B et al (2001) Resource needs for HIV/AIDS, Science

Lack of education

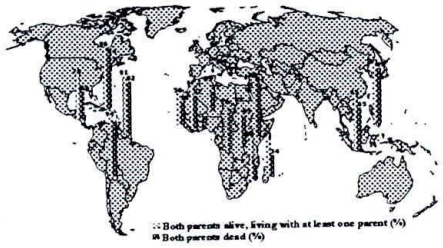
- Young people unskilled and unoccupied
- Future micro- & macro economic impact
- Myths & stigma
- Lack of knowledge about HIV/AIDS & other STDs
- Sex at earlier ages
- Pregnancy (+ MTC)

Education systems collapsing ...

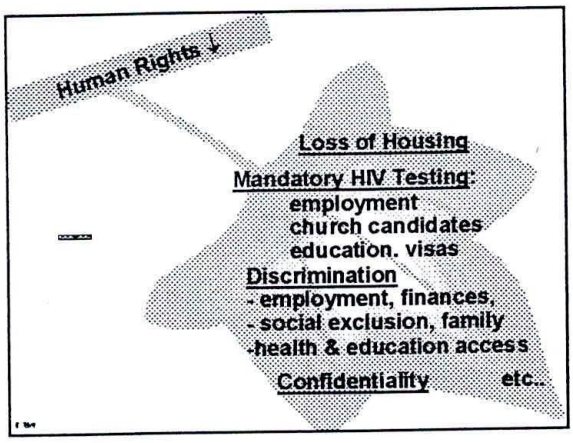
- **AIDS has an impact on both the availability and the use of schooling.**
- **In Central African Republic and Swaziland, school enrollment is reported to have fallen by 20% and 36% due to AIDS and orphanhood, with girl children most affected.**
- **In Guatemala, studies have shown that more than a third of children orphaned by HIV/AIDS drop out of school.**

Source: *HIV/AIDS: Implications for Poverty Reduction.* United Nations Development Program Background Paper prepared for the UN General Assembly Special Session on HIV/AIDS, 25-27 June 2001.

Percentage of children aged 10-14 who are still in school, according to whether their parents are alive: selected countries, 1997-2001



Source: UNICEF (1997-2001) Multi-Indicator Cluster Surveys; Macro International (1997-2001) Demographic and Health Surveys



Stigmatization and Marginalization

- **Studies in Côte D'Ivoire and South Africa show that, in places with extremely high HIV prevalence, women refused testing or did not return for their results.**
- **In southern Africa, a study on needle stick injuries found that nurses did not report the injuries because they did not want to be tested for HIV.**
- **In a study on home-care, fewer that 1 in 10 people caring for an HIV patient acknowledged the disease affecting their loved one.**

Stigmatization and Marginalization

- **Attempts to "cast out" those affected by HIV/AIDS - from villages, hospitals, educational institutions, and even faith communities - have been experienced in all parts of the world.**
- **Sadly, some priests and ministers have even refused pastoral care and church burial to HIV-infected.**
- **Many governments have enacted policies of forced isolation or restrictions of travel by HIV-infected.**

Pope John Paul II on acceptance of people living with HIV/AIDS

"God loves you all, without distinction, without limit. He loves those of you who are elderly, who feel the burden of the years. He loves those of you who are sick, those suffering from AIDS. He loves the friends and relatives of the sick and those who care for them. He loves all with an unconditional and everlasting love."

Given at Mission Dolores, San Francisco, CA (1989)

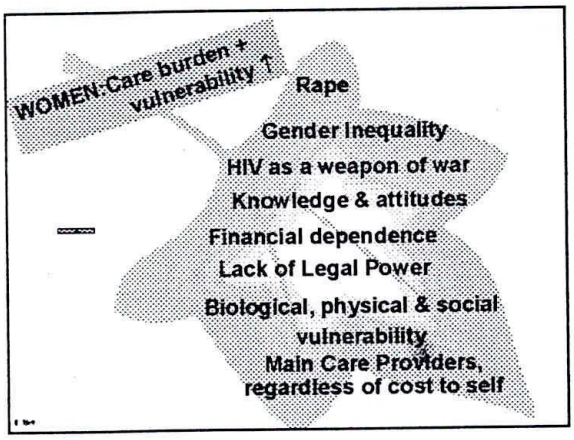
Privacy, Confidentiality, and Responsibility

- Many people, including some clergy, have the false concept that HIV could be spread by casual means and think that HIV-infected need to be publicly identified in order to avoid infection.
- Instead of adopting "universal" health care precautions - valid preventing spread of HIV and other blood-borne diseases, some health care workers think that HIV patients require special precautionary measures and thus disregard the patient's right to **confidentiality.**

Rights to Privacy and Confidentiality

"Every precaution should be taken to protect the confidentiality of records, files and other information about the HIV status of employees." *The Many Faces of AIDS: A Gospel Response*, U.S. Catholic Bishops' Administrative Board, 1987.

"No one may unlawfully harm the good reputation which a person enjoys, or violate the right of every person to protect his or her privacy. *Code of Canon Law*, #220.

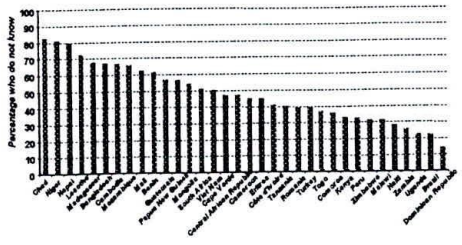


Women severely affected ...

- **Women are more vulnerable to HIV/AIDS because they have less secure employment, lower incomes, less access to formal social security, less entitlement to assets and savings, and little power to negotiate sexual contacts.**
- **They are more likely to be poorly educated and have uncertain access to land, credit, and education.**
- **Women-headed households are poorer and have less control over productive resources.**

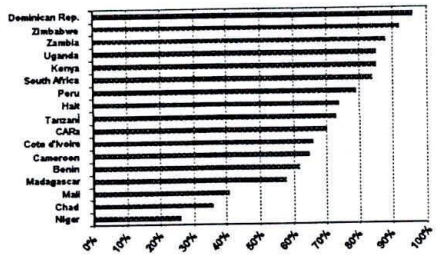
Source: *HIV/AIDS: Implications for Poverty Reduction*. United Nations Development Program Background Paper prepared for the UN General Assembly Special Session on HIV/AIDS, 25-27 June 2001.

Percentage of 15-19 girls who do not know that a HIV-infected person may look healthy, 1994-1999



Source: UNICEF, *DHS surveys and other nationwide surveys*, 1994-99.

Percentage of 15-49 year old women who are aware that HIV can be transmitted from a mother to her child, 1994-1999



Source: UNICEF, *DHS and other nationwide surveys*, 1994-1999

Pope John Paul II, in his Apostolic Letter, *Novo Millennio Ineunte,* at the close of the Jubilee Year 2000:

"Our world is entering the new millennium burdened by the contradictions of an economic, cultural, and technological progress which offers immense possibilities to a fortunate few, while leaving millions of others not only on the margins of progress but in living conditions far below the minimum demanded by human dignity. How can it be that even today there are still people dying of hunger? Condemned to illiteracy? Lacking the most basic medical care? Without a roof over their heads?"

Church looks at both individual and social values

Statement of Archbishop Javier Lozano Barragan at UN Special Session on AIDS July 2001:

"In many cases, HIV/AIDS implies problems also at the level of existential values; it is true pathology of the spirit which harms not only the body, but the whole person, interpersonal relationships and social life, and is often accompanied by a crisis of moral values."

Archbishop Javier Lozano Barragan continued...

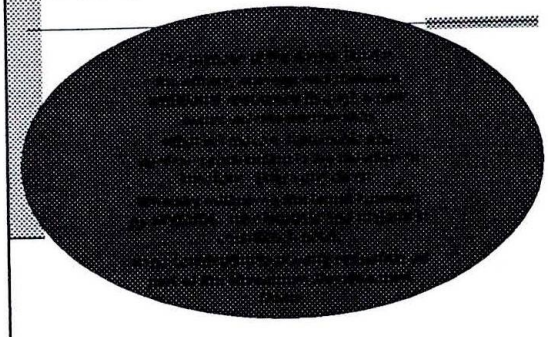
"An important factor contributing to the rapid spread of AIDS is the situation of extreme poverty experienced by a great part of humanity. Certainly a decisive factor in combating the disease is the promotion of social justice, in order to bring about a situation in which economic consideration would no longer serve as the sole criterion in an uncontrolled globalization."

'We just have to do some simple math to save the developing world!

- **Macroeconomist, Jeffrey Sachs, says that we could fight malaria, TB, and HIV, by providing medications, technology, and prevention funding to the poorest countries with only $27 billion per year; that is 1/1000 of the income of the "rich countries.**
- **Sachs maintains that we could save 8 million lives per year if the "rich world" were willing to set aside 10 cents on every $1000.**

Source: Source: *AIDS 2002 Today*, Newsletter of XIV International Conference on AIDs, 30 July 2002 and Jeffrey Sachs Senior Lecture at Barcelona, 11 July 2002.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

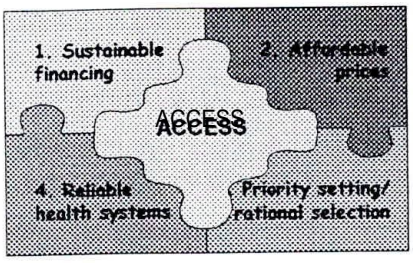


Source: Framework document from First Board Meeting, January 28-29, 2002

The Global Fund to Fight AIDS, Tuberculosis and Malaria – Progress to Date

- $866 million awarded over a two-year period
- To help fight the 3 diseases in 60 countries
- 60% of the money will be used to fight HIV/AIDS
- This will enable a 6-fold increase in the number of people in Africa being treated with combination anti-retroviral medications
- Thus it will ensure that more than 500,000 people in developing countries can have access to such medication.

Four factors underpin access to essential drugs- money is involved in each



WHO - EDM

67

Major Learnings at Present Stage of Pandemic

- The HIV/AIDS pandemic is still at an *early* development and its long-term evolution is still unclear.
- Some success in prevention activities (e.g., in Thailand and Uganda) has been achieved in particular countries - usually this has happened with a multi-sectoral approach and with active involvement of young people.
- A necessary component in this success has been community mobilization, including elimination of stigma, partnership between government and others in the community, and involvement of all sectors in the community.

Source UNAIDS Barcelona 2002 Report

Major Learnings at Present Stage of Pandemic

- Access to comprehensive care and treatment for HIV/AIDS is not an optional luxury in global responses - this must be made available in *all* parts of the world.
- It is crucial to address the economic, political, and cultural factors that render individuals and communities vulnerable to HIV/AIDS.
- While the lack of capacity and infrastructure must be addressed in developing countries, it should not be an obstacle to making comprehensive care and prevention available in all countries that show a commitment to an expanded response.

DIS 2N.7

CHAI's Effort to Deal with HIV/AIDS

Introduction about CHAI

The Catholic Health Association of India (CHAI) is one of the world's largest non-governmental organization in the health sector with about 3080 member institutions, which include big, medium and small hospitals, health centers and diocesan social service societies is fifty eight years old.

The members of the association extend health care facilities to the poor and the marginalised. These members are located in various parts of the country – urban, semi-urban, rural and tribal settlements. The member institutions are predominantly engaged in providing preventive, curative and promotive care.

The main thrust of CHAI was promotion of Community health for nearly two decades now. During the Golden Jubilee year CHAI evaluated its impact and brought out direction with which it has to be proceeded in the future. The priorities identified in the evaluation included reemphasizing the importance of promoting community health, decentralization of the organizational responsibilities towards its member institutions, continuing medical education with special emphasis on HIV/AIDS and Communicable Diseases.

Involvement with HIV/AIDS work

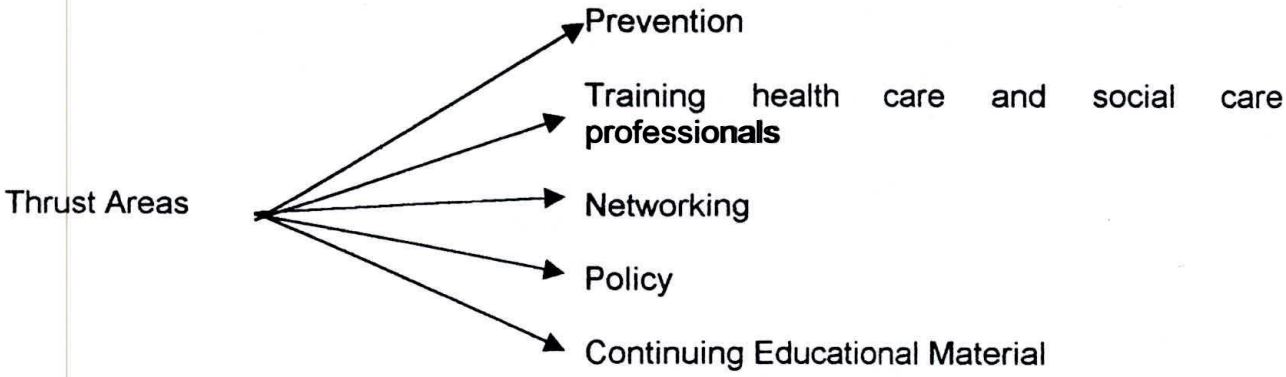
As HIV/AIDS was becoming a serious health and social problem, there was an urgent cry from all quarters of the church to respond to this grave situation. Since CHAI is the structural body responsible for health, everyone looked up to CHAI for guidance and direction on HIV/AIDS.

Milestones of CHAI's growth with specific focus on HIV/AIDS

1993	–	AIDS Desk was formed "Think-tank" group
1994		CHAI's Policy on HIV/AIDS
1995		CHAI's Plan on HIV/AIDS
1996 – 1997		Personnel from the member institutions were trained to plan and initiate actions in their regions
1998 – 2001		-Developed human resources in care and support -Networking with like-minded organizations for policy lobbying and advocacy.
2002 – 2004		The quality of life of the persons infected and affected with HIV/AIDS is enhanced through a process of specific interventions such as implementer's forum and promoting access to parallel system of medicine.

Specific Areas of Involvement

CHAI approached the situation at various levels



Prevention

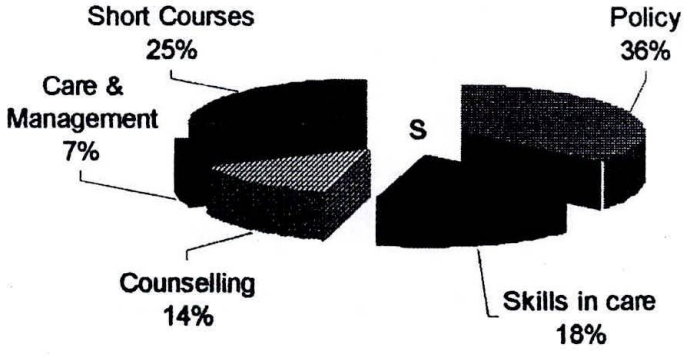
Prevention had been an utmost concern. CHAI had done pioneering work in the area of school health. Developed modules and innovative approaches for Life Skill Education in schools ad colleges with the collaboration of CRI in 1997- 1999.

Now we have been invited by Andhra Pradesh State AIDS Control Society to be the nodal agency for the school health programme in the state of AP for the non-government schools.

Training

Training of the health care personnel with specific skills on prevention, counselling, care and management. About 650 persons have been trained and about 50% of them are directly involved in giving care while others have initiated activities along with their ongoing work.

Training Programmes & Participants trained



Networking

Networking with church related institutions, NGOs and Government agencies – such as APSACS for the school health programmes "Life Skills Education" and Drop-in Centers".
TB and Malaria Control Programme through the regional units.
Training on microscopy through Government agency.
Collaborating and networking with other Churches for care and prevention – Community Health Watch Groups.

Policy

Consultations were organized at Regional and National level to form policies

1. *Common church policy*

Intensive efforts had been taken to network and collaborate with church bodies, church related institutions and NGO's to bring out a common church policy on HIV/AIDS. Prevention, care, management, counselling and training of personnel. This policy would be available in six months.

2. *Congregation and institution policy*

Policies to be made flexible to ensure that persons infected and affected are cared and supported. Consultations and discussions with 212 decision and policy makers of the member institutions were organized.

(St. Ann's of Luzen sought help in developing the policy and now they have started a center in Vijayawada, Andhra Pradesh for both men and women with HIV/AIDS).

Continuing Educational Material

Through our interventions, there was a felt need for scientific and updated information among our membership. Personnel who have been trained by us are updated with the recent developments with continuing educational material on HIV/AIDS and the concerns and issues. This material is sent once in four months.

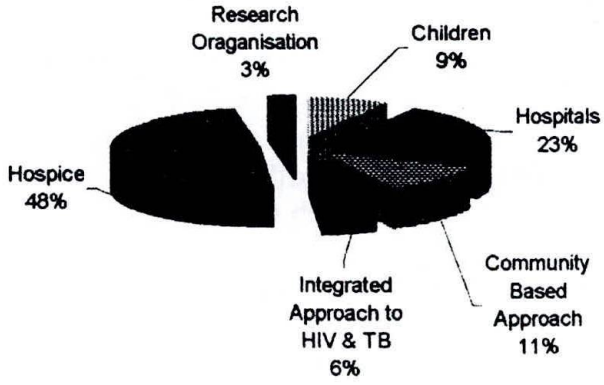
Impact

Nine years into HIV/AIDS work – we stop to look back and see if we have made a dent in the epidemic. Has our mission of Christian love reached to the forsaken one?

We feel content enough to say YES!! We made a dent in this epidemic through our love, service, and efforts.

The approaches and strategies used during the past nine years in the areas of prevention, training, networking, impact on the policies, and disseminating information enabled us to be instrumental in starting 35 organizations/ institutions in India for the care, support and management of persons infected and affected with HIV/AIDS.

Organisations working for HIV/AIDS



Back in 1993 when the challenge of HIV/AIDS was hurdled at us, there was not even a single church related institution for the care and support of these most neglected and rejected ones. But today we are glad to see 35 institutions giving these services. One young sister from Mumbai says that she feels it is enough if we can allow them to die in peace and dignity.

Institutional care has always brought criticism about the sustainability, feasibility and impact in the long run. However, when we look closely we found the impact the institutions have made:

- The institution facilitates acceptance in the community.
- The local community contributes in caring for persons with HIV/AIDS through volunteering to serve or meet their needs. Thereby through this process remove stigmatization.
- The organization facilitates to build back the lost relationships of the persons with their family and community.
- Promotes dignity of life.
- The experiences shared by our member institution working with HIV/AIDS have shown that institution/ organizations are instrumental in fostering community support in the course of time. (eg. Jyothi Terminal Care center)

The membership involved in HIV/AIDS works were initiated based on the needs of the people. The situation differs from state to state thus each organization is a unique model by itself. Some of them focus on children while others care for men and women.

Few approaches that have made difference.

Integrated Approach

Mukta Jeevan now has an integrated approach to communicable diseases. The pioneer institution by sisters of Helpers of Mary in Thane was started for the Leprosy patients. After the outbreak of HIV/AIDS as some of patients also are with HIV. The management

inmates who live as a family there. There are men, women and children with and without infections.

The families are supported to earn their livelihood through various income generation programmes. The children are sent to the local schools.

Community Involvement
Jyothi Terminal Care Center - A hospice was started two years ago in Mumbai has about 40 inmates. There was a stiff resistance from the local community. They have even requested the hospice to be shifted. However, over a period of six months, the community observed that the patients were cared by the caregivers without fear or stigma. The carers also started going into the community and sensitizing them. The response was overwhelming.

The organization is now run solely on local contribution, which even includes food, clothing and medicine. The local community takes care of the dead. They perform the last rites according to the patient's wishes. The women folk of the community volunteer their services in the kitchens. A place, which was started as a hospice, has generated such a large community response.

Implementers Forum
A forum of organizations is envisaged at regional level of the members involved in HIV/AIDS related work. The main aim of the forum is to:

- Training and enhancement of skill development
- Establishing linkages/network with others working for HIV/AIDS
- Collaborate for specific issues such as gender sensitivity, care and support
- Updating and sharing of resources - material and man power.
- Support and care of the caregivers.

Some of our *learning and challenges* over the nine years are:

- As India is a vast country having different cultural, the problems presents and the approach needs to different.
- A significant finding is that the training programme enabled the members to address the concerns of the HIV/AIDS.
- There has been an attitudinal change among the membership and a considerable shift in the policy regarding admission for treatment.
- Some of the membership has made a shift from institutional care to community based care, which is foreseen as a positive development towards the mainstreaming of the persons infected and affected with AIDS.

New initiatives

- Based on our learning, the new initiatives envisaged are:
- Implementers forums
- Integration of HIV/AIDS to communicable diseases
- Research and promotion of parallel system of medicine
- Training on care and management
- Research documentation

Through the initiatives

- We hope to evolve care and support from the community-based organization and providing basic care and counselling at home.
- To establish much stronger network with national and international agencies working in this field to mobilize a massive effort against HIV/AIDS to meet this challenge adequately, efficiently and effectively.

DIS 2N.8

Church's Response to the HIV/AIDS Pandemic in India: A Collective Catholic Action Against AIDS – A Proposal

Bishop Bernard Moras
Bishop of Belgaum
Chairman. CBCI Commission for Health

- Welcome!
- We are aware of the multifaceted faces of HIV/AIDS
- It is spreading with unprecedented rapidity
- It has devastating effects on the entire fabric of our society
- More than just a medical issue, it is a social, developmental & humanitarian issue
- We are aware of the combined efforts in other parts of the globe, especially by the Govt., the Church and other faith-based groups and NGOs
- The Church in India is involved in the prevention and care to a great extent

- But, now it is the most appropriate time to think together to design a strategic plan for a concerted action, as HIV/AIDS cases are rising at an appalling speed

1. OUR PERSPECTIVES

1. The Christian commitment to serve the sick has its mandate from Christ, the Divine Healer. (Lk 9:1; Mt 10:1). It is a call to serve with the same love and compassion of Christ in front of human suffering (Cf. Mk 1:41; Mt 20:34). It is a commitment to continue the action of Jesus, who came to give life and to give it in abundance (Cf. Jn 10:10). Our involvement in healthcare is Christ-centered and derives its inspiration and guidance for values and action from Jesus, the Master.

2. Service to the sick is an integral part of Church's mission (Cf. *Dolentium Hominum*, n.2). Our care, compassion and love towards those affected by HIV/AIDS are the expression of our faith in solidarity with them in their pain. Our service to them and to the members of their family is our genuine response as they are our sisters and brothers in Jesus the Lord, who is present in those who are suffering (Cf. Mt 25:45). "Those suffering from HIV/AIDS must be provided with full care and shown full respect, given every possible medical, moral and spiritual assistance, and indeed treated in a way worthy of Christ himself" (Pope John Paul II).

3. Our approach is guided by a precise and all-round view of human person "created in the image of God and endowed with a God-given dignity and inalienable human rights" (*Ecclesia in Asia*, 33). We do not approve any sort of discrimination or hostility directed against persons with AIDS, which is unjust and immoral.

4. What we aim is a collective response and an inter-sectoral approach. The Church is called to collaborate with national and state governments, international agencies and NGOs, in addressing the issues pertaining to HIV/AIDS. In our interventions we will adhere to the moral teachings of the **Church.**

5. Though we continue to concentrate on care and support of those infected by HIV, our priority will be the preventive approach with community participation. So, health education, awareness building, campaign for prevention, teaching of values for behavioural change etc. will be our strategy.

2. RELEVANCE OF OUR CONCERTED ACTION

i. Magnitude of the issue: Urgency, Prevalence of the Pandemic
ii. The gravity of the pandemic is still not properly assessed and understood
iii. Limitation of the existing isolated, diversified interventions
iv. Our personnel and facility is remarkable, yet not well coordinated, not sufficiently united
v. We need to have a common agenda, plan and policy

Therefore,

1. Intensification of our involvement,
2. Functional programme, system and structure
3. Coordinated, combined, scientific, collective and intensive intervention

3. HOW TO ACHIEVE THIS?

1. Intra-coordination
   - Actors within the Church

2. Inter coordination
   - Actors other than the Church

4. OUR STRENGTH

- National and 12 Regional Episcopal Bodies
  CBCI Commissions like Health, Youth, Women & Education Peace + Justice
- National Organizations / Associations
  Developmental: CMMB, Caritas India, CRS, IGSSS, etc.
  Health: CHAI, CNGI, SDFI, etc.
  Religious: CRI
  Social: ICYM, AICUF
- Academic Medical Faculties
  St. John's, Fr. Muller, Pushpagiri, Amala
  112 Nursing Schools
- Diocesan
  148 dioceses / 12 Regions 165 Bishops. 13,000 priests 90,000 professed religious
- Parish level 17,000 units
- Health / Educational / Social Institutions
  5000 units 100 Seminaries
  2-300 formation houses

32% of health personnel are catholics?
nurses - ?60%.

reach 200 mill pop.

20 mill catholics

5. AREAS OF INTERVENTION

A. Prevention

1. Facilitate a movement to address the issue
2. Awareness campaign in parishes, health and education institutions
3. Education for Prevention, esp. training in the authentic values of life, love and sexuality
4. Blood Transfusion
5. Issues like needle sharing, drug addiction
6. Prevention of Mother to Child transmission

B. Care and Support

1. Home-based / community care
2. Institution based
3. Care of care givers

C. Rehabilitation

D. Research

E. **Addressing social issues**: stigma, discrimination, misconceptions

Staff policies in church urgt.

6. FINANCE

- Mobilisation of funds
- Financial support: Govt. resources, NACO; CMMB, Caritas, IGSSS and other organizations; local resources.
- One Sunday collection can be devoted to this cause. A request can be made to the CBCI for this.

7. APPROACHES

1. Inter-sectoral
2. Advocacy and net-working
3. Collaborative

1. Inter Sectoral

- Greater involvement and participation of the church and church-related organizations and institutions in tackling the problem of HIV infection and AIDS in the country.
- Institutions of Communication, print and electronic media to involve in campaign and awareness building.

- To build linkages at all levels for overall support in enhancing the quality of life for people infected and affected with HIV/AIDS.

- Situating HIV infection and AIDS in the context of comprehensive health of the people and the emerging and re-emerging infections.

2. Advocacy & Net-working

1. Motivate different groups in the church to participate in these activities i.e. CRI, Religious Congregations, Parishes, Social work organisation .
2. Network with others to form a Forum.
3. Training and Re-orientation
4. Bring together practitioners at regional levels to reflect & design follow up
5. The policy of the Church developed could be integrated with other commission in the Church (Commission for Education; Youth; Women etc.)
6. Church could take initiative on education and health ministry regarding HIV/AIDS related awareness to Church personnel and at parish level.
7. No church organization should close its doors to HIV/AIDS affected persons
8. Need to educate for community / home based care.
9. During formation, exposure program to Novices in the institutions where caring for HIV/AIDS patients should be part of their experiences.
10. Lobbying with the Govt and other agencies to put pressure on the pharmaceutical companies for the availability of high-cost patented medicines at a cheaper rate to the HIV/AIDS patients.

CCMAI

3. Collaboration

- To collaborate/network with State AIDS cell

- District health action forum to address on HIV/AIDS

- The Rel. Congregations involved in HIV/AIDS program to network with others.

- Basic Christian communities and basic inter religious communities - to be the forum for information, dissemination as well as health activist network at different level with NGOs and GOs.

8. STRATEGY

1. A National Coordination Team
2. Finalisation of a National HIV/AIDS Policy
3. Collaboration with international & national agencies in intensification of our involvement in prevention and care
4. Provide support in HIV/AIDS awareness programmes for school and college students and communities. Promotion of increased scholastic and extracurricular education about values of life, love, sexuality and family and elimination of all forms of discrimination of people suffering from HIV/AIDS
5. Encouraging Dioceses/Religious Congregations/NGOs to open Care and Support Centers; programmes to protect of AIDS orphans and to give attention to the vulnerable groups.
6. Equip the Catholic healthcare network to offer quality treatment for opportunistic infections

gender
Co-ordinating body
strengthening infrastr. - collabor i
moral & ethical issue
Rx & care. - Access to essential medicine

Conclusion

Statistically 12% of those providing care to HIV/AIDS patients worldwide are agencies of the Catholic Church, and 13% are Catholic non-governmental organizations. The Catholic Church is thus carrying out 25% of the total care given to HIV/AIDS victims, which makes the Church the major supporter of States in the fight against this disease. (Cf. Archbishop Lozano's speech at UN's XXVI Special General Assembly on HIV/AIDS, New York, June 27, 2001).

Christians in India are a tiny minority community, just about 2.3% of the total population. Yet, the contribution of this miniscule community in health, education and social service is remarkable and effective. In the fight against HIV/AIDS, the Church, though involved to a great extent, it has a major mission to achieve. Considering the magnitude of the HIV/AIDS pandemic, the entire Christian community needs to be motivated and mobilized for which a concerted action and collective response is imperative.

The Statement of the United States Catholic Conference, "The Many Faces of AIDS: A Gospel Response" concludes like this: "Our response to the needs of those persons with AIDS will be judged to be truly effective both when we discover God in them and when they, through their encounter with us, are able to say: "In my pain, fear, and alienation, I have felt in your presence a God of strength, hope, and solidarity". By the grace of God, may this happen soon!" For the Church in India too this is a mission and a challenge today.

Commission Secretariat to be strengthened — animation / facilit.
Continuity to be safeguarded — pol. ... to place before standing committee / Gen. Assembly
- we are going in right direction democratically
- CBCI to empower HIV commission with preemptive
- Caritas - sending of CBCI - down to local
- use existing structures
- new structures with help
- Fr Alex - Director

A COMMON POLICY STATEMENT OF CHURCH IN INDIA ON HIV/AIDS

A DRAFT

PREAMBLE

The Catholic Church in India is concerned at the alarming increase in the incidence and prevalence of HIV infection in India. The Human Immuno Deficiency Virus (HIV) is a blood borne virus that can cause AIDS (Acquired Immune Deficiency Syndrome). Fifty percent of people living with HIV will develop AIDS within two to ten years of becoming infected. It is expected that ninety nine percent will eventually develop AIDS while there are treatments for opportunistic infections. There is no cure for the HIV virus. There is currently no effective vaccine against this virus.

The personal and social implications of HIV are significant and cannot be ignored. This policy has been made to address the implications of HIV/AIDS for Catholic Church bodies in India especially with regard to health care services. This policy is the outcome of a series of consultations and dialogues jointly organised by the CBCI health commission, Catholic Health Association and St. John's Academy of Health Sciences and wider discussions with other church bodies.

As a Catholic body the Catholic Bishops Conference of India (CBCI) has developed the policy on the foundation of the Gospel and Catholic Traditions. This policy is presented as a guide to all Catholic health care service, teaching and research institutions in India.

In developing this policy CBCI has been especially guided by the principles of the church's social justice teachings and statement by the Holy See, Catholic Bishop's of India, other pastors and teachers / experts in the church.

- The dignity and uniqueness of person created in the image and likeness of God (Ge. 1/1)
- The equality of all people as children of God (Gandiem et spes)
- The Christian acceptance of responsibility for the self, each other and service for the God of All (G.S)

This Espouses a Truly Christian Response.

A Christian Response to HIV/AIDS is based on truth and love. When truth is embraced, courage and balance prevail: When love is embraced our response is characterized by compassion and care for all.

This policy calls upon All Catholic health care institutions to implement such a Christian response to HIV/AIDS and so promote justice and the dignity of the human person.

The policy provides guidelines for the implementation of sound standards and procedures. In prevention, care, testing, treatment, management, advocacy and networking, with all people and associations of good will.

HIV / AIDS IN INDIA:

Introduction:
In India the pandemic of the Acquired Immune Deficiency Syndrome (AIDS) is in its second decade. According to the estimates of the World Health Organization (WHO), at least 16 million people are infected by the Human Immune Deficiency Virus (HIV) and 4 million people have developed AIDS worldwide. The infection is spreading unchecked.

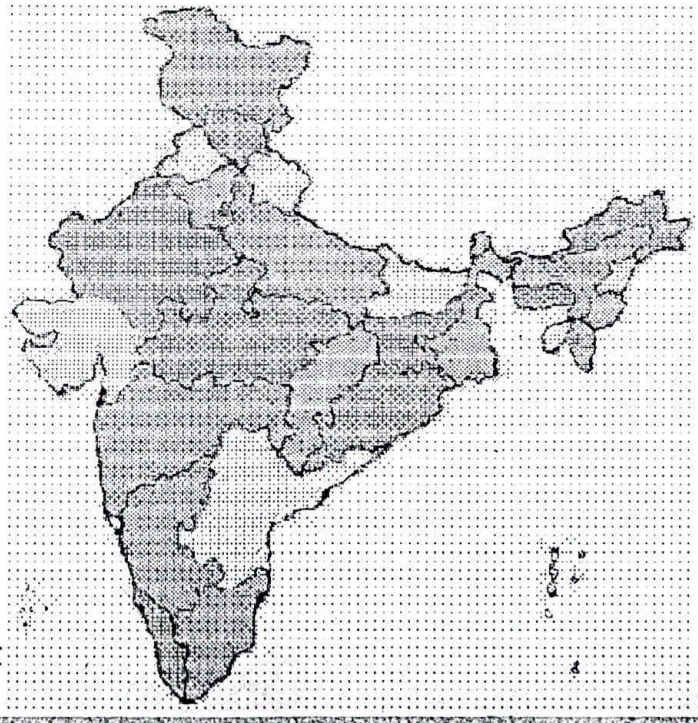
Some characteristics:

- The pandemic is accelerating in South and South East Asia.
- The infection affects everyone; the people most at risk are the socio-economically poor.
- HIV/AIDS could cause modern economic underdevelopment.
- Women and children are increasingly bearing the brunt of AIDS.
- No cure is in sight; the possibility of a vaccine is also remote.
- Heterosexual transmission accounts for at least 75% of HIV infection in adults across the world.
- Prevention requires behavioural changes. Being essentially a sexually transmitted disease, prevention requires change in sexual behaviour.

HIV/AIDS A Priority Focus?

Is AIDS a priority in India? Yes, it is. Out of the 16 million persons infected globally, more than 2.5 million are in South and South East Asia. In recent times, there has been a marked increase in the number of infected persons in India. If transmission of HIV continues at the same pace as at present, by the year 2010 AD, about 8 million persons would have been infected in India; the number of persons with AIDS would exceed one million
India has the burden of malnutrition, tuberculosis, diarrheas and other infectious diseases. AIDS deaths are additional. The combination of AIDS and tuberculosis is fatal. AIDS hits those in the prime of life, leaving families economically and psychologically wasted.

HIV/AIDS IN INDIA



HIV/AIDS is a global pandemic which is unproved in human history. The people with HIV/AIDS, by the way they are treated and regarded have become the equivalent of the lepers of former times. In the gospels, Jesus not only physically cured the ten lepers and the paralytic, and the women with the hemorrhage, but he also restored to them their human dignity, and their rightful place in the community. St. Francis of Assisi and St. Catherine of Sienna kissed the lepers sores not simply because they were sores but because they were the living wounds of sufferings of **Christ.**

For those of us who are dedicated to the service within the Christian community, it is especially important not to become paralyzed by fear in the face of this disease, nor polarized in sterile debate. We should instead perceive the pandemic as a crucial moment in the world's history, when the church can once again respond to fresh challenges and opportunities with unselfish love and without prejudices in the footsteps of Jesus our ~~Mother.~~ This echoed in Pope John Paul II speech in Arizona, USA "Today we are faced with new challenges, new needs. One of these is the present crisis of immense proportion, which is that of AIDS. Besides your professional contribution and your activities towards all affected by this disease you are called to show love and compassion of Christ and his church."

To respond with love and compassion, with commitment and determination, with integrity and humility to people with HIV/AIDS must be an intrinsic element of our preferential option for the poor today. In many of our communities people with HIV/AIDS are the excluded poor, the poorest of the poor; they are marginalized. To share, and truly share the concerns of the marginalized always require both courage and great discernment. First we must understand HIV/AIDS is not Africa's disease, nor the homosexuals nor the drug users, nor the prostitutes disease, but a human tragedy affecting people of every gender, race, age group, sexual orientation, marital status or state of life, babies, high school students, army officers, married women and men, catholic priest and religious, protestant pastors and are in danger of dying today of HIV/AIDS and AIDS related conditions. Whether they contract it from blood transfusions from sexual intercourse, from mother to child in the womb, from sharing syringes, or from dirty hospital equipment, they are all to be loved and embraced unconditionally and non judgmentally as sons and daughters of our God.

It is time for the entire church, bishops, priests, religious and people of God, join hands to make efforts for its prevention and control. It is time for the Christian teachers and leaders to educate our people a way of life that is most likely to protect them from HIV infection. It is time for us to show compassion and love to those already infected. It is time for us to know to fight this disease while taking care not to fight the infected. It is time for us to learn to take care of those infected and help them to live positively with HIV/AIDS. it is time for us to follow the footsteps of Jesus and walk an extra mile (Mt.5.4) along the infected. We cannot stand still and stare but act/respond with love and compassion, with commitment and determination, with integrity and humility to people with HIV/AIDS.

CHURCH'S RESPONSE TO HUMAN TRAGEDY

The church in India has always considered health care as one of her major apostolate. The special mission to heal the sick and comfort the sick" is clear for her presence in the health care sector of the country through 4967 hospitals (includes health care centers) 62 nursing schools 1981 rehabilitation centers and 3 medical colleges and through many other health initiatives both formal and informal, especially community health programmes

The service rendered through the number of institutions in specialized service sectors like Leprosy relief and rehabilitation units, centers for the disabled persons, hospices for terminally ill and now many new centers for the HiV/AIDS patients etc. Is not worthy. The church has a great share of the nations health care facilities.

THE INVOLVEMENT OF CATHOLIC HEALTH CARE ASSOCIATION

As HIV/AIDS was becoming a serious health and social problem, there was an urgent cry from all quarters of the church to respond to this grave situation. Since The Catholic Health Association of India (CHAI) is the structural body responsible for health, everyone looked up to CHAI for guidance and direction on HIV/AIDS.

Milestones of CHAI's growth with specific focus on HIV/AIDS

1993	–	AIDS Desk was formed "Think-tank" group
1994		CHAI's Policy on HIV/AIDS
1995		CHAI's Plan on HIV/AIDS
1996 – 1997		Personnel from the member institutions were trained to plan and initiate actions in their regions
1998 – 2001		-Developed human resources in care and support -Networking with like-minded organizations for policy lobbying and advocacy.
2002 – 2004		The quality of life of the persons infected and affected with HIV/AIDS is enhanced through a process of specific interventions such as implementer's forum and promoting access to parallel system of medicine.

Specific Areas of Involvement

CHAI approached the situation at various levels

Thrust Areas

- Prevention
- Training health care and social care professionals
- Networking
- Policy
- Continuing Educational Material

Prevention

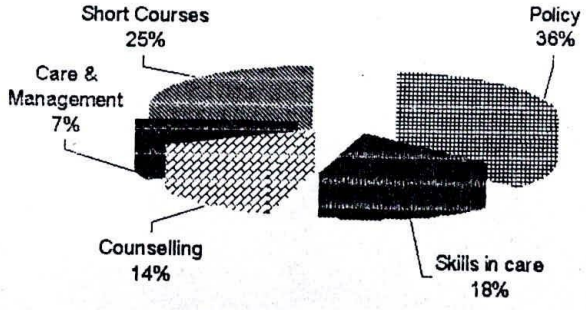
Prevention had been an utmost concern. CHAI had done pioneering work in the area of school health. Developed modules and innovative approaches for Life Skill Education in schools and colleges with the collaboration of CRI in 1997- 1999.

Now CHAI has been invited by Andhra Pradesh State AIDS Control Society to be the nodal agency for the school health programme in the state of AP for the non-government schools.

Training

Training of the health care personnel with specific skills on prevention, counseling, care and management. About 650 persons have been trained and about 50% of them are directly involved in giving care while others have initiated activities along with their ongoing work.

Training Programmes & Participants trained



Networking

Networking with church related institutions, NGOs and Government agencies – such as APSACS for the school health programmes "Life Skills Education" and Drop-in Centers". TB and Malaria Control Programme through the regional units. Training on microscopy through Government agency.

Policy

Consultations were organized at Regional and National level to form policies

1.Common church policy

Intensive efforts had been taken to network and collaborate with church bodies, church related institutions and NGO's to bring out a common church policy on HIV/AIDS. Prevention, care, management, counseling and training of personnel. This policy would be available in six months.

2.Congregation and institution policy

Policies to be made flexible to ensure that persons infected and affected are cared and supported. Consultations and discussions with 212 decision and policy makers of the member institutions were organized.

CHAI has helped some member institutions in developing specific policy for their institutions.

(Other Church Bodies Involvement in the area of HIV/AIDS could be added; like the CNGI, St. Johns Medical College, and CBCI – IGNOU etc)

Leave out

THE MAJOR THRUSTS OF THE CHURCH IN ADDRESSING THE HUMAN SCOURGE

1. Prevention
2. Care
3. Rehabilitation
4. Advocacy
5. Networking
6. Living Positively.

1. Prevention:

Prevention is the best cure. This is an old adage, which is invaluable in the area of HIV/AIDS. In fact so far prevention is the only cure for HIV/AIDS. There is as yet no other remedy for it.

The Three Major Mode of prevention is possible for each mode of Transmission by using the correct method of **prevention.**

- Sexual
- Parental (Blood Born)
- Perinatal (Mother to child)

Methods to Prevent HIV/AIDS Transmission:

Prevention of HIV/AIDS cover 4 broad aspects:

1. Awareness Campaign
2. Infection Control
3. Lifestyle Education – sexual abstinence before marriage
4. Safe Blood
5. Mother to child transmission

1. Infection Control

All health care givers adopt universal precautions as peer NACO & WHO guidelines.

2. Life Style Education:

All health care providers and institutions shall inculcate a healthy life style in their clients emphasising the following areas:

a. Nutrition and diet
b. Exercise
c. Stress and anxiety
d. Mental health
e. Drugs and dependence patterns
f. Injection practice –use of staff/sterilised/disposable equipment
g. Sexual practices: Safe sex within marriage if not abstinence is the best method. The best policy is sexual abstinences before marriage and fidelity in marriage.

3. Safe Blood:

Only HIV free blood should be used for transfusion, organs for transplantation also should be free of HIV contamination.

4. Awareness Campaign:

Ongoing awareness through talks, mass media, discussions, lectures, etc. all church institutions, parishes, village communities and NGO sectors could be undertaken.

5. Mother to Child Transmission:

HIV/AIDS positive mothers are recommended to avoid pregnancy. In case one is pregnant, the HIV Positive mother should continue her pregnancy and do not opt for abortion, because about 65% of the children are known to survive the risk of getting infected with HIV/AIDS. HIV positive mother should opt for caesarean because through normal delivery a child has every chance to get infected during the process of delivery. HIV/AIDS mother may avoid breast-feeding

TESTING:

In testing on HIV/AIDS, all church institutions shall follow the National AIDS control programme (NACO) guidelines.

i. No individual should be made to undergo a mandatory testing for HIV.

ii. No mandatory HIV testing should be imposed as a precondition for employment or for providing health care facilities during employment.

iii. In case a person likes to get his HIV status certified through testing all necessary facilities should be given to that person and results should be kept strictly confidential and should be given out to the person and with his consent to the members of his family. Disclosure of HIV status to the spouse of the person will entirely depend on the person's willingness to share the information. However the person should be encouraged to share this information with the spouse and family as it helps the person in getting proper home based care when he is afflicted with **AIDS**.

iv. In case of marriage, if one of the partners insists on a test to check the HIV status of the other partner, the contracting party to the satisfaction of the person concerned should carry out such tests.

CARE: There is no cure, yet no limit to care all patients should be given adequate care and emotional support visiting our institutions.

A. Institutional Care:

- Christian Institutions should be visible manifestations of God's Love.
- All members of health care institutions recognise their obligations to render all possible and adequate care to every patient. There will be no discrimination on the basis of HIV status in matter admissions and treatment
- Our hospitals are encouraged to establish diagnostic facilities, which will include those for testing for HIV and STD.
- Our health care institutions will provide health care services social and counselling support and spiritual and pastoral care to the people with HIV/AIDS. Every hospital will have at least one trained counsellor.
- All catholic health care institutions will take adequate infection control measures (universal precaution) to the extent possible.

- Each institution will have a designated person as contact/liaison person for all matters connected with HIV/AIDS. Larger institutions and dioceses will have HIV/IDS committees.

B. Home Based Care

This is an integral part of caring. It is needed when the individual has developed AIDS or even during about of opportunistic infection. Family members or any one available provides Home-based care. Home-based care includes treatment of common symptoms such as fever, diarrhoea, cough and other health problems related to HIV/AIDS. It is basically palliative in nature and includes maintaining proper nutrition and patient hygiene. Families and care givers at home. Need to be trained in day-to-day care of the patient. The training should include such as planning a balanced diet, principles of hygiene, disposal of _____linen etc.

C. Community based care

As there is no care yet for HIV/AIDS, the only treatment is for opportunistic infection, which all catholic health care facilities will extend to HIV/AIDS sufferers of will include.

1. Clinical Management for diagnosis, testing, rational treatment (including prophylactic interventions) and follow up care.
2. Nursing care to promote and maintain hygiene and nutrition, to asset the family in day today care and to take necessary precautions.

D. Introducing and sustaining anti-retroviral therapy

Nothing should no efforts should be spared to care and treatment HIV/AIDS victim in our hospitals and health care institutions?

However, the use of antiretroviral therapy is very expensive and beyond the limits of sustainability of average India, it should be the Doctor of the individual and the institution.

E. Treatment

As there is no care yet for HIV/AIDS, the only treatment is for opportunistic infections, which all Catholic Health Care facilities will extend to HIV/AIDS sufferers of will include.

1. Clinical Management for diagnosis, testing, retinal treatment (including prophylactic interventions) and follow up care.
2. Nursing care to promote and maintain hygienic and nutrition, to asset the family in day-to-day care and to take necessary precautions and to give health education.
3. Counselling services
4. Psychological, pastoral and spiritual support
5. Social support, including material support when necessary

6. As India is the home of so many alternatives systems of prophylactic interventions proven and effective remedies which are commonly available and economically affordable should be encouraged to be used in treating HIV/AIDS related **infection.**

The church encourages the development of programmes to care for infants and children with AIDS, especially those facing life and death without parental care and encourage healthy coupies to adopt or sponsor these children.

REHABILITATION

LIVING POSITIVELY

The church urges the people living with HIV/AIDS (PLWHAS) to live positively. Living positively with HIV/AIDS means spending time with family and friends.

- Planning for the future of loved ones
- Maintaining spiritual health
- Having hope
- Taking care of oneself
- Eating a balanced diet
- Keeping busy and remaining productivities

Getting enough physical exercise
Free from substance abuse
Seeking medical help whenever an illness arises
Getting enough sleep and rest
Going for individual and group counseling
Learning about the virus
Protecting others from HIV/Infection

The HIV/Positive person should be guaranteed equal rights to education and employment as other members of the society. HIV status of a person should be kept confidential and should not in any way affect the rights of the person to employment, his or her position at work place, marital relationship and other fundamental rights.

HIV positive women should have complete choice in making decisions regarding pregnancy and childbirth. There should be no forcible abortion or even sterilization on the ground of the HIV status of women.

As regards the treatment care and support to PLWAS, the policy should be to build up continuum of comprehensive care comprising of clinical management, nursing care, pastoral care, counseling and socio economic support through home-based care. Resources from the government and community sectors should be mobilized for this purpose.

To the extent possible, person with HIV/AIDS should be encouraged to continue to lead productive lives in their community and place of work. They also have the right to decent housing and landlords are not justified in denying them this right merely because of their illness.

ADVOCACY

In spite of the strong IEC campaign on HIV/AIDS there is still inadequate understanding of the serious implications of the disease among the church personnel, church leaders, professional agencies, teachers and administrators not to speak of the medical and paramedical personnel engaged in health care delivery system. A strong advocacy campaign needs to launched at all level of the opinion leaders, policy makers and service providers to make them understand and feel motivated about the need for immediate prevention of the disease and also for adoption of human and Christian approach towards those who are already been infected with HIV/AIDS. The advocacy should start from the topmost level of hierarchy of the church.

There is a serious information gap about the causes of spread of the disease even among a large number of medical and paramedical personnel in church run institutions. This leads to situations of discriminations. HIV/AIDS infected persons in hospitals and dispensaries and work places not to speak of community at large. There is a strong need for advocacy, at all levels to eliminate such discrimination and overreaction both by the authorities, and general public.

In church related educational institutions HIV/education should be imparted through curricular and extra curricular approach.

All Christian newspapers and magazines and other print media should be used for conducting campaigns for social mobilization and generate awareness about preventions and for sharing information and expertise. The media should be in general play a positive role in generating an enabling environment for HIV/AIDS prevention and control and care of the HIV-infected people.

Church related institutional management would initiate intensive advocacy and sensitization among Doctors, Nurses and other paramedical workers so that PLWAS are not discriminated, stigmatized or denied or services. The church expresses serious concern at instances of denial of medical treatment by doctors in their clinics, nursing homes and hospitals, which is causing enhanced stigmatization to the PLWAS.

NEED FOR NETWORKING

This global crisis of such great magnitude and perversity cannot be tackled by any one single agency, but cooperation and collaboration of all both government and non-governmental agencies are needed. The church would be ready to cooperate and collaborate with the National AIDS control organization and State AIDS control organizations in various States.

Each diocese and congregation are advised to formulate their plans and strategies to combat HIV/AIDS spread containment and care and management of HIV/AIDS affected and infected people within their areas of service in dialogue with all agencies committed to the cause.

ECUMENICAL NETWORKING

While we differ widely in certain theological teachings and other Pastoral practices let us not forget that we are called by the same, Lord, Jesus Christ, to proclaim His Kingdom and therefore we are united in many common values and a tradition of Christian service with our brothers and sisters who belong to other Christian churches. Many of these churches have also been active in responding to the AIDS pandemic.

Networking with these churches can bring strength to our own catholic efforts in this **field.**

CARE FOR THE CARE ~~COVERS~~

In the course of our dedicated commitment to the PLWAS, let us not forget the need to support those who are serving PWAS on a day-to-day basis. Such work is extremely difficult and can cause physical psychological and spiritual exhaustion. We encouraged periodic/ongoing gatherings of HIV/AIDS caregivers for mutual support and further updating in relevant areas of knowledge and skills.

THE CHALLENGE TO BE HIS LIGHT TODAY

A MESSAGE FOR THE WORLD AIDS DAY

December 1, 2003

St. Mathew, the evangelist quotes the Prophet Isaiah to introduce the mission and message of Jesus, in these words: *"The people who walked in darkness have seen a great light, and for those who sat in the region and shadow of death light has dawned"* (Mt. 5:16). As the Chairman of the CBCI Commission for Healthcare, I would like to reflect with you on this theme in the context of the devastating scourge of HIV/AIDS that is affecting ~~our dear people and the whole of our beloved~~ nation. This message is the fruit of the suggestions by the Bishops in-charge of Health Commissions in the Regional Bishops' Councils and the Heads of National Health and Developmental Organisations, who came together for a National Consultation on `the Response of the Church on HIV/AIDS', held on August 8-9, 2003 at St. John's National Academy of Health Sciences, Bangalore. As you all know, each year, December 1 is observed globally as "the World AIDS Day". Such a reflection is more appropriate since we begin the sacred season of Advent, and prepare ourselves to celebrate the birth of Jesus, the true Light, *that `dispels despair and darkness'*, and *`enlightens everyone in this world'* (Cf. Jn 1: 5,9).

1. The first case of Human Immunodeficiency Virus (HIV) was detected in India in 1987. In the last 15 years, the epidemic has spread rapidly all over the country. Today India has about 4.5 million HIV positive people. The infection is spilling over from high-risk groups, earlier considered as the reservoir of HIV to low-risk groups and from urban to rural areas. If the pandemic continues at its present pace, it is going to have devastating effects on the entire fabric of our society. It is said that if the spread of HIV/AIDS is not checked and the problem reversed, it is likely to wipe out decades of development made in our country. It is also projected that in terms of the number of the HIV infected, the Indian subcontinent will overtake the other nations ~~and continents~~, and will become the 'AIDS capital of the world'.

It is going to pose a formidable challenge to Christian teachings, moral values, family bonds, marital fidelity, medical care, social work and pastoral care. The situation is unpredictable – we do not know where it is leading us. The damage done is huge – it has infected millions. The scourge is unstable – it keeps changing its types and forms, ~~with no rhyme and reason~~ for the way it functions. It is invisible – it lies unnoticed within our body and keeps infecting others. It is dangerous – it affects people mostly in their productive age, that is, from of 15 to 50 years, which is bound to have irreparable consequences for any society.

Church HIV/AIDS policy file.
JN
14/11/03

2. The Holy Father, Pope John Paul II has affirmed that those suffering from HIV/AIDS must be provided with full care and shown full respect, given every possible moral and spiritual assistance, and indeed treated in a way worthy of Christ himself. The entire Church needs to join hands to make efforts for HIV prevention and control. Pope John Paul II states that "the battle against AIDS ought to be everyone's battle."[1] With existing exigencies of our country such as poverty, poor hygienic conditions, illiteracy, ignorance and diversity in culture, tradition and language, it becomes absolutely necessary for the Church to get involved in the care and support of the infected and awareness building programmes for prevention.

In response to the appeal of the Holy Father, the Catholic Church has been a major provider of competent and compassionate care to people living with HIV infection around the globe. The Catholic Church provides approximately 25% of the total care given to those infected with HIV/AIDS, which makes the Church the major supporter of Nations in the fight against this disease[2].

In India, over and above 5000 Catholic healthcare institutions, the Church runs 39 care and support centers specifically for those infected with HIV and AIDS in different parts of the country.

Through the efforts of the Commission for Healthcare, the CBCI signed a Memorandum of Understanding (MoU) with Indira Gandhi National Open University and a programme of Study on "HIV and Family Education" was launched and 2200 students have enrolled themselves for this course in the last academic year. We know that education, awareness building and training for the prevention of HIV/AIDS play a major role. Hope many more, especially those who are in the education and healthcare field will join the course and profit by it.

Developmental organizations like Caritas India, Catholic Relief Services (CRS), Catholic Medical Mission Board (CMMB) and so on have various programmes to curb the menace in our country. St. John's National Academy of Health Sciences, the Catholic Health Association of India (CHAI), the Catholic Nurses Guild of India (CNGI), and so on maintain various programmes and projects responding to HIV/AIDS.

In the fight against AIDS though the Church is involved to a great extent, it still has a major mission to fulfill. Considering the magnitude of the HIV/AIDS pandemic, the entire Christian community needs to be alive, active and involved. Following the footsteps of Jesus, the Divine Healer, we need to bring joy and hope to *"all those who walk in darkness"* and left alone and abandoned in the *"region and shadow of death'* due to HIV/AIDS. The darkness of their gloom, guilt, ignorance and loneliness need to be changed into a new hope through our love and acceptance.

St. Paul affirms, "*None of us lives for himself, and no one dies for oneself*" (Rom 14:7-8). *If one part suffers, all the parts suffer with it... You are Christ's body, and individually parts of it*" (I Cor 12:26-27). One ceases to be a true Christian, when one ceases to have mercy and compassion in one's heart towards the suffering and sick, and

discriminates and condemns because the other is infected with HIV. We keep in our minds, these words of the Second Vatican Council, saying, "The joy and hope, the grief and anguish of the people of our time, especially of those who are poor and afflicted in any way, are the joy and hope, the grief and anguish of the followers of Christ as well."[3]

3. *Let us change the darkness of ignorance and misconception into the bright world of prevention and positive action*: HIV infection is transmitted mainly in three ways - through sexual contacts with a person infected and thus through the exchange of blood, semen and vaginal secreations; from a mother infected with HIV to her baby during pregnancy, delivery or breast feeding; and, through the transfusions of blood and blood-products. We need to build awareness among the people of the nature of the disease and the ways of its transmission. Prevention means choosing responsible behavioural patterns that are based on true human and moral values and strictly adhering to them in one's life. This implies fidelity in one's marriage, sexual abstinence outside marriage and responsibility to one's life and commitment. The youth of today needs to informed and formed in the human and religious meanings of personal integrity and commitment to chastity.

There are many agencies that campaign for prevention of HIV/AIDS by advocating "safe sex" or "safer sex" through condom use. Unfortunately it offers a false sense of security. The protection it offers is a myth. It has been scientifically established that condom often fail in prevention of sexually transmitted diseases such as HIV or the incurable Human Papilloma Virus (HPV) that increases one's susceptibility to HIV infection.

Proper awareness on HIV/AIDS should help us to overcome our prejudices and fears. Those who contract HIV/AIDS, whether by accident or by consequences of their own actions, carry with them a heavy burden of social stigmatisation, ostracism and condemnation. Let us reach out to those infected and welcome them, with a compassionate heart like that of Jesus! Let us join with the World Health Organization in the campaign, "Live and let live", to eliminate stigma and discrimination associated with HIV and AIDS. I appeal to the parish communities, educational institutions and healthcare facilities to periodically organize awareness programmes, campaigns, and study-seminars,

4. *Let us help those people living with HIV to come out of the shadow of despair, gloom and guilt and enter into a joyful hope and acceptance*. Those among us who are living with HIV/AIDS must not feel that they are alone and abandoned. We, who are their brothers and sisters in the Church, must walk in solidarity with them on their journey. As our Holy Father, Pope John Paul II, has said, "Solidarity is not a feeling of vague compassion or shallow distress at the misfortunes of so many people. On the contrary, it is a firm and preserving determination to commit oneself to the common good; that is to say, to the good of all and of each individual because we are really responsible for all." As the body of Christ, the Church needs to take care of those infected and help them to 'live positively' with HIV/AIDS. Let us follow the footsteps of Jesus and walk an extra mile (Mt. 5:41) along with the infected.

One of the serious concerns of the Church is to make sure that the infected regularly get the antiretroviral (ARV) treatment at a reasonable price. We are happy that WHO, together with other agencies is launching a campaign this year to provide antiretroviral medicines to three million people by the end of 2005, the "3 to 5" target. The Church in India whole-heartedly supports this campaign. On behalf of our brothers and sisters living with HIV, I appeal the Pharmaceutical Companies in India, who are producing a large share of the medicine for global supply, that not profit, but humanitarian concern should be your motive and primary concern.

We need to acknowledge the fact that people living with HIV/AIDS continue to contribute to their family and society in their own way. They are to be reassured of the value of their lives, their worth in the larger society and the possible contribution they can make to further enrich it.

Parish communities, especially through the basic ecclesial communities, should reach out to those families of HIV patients. We should create a network of people prepared to assist such families in care, counselling and support.

All the Catholic healthcare institutions, as we are serving the Lord in the abandoned and afflicted, will admit and care for the people living with HIV/AIDS. As Blessed Teresa of Calcutta used to say, 'a person affected by HIV/AIDS is Jesus among us. How can we say no to him!' Every baptised is invited to show compassion and love to those already infected. We need to know how to fight this disease, while taking care not to discriminate and stigmatize the infected.

As we conclude the year of Our Lady of the Rosary, the Mother of Hope and Strength, I entrust to her maternal care and intercession all those who are living with HIV/AIDS. May she also intercede for all of us so that the Babe of Bethlehem, may remove all the shadows of despair, discrimination and fear and bring to our hearts the true light of hope and loving acceptance of everyone, especially those who are sick and suffering.

+ Msgr. Bernard Moras
Bishop of Belgaum and
Chairman, CBCI Commission for Health

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[1] Ecclesia in Africa, Sept. 14, 1995, AAS 88 (1996) 70.

[2] United Nations General Assembly, Special session on HIV/AIDS, June 21, 2001, Intervention of Cardinal Javier Lozano Barragan, President of the Pontifical Council for Pastoral Health Care, Vatican.

[3] Vatican II, On the Church in the Modern World, no.1

POLICY AND PLAN OF ACTION OF THE CHURCH IN INDIA ON HIV/AIDS

- DRAFT -

1. PREAMBLE

The entire Church in India is concerned at the snowballing increase of the HIV/AIDS pandemic in this country. The CBCI Commission for Health Care Apostolate and other National Organizations like Catholic Health Association of India (CHAI), Catholic Nurses Guild of India (CNGI), Sister Doctors Forum of India (SDFI) and Medical Institutions like St. John's National Academy of Health Sciences, Bangalore, Bio-Medical Ethics Centre, Mumbai, Fr. Muller's Charitable Institutions Mangalore, Pushpagiri Hospital, Tiruvalla, Amala Institute of Medical Sciences, Trichur, and Developmental organizations like Caritas India, Catholic Medical Mission Board (CMMB), Catholic Relief Services (CRS), Indo-German Social Service Society (IGSSS), and Catholic Religious of India (CRI) and similar Associations came together to form a common policy and implementation strategy for a collaborative endeavour to fight against this pandemic.

The personal and social implications of HIV are significant and cannot be ignored. It seems, indeed, desirable to draw up a policy to address the implications of HIV/AIDS for Catholic Church institutions and individuals involved in this field in India, especially with regard to healthcare services.

As a Catholic body, the Catholic Bishops Conference of India (CBCI) has developed the policy statement on the foundation of the Gospel and Catholic Traditions, in order to present it as a guide to all Catholic healthcare service, teaching and research institutions in India.

Our Perspectives

The Christian commitment to serve the sick has its mandate from Christ, the Divine Healer. (Lk 9:1; Mt 10:1; Mk 16:15-18). It is a call to serve with the same love and compassion of Christ while facing

Church HIV/AIDS policy file
14/10/03

human suffering (Cf. Mk 1:41; Mt 20:34). It is a commitment to continue the action of Jesus, who came to give life and give it in abundance (Cf. Jn 10:10). Our involvement in healthcare is Christ-centered and derives its inspiration and guidance for values and action from Jesus, the Master.

By the way they are treated and regarded, the people with HIV/AIDS have become today's version of the leprosy patients of former times. In the Gospels, Jesus not only physically cured the ten lepers and the paralytic, and the women with the hemorrhage, but he also restored to them their human dignity, and their rightful place in the community. St. Francis of Assisi and St. Catherine of Sienna kissed the lepers' sores not simply because they were sores but because they were the living wounds of Christ's sufferings. We, too, perceive the same Christ alive in every individual infected with HIV.

Service to the sick is an integral part of Church's mission (Cf. *Dolentium Hominum*, n.2). Our care, compassion and love towards those affected by HIV/AIDS are the expression of our faith in solidarity with them in their pain. Our service to them and to the members of their family is our genuine response as they are our sisters and brothers in Jesus the Lord, who is present in those who are suffering (Cf. Mt 25:45). "Those suffering from HIV/AIDS must be provided with full care and shown full respect, given every possible medical, moral and spiritual assistance, and indeed treated in a way worthy of Christ himself" (Pope John Paul II).

Our approach is guided by a precise and all-round view of human person "created in the image of God and endowed with a God-given dignity and inalienable human rights" (Ecclesia in Asia, 33). We do not approve any sort of discrimination or hostility directed against persons with HIV/AIDS, which is unjust and immoral. We uphold the equality of all people as children of God (*Gaudium et Spes*).

Our aim is a collective response and an inter-sectorial approach. The Church is called to collaborate with national and state governments, international agencies and NGOs, in addressing the issues pertaining to HIV/AIDS. In our interventions we will adhere to the moral teachings of the Church.

Though we continue to concentrate on care and support of those infected by HIV, our priority will be the preventive approach with community participation. So, health education, awareness building, campaigns for prevention, teaching of values for behavioural change, etc. will be our strategy.

2. HIV/AIDS in India

Though HIV appeared in India comparatively later than other parts of the world, it is spreading with unprecedented rapidity. Every region in India is experiencing a snowballing increase in the transmission of HIV. The infection is spilling over from high-risk groups, earlier considered as the reservoir of HIV to low-risk groups and from urban to rural areas. If the pandemic continues at its present pace, it is going to have devastating effects on the entire fabric of our society. It is said that if the spread of HIV/AIDS is not checked and the problem reversed, it is likely to wipe out decades of development made in our country. It is also projected that in terms of the number of the HIV infected, the Indian subcontinent will overtake the other nations and continents, and will become the 'AIDS capital of the world'.

It is going to pose a formidable challenge to Christian teachings, moral values, family bonds, marital fidelity, medical care, social work and pastoral care. The situation is unpredictable – we do not know where it is leading us. The damage done is huge – it has infected millions. The scourge is unstable – it keeps changing its types and forms, with no rhyme and reason for the way it functions. It is invisible – it lies unnoticed within our body and keeps infecting others. It is dangerous – it affects people mostly in their productive age, that is, from of 15 to 50 years, which is bound to have irreparable consequences for any society.

3. TIME TO ACT

The time has come to accept and acknowledge that HIV/AIDS affects everyone – men and women, young and old, without any distinction of caste, creed, religion, colour, state, age, sex, profession, qualification, social and economic status.

It is time for us to pool all our wisdom, knowledge, skills and resources to fight this pandemic. The time has come to deal with the disease decisively and to treat the people, who are infected, with compassion, concern, love and care. We need to learn from the initiatives taken and the success achieved by those countries that are worst affected by the pandemic in the recent **past**.

The entire Church - Bishops, priests, religious and laity – are urged to join hands to make efforts for HIV prevention and control. All the Christian teachers and leaders have a unique mission to educate our people in a way of life that is most likely to protect them from HIV infection. Every baptized is invited to show compassion and love to those already infected. We need to know how to fight this disease, while taking care not to discriminate and stigmatize the infected. As the body of Christ, the Church needs to take care of those infected and help them to 'live positively' with HIV/AIDS. Let us follow the footsteps of Jesus and walk an extra mile (Mt. 5:41) along with the infected.

We need to acknowledge the fact that people living with HIV/AIDS continue to contribute to their family and society in their own way. They are to be reassured of the value of their lives, their worth in the larger society and the possible contribution they can make to further enrich it.

4. THE CHURCH AND ITS NETWORK IN INDIA

The Church in India has always considered healthcare as one of her major apostolates. This special mission to 'heal the sick and comfort the afflicted' is clear from her presence in the healthcare sector in the country through about 5000 Hospitals (that includes Health Centers), over 100 Nursing Schools, about 200 Rehabilitation Centers and 5 Medical Colleges, besides the many other health initiatives, both formal and informal, including community health programmes. The service rendered through these institutions in specialized sectors, including HIV/AIDS, is noteworthy. The Church has a major share of the nation's healthcare facility, which is about 15 percent. In other words, the Church in India is reaching out to approximately 150 million people.

The Church has a very influential position in the educational sphere, too. She runs around 17,000 educational institutions, which include Schools: pre-primary to higher secondary; colleges, including community

colleges; vocational and technical institutions. It is estimated that these institutions cater to over 3 million students and, through them, the Church has an outreach to about 15 million individuals. If we consider School Health Education as one of the strategies, the influence that the Church can make in the society is enormous.

Statistics point out that we can make a positive contribution to meet the challenge caused by the HIV/AIDS pandemic. Once members of the Church are convinced about her mission and task, the Church could play a decisive role in the area of prevention and control of HIV/AIDS in the country.

1) Concerns of the Church

In trying to be relevant and meaningful for today's society, through addressing the issue on HIV/AIDS, the Church has several concerns:

- HIV has created panic among people because it is medically so devastating as there is no vaccine for prevention or drugs for cure. It threatens life upon which all other values depend.

- In India, though HIV was first detected in 1986, the infected are still being refused treatment, care and support. This deplorable situation is true in most institutions run by the Government, Church and other responsible agencies. There is a need for Church-based bodies such as Dioceses, parishes, basic Christian communities, Religious Congregations and developmental agencies, etc. to wake up to the present situation and do all they can to alleviate the suffering and pain of the infected.

- Persons with HIV/AIDS across the country still face large-scale discrimination and violence that are unjust, immoral and inhuman.

- Social realities like poverty, illiteracy, ignorance and oppression, and psychological factors such as loneliness and isolation, influence people's decisions to behave in ways, which expose them to HIV.

- There is a gradual deterioration of moral and human values in the larger society as a result of media explosion and consumerism. **This**

has undermined the sanctity of human sexuality, marriage and parenting.

- ❖ Most of the intervention programmes for prevention and control of HIV/AIDS are not in line with the religious and socio-cultural traditions of our nation. This has created misunderstanding and lack of clarity in addressing the issues related to the pandemic, even among the Catholic healthcare providers.

2) Existing Limitations and Hurdles

A close examination of the existing scenario with regard to the prevention and control of HIV/AIDS, brings to light several limitations and hurdles:

- ❖ Public campaigns continue to promote solutions which are contrary to morality and against human dignity
- ❖ Lack of awareness and education about the what, why and how of HIV/AIDS among most of the people
- ❖ Large scale abuse of drugs and sexual promiscuity
- ❖ Lack of concerted effort in providing HIV/AIDS education in School and University curriculum and in catechism/moral education programmes
- ❖ Most infected in rural as well as in urban areas are unaware of their state of infection
- ❖ Government and non-governmental funding for HIV/AIDS research, treatment, care and rehabilitation continue to remain inadequate
- ❖ The existing healthcare system does not have required facilities such as infrastructure, medical equipment and trained personnel to take care of the infected
- ❖ Dearth of professionally trained personnel/institutions where healthcare providers and educators can get adequate training and guidance in line with the teachings of the Church
- ❖ Inadequate intervention from the media and insufficient involvement of leaders of the Church communities at various levels

3) Goals And Objectives of the Church's **Involvement**

- ❖ To follow the mandate given by the Lord "to heal every disease and every infirmity" (Mt 10:1) and give care (Cf. Mk 16:18)

- ❖ To evolve a set of meaningful strategies and plan of action for timely intervention in the prevention and control of HIV/AIDS
- ❖ To provide a set of guidelines to healthcare workers in Catholic institutions for offering compassionate and loving care to the infected in various settings such as hospitals, hospices, palliative care units, community and families.
- ❖ To motivate schoolteachers and other academicians in Catholic Institutions to make appropriate health education interventions.
- ❖ To conscienticize people on HIV/AIDS preventions and control and, with Christ-like charity and concern, to take care for those infected.
- ❖ To help people to perceive the HIV/AIDS pandemic and those infected with a right and non-judgmental attitude.

4) **Strategies To Be Adopted**

I. Prevention
II. Treatment
III. Care and Support for Living Positively
IV. Networking
V. Research
VI. Advocacy

I. Prevention

Concept: HIV/AIDS is an epidemic that can be prevented, since it is spread through certain definite and limited routes. The HIV virus spreads through sexual activities, transfusion of unscreened blood and blood products, contaminated needles/syringes and from an infected mother to her child during pregnancy, childbirth or through breastfeeding. Once the HIV infection is established, it is for life and will probably succumb to serious opportunistic infections caused by the weakening of the person's immune system.

i. Information, Education and Communication (IEC)

With the help of Information, Education and Communication people can be motivated to adopt and maintain healthy practices and lifestyles. This will protect them from acquiring infections and ill

health. IEC is useful in educating the public by clarifying general misconceptions and ignorance.

A) The objectives of IEC strategy are:

a) To raise awareness, improve knowledge and understanding among the general population about HIV/AIDS infection and STDs, routes of transmission and methods of prevention

b) To promote desirable practices such as:
   - avoiding sex outside marriage
   - sterilization of needles/syringes; use of disposable needles/syringes
   - encouraging voluntary donation of blood

c) To mobilize all sectors of the Church to integrate messages and programmes on HIV/AIDS into their existing activities

d) To train healthcare providers, schoolteachers, NGO functionaries and other volunteers in HIV/AIDS counseling, communication and coping strategies

e) To create a supportive environment for the care and positive living of people with HIV/AIDS

The IEC strategic plan has the following components:

A. Multimedia Awareness Campaign: Awareness building can be done through well-designed materials. Posters, pamphlets, booklets, newspaper advertisements, film clippings, TV spots, radio spots, wall paintings and cinema slides, street plays etc.

B) Education programmes:

a) The CBCI-IGNOU Chair for Health and Social Welfare has launched a Diploma and Certificate programme of Study on "HIV and Family Education" through correspondence courses. People from any part of the country can benefit from this programme.

b) CHAI's AIDS Desk has training programmes.

c) CNGI's Hope Centre has special programmes for nurses in pre-test and post-test counseling

d) St. John's National Academy of Health Sciences, Bangalore organizes training programmes for healthcare providers, pastors, etc.

C). An inter-sectorial networking effort:

a). CBCI Commission for Health will collaborate with other Commissions such as Education, Youth, Women, Labour, Communication, **etc.**

b). Motivate Communication and Media Centers for preparation of IEC materials which are locally relevant The print and electronic media need to give adequate coverage on this pandemic and the efforts made for its prevention and control by the Church-related institutions.

c). Education and Healthcare Institutions need to concentrate on IEC implementation

d). Youth Organizations such as ICYM, YCS/YSM, AICUF, YCWS and similar other youth groups are to be motivated

ii. Universal Precautions (Hospitals & Primary Health Centers)

Concept: Universal precautions consist of a set of guidelines created to prevent the spread of diseases transmitted through body fluids, blood spillage, soiled linen, etc. for the protection of caregivers. These precautions were created primarily for medical professionals working in a hospital setting whenever they are likely to come into contact with blood or other body fluids. Because any patient could be infected, all blood must be treated as infected by any person handling or exposed to blood. These precautions also apply to other bodily fluids that are a potential source of HIV, including semen, vaginal secretions and tissues.

Universal precautions include the following practices:

A) Washing the hands with soap and water before and after contact with each patient. Hands should always be washed even when gloves are worn. If one touches blood or other bodily fluids by mistake, hands are to be washed thoroughly. Therefore, adequate facilities such as wash basin, liquid soap (preferably with antiseptics like chlorhexidine) and disposable paper towels should be made available in all areas and wards of the hospital and centers of care.

B) Disposable plastic gloves should be worn by anyone collecting or handling blood or bodily fluids. Double gloves are to be used during surgical procedures. Those with open skin lesions should not perform procedures if they are exposed to body fluids. Used gloves should be disinfected with bleach and disposed off.

C) Wearing of gowns when clothes may be exposed to body fluids.

D) Wearing of masks and eyewear when performing procedures that may splash the worker with body fluids.

E) Disposal of ward wastes:

a) Infected wastes: Any waste that comes in contact with blood or body fluids should be considered infected. Such waste should be collected in bins lined with plastic garbage bags. Once filled. the bag should be tied up and marked with a biohazard label. They should be transported in a closed trolley to prevent spillage. The bag should be incinerated unopened.

b) Sharp wastes: Sharp instruments should be disposed of in puncture-resistant containers immediately after use. Needles should be disposed of immediately after use without recapping. Disposal containers should be placed in all areas where sharp objects are used.

iii. Awareness Campaign

A) Schools/Colleges

a) Catholic Colleges, Colleges/Schools of Social Work; Associations like AINACS, Xavier Board of Education etc. are to be involved

b) Moral education classes/catechism classes can be a forum where information-sharing on HIV and related areas such as character formation, life-style behaviours, etc., can be dealt with

c) Schools/Colleges could organize talks by experts on HIV/AIDS in line with Church magisterium; seminars, debates, poster-making or painting competitions, **etc.**

d) Youth forums like NSS, AICUF etc, could integrate HIV/AIDS prevention programmes into their activities.

e) Catholic medical colleges and nursing schools need to incorporate HIV/AIDS topics into their curriculum which is in line with the magisterium of the Church

f) Colleges could organize voluntary donation programmes once in a year

B) Diocese

a) A pastoral letter by the diocesan bishop on the issue of HIV/AIDS which is to be read in the communities on the Sunday nearer to the World AIDS Day (December 1)
b) Formation of a group of experts / trainers of trainees (TOTs) who will be available for awareness building
c) Topics on HIV/AIDS can be incorporated in the marriage preparation courses
d) Encouraging the opening of hospices/palliative care centers in the Diocese if need be

C) Parishes and basic Christian communities

a) The parish community can be enlightened about the what, why and how of HIV as well as the need to adopt a compassionate and caring approach to the people living with HIV/AIDS
b) Organizing a HIV/AIDS Sunday every year, preferably on the last Sunday of November or first Sunday of December (as World AIDS Day falls on December 1 every year)
c) As a sign of solidarity to the infected, mobilization of funds for their care and support and for IEC (preferably a Sunday collection)

d) At the parish and BCC level, initiatives need to be taken to create a conducive atmosphere for those living with HIV
e) Organizing voluntary blood donation camps

D) Formation Houses

a) HIV/AIDS related topics should become a part of the curriculum in the seminaries and formation houses of the religious
b) Possibility of providing exposure / involvement in HIV related care and support initiatives for the candidates in formation houses
c) Encourage blood donation at least once in a year

E) Village communities and NGOs

a) Sensitization programmes need to be organized at the village level by Church-related NGOs, so that the entire community is prepared to accept the reality and extend care and support
b) To bring about behavioural changes on life-style that may otherwise cause HIV infection, such as promiscuity, drug abuse etc.

5. ROUTES OF HIV TRANSMISSION

There are three well-known routes of transmission of HIV from one person to another, namely, sex, blood and from mother to child. Unlike other killer diseases like cancer and heart attack, HIV/AIDS is one in which we exactly know how it is spreading from one person to another. We also know the ways and means of prevention. Therefore, if there is a will to prevent and control the transmission of HIV, one can certainly dream of a world free of **HIV/AIDS.**

1) HIV Transmission through sex

: The Catholic Church promotes some of the best educational programmes designed to prevent the transmission of HIV through sexual activities. Several dioceses in India have introduced Marriage Preparation Courses as a pre-requisite to the reception of the Sacrament of Matrimony. Many of these programmes do have components relating to the purpose and value of sex and sexuality, HIV/AIDS, family life education, etc. The Health Commission of CBCI has also developed a set of excellent print materials. Apart from this, the Commission also facilitated the preparation and launching of two programmes of study on 'HIV and Family Education' through distance learning correspondence courses at Indira Gandhi National Open University, Delhi. Organizations like CHAI and several dioceses have developed curriculum/materials in line with the teachings of the Church for the benefit of the people. These programmes aim at helping young people to learn about their bodies, to develop mature interpersonal relationships and the need to attain self-discipline so that they will not be exploited or become manipulative. The core message of these initiatives is that sexual activity is to be restricted to faithful marriages and abstinence can and must be practiced outside **marriage.**

- The Church should continue to uphold and promote the values embodied in her teaching of sexual abstinence before marriage and fidelity within marriage
- The Church should provide accurate and complete information on all means of HIV prevention so that the people are enabled to take appropriate decisions in consultation with their spiritual guides
- Through the educational and healthcare institutions, the Church should make efforts to provide adolescent sexual health education in line with the Magisterium of the Church

Use of Condom

Since the most common means of HIV spread is through sexual activities, most governments, donor agencies and NGOs continue to advocate the use of the latex condom as a popular means for prevention of HIV/AIDS. One needs to speak the truth about condoms that it is not 100 percent safe. In fact advocates of condom use promote premarital sex, extra-marital sex and infidelity, which are not acceptable to the Church's teachings.

However, in exceptional cases where one of the partners is infected the couple may seek appropriate guidance from their spiritual father/guide.

2) Blood

: The second most common route of HIV transmission in India is through blood and blood products. There are several diseases that are transmissible via blood, such as HIV/AIDS, syphilis, malaria and other viral infections. Therefore, transmission of blood can lead to transmission of blood transmissible diseases. In fact studies have shown that transfusion of HIV infected blood is the most common means of transmitting HIV/AIDS infection. The transmission rate of HIV via blood is estimated to be 90 percent.

Our healthcare system is managed by thousands of physicians, nurses and other para-medicals who come in close contact with the blood of patients whom they serve. Several cases have been reported from across the country about healthcare providers getting infected through needle prick and surgical instruments.

It is a fact that the HIV infection rate in some states is due to drug addicts' practice of injecting drugs into their veins and sharing needles. The Church has several de-addiction centers that provide care, treatment, counseling and spiritual guidance to the victims.

Thalassemic patients are at a higher risk of getting infected with HIV through blood transfusion. Similarly people with burn injuries too face the vulnerability of the use of first aid, namely, the use of fresh placenta. Similarly other sources of HIV infection involve barbershops, skin-piercing instruments including tattooing, etc.

- Every unit of blood should be tested for HIV before transmission of blood
- Before organ transplantation or use of blood products the HIV status of the donor should be established
- Use of sterile needles/disposable needles and syringes should made mandatory in every hospital & health clinics
- For healthy and hygienic reasons ear and nose piercing need to be done by a qualified person using sterile instruments

❖ Avoid injecting drugs and needle sharing
❖ Healthcare providers must follow the universal precautions promoted by WHO

3) **Mother to Child Transmission**

: Child victims are the horrifying new faces of HIV/AIDS in India. One of the three main known routes of transmission of HIV from one person to another is the transmission from a mother to her child during pregnancy, during child-birth and through breast feeding. Although every child born to an HIV positive mother will test positive to antibodies for HIV, only about 25 to 30 percent are likely to get infected with HIV/AIDS. Through advanced medication the chances of a child getting infected during pregnancy has been reduced.

- HIV positive mothers should avoid pregnancy
- In case a woman is pregnant, and HIV positive, she should continue her pregnancy, and do not opt for abortion, because about 75 percent of children are known to be surviving the risk of getting infected with HIV/AIDS
- HIV positive mothers should opt for caesarean because through normal delivery a child has every chance to get infected during the process of a normal delivery
- HIV positive mothers may avoid breast-feeding

6. TESTING:

In HIV/AIDS testing all church institutions shall follow the guidelines prescribed below:

1) No individual should be made to undergo a mandatory testing for HIV.
2) No mandatory HIV testing should be imposed as a precondition for employment or for providing health care facilities during employment.
3) In case a person likes to get his HIV status certified through testing all necessary facilities should be given to that person and results should be kept strictly confidential and should be given out to the person and with his consent, to the members of

his family/relatives and friends. Disclosure of HIV status to the spouse of the person is recommended as a sign of responsibility and mutual love to the partner. This will also help the person in getting proper home care when he/she is living with HIV/AIDS.

4) In case of marriage, if one of the partners insists on a test to verify the HIV status of the other partner, the contracting party to the satisfaction of the person concerned should carry out such tests.
5) Every testing center should have the facility for pre-test counselling and post-test counselling in HIV/AIDS by professionally qualified counsellors or they should be referred to such professionals.
6) If a first test proves HIV positive, do a re-test to procure certainty about test **results**.

7. Treatment

As there is no cure yet for HIV/AIDS, the only treatment is for opportunistic infections, which all Catholic Healthcare facilities will extend to people living with HIV/AIDS. This will include:

- Clinical Management for diagnosis, testing, retinal treatment (including prophylactic interventions) and follow-up care
- Nursing care to promote and maintain hygiene and nutrition; to assist the family in day-to-day care of the patients and to take necessary precautions suggested under universal precautions above
- Counselling services
- Psychological, pastoral and spiritual support
- Socio-economic support, wherever necessary and possible
- As India is the home of so many alternative systems of medicines (proven and effective remedies) in treating HIV/AIDS related infections, we should encourage use of those that are commonly available and economically affordable should be encouraged to be used.

8. CARE AND SUPPORT FOR LIVING POSITIVELY

1. LIVING **POSITIVELY**

The Church urges the people living with HIV/AIDS (PLWHAS) to live positively. Living positively with HIV/AIDS means spending time with family and friends while contributing whatever they can for the benefit of the family and the society.

- *Continuing one's profession as long as one is able to do so*
- *Planning for the future of loved ones*
- *Maintaining spiritual health*
- *Having hope*
- *Taking care of oneself*
- *Eating a balanced diet*
- *Keeping busy and remaining productive*
- *Getting enough physical exercise*
- *Free from substance abuse*
- *Seeking medical help whenever an illness arises*
- *Getting enough sleep and rest*
- *Going for individual and group counseling*
- *Learning about the virus*
- *Protecting others from HIV infection*

The HIV-Positive person should be guaranteed equal rights to education and employment as other members of the society. HIV status of a person should be kept confidential and should not in any way affect the rights of the person to employment, his or her position at the work place, marital relationship and other fundamental rights.

As regards the treatment care and support to people living with HIV/AIDS, the policy is to build up a continuum of comprehensive care comprising of clinical management, nursing care, pastoral care, counseling and socio economic support through home-based care. Resources from the government and community sectors should be mobilized for this purpose.

1) Institutional Care

- Christian Institutions should be visible manifestations of God's Love.

- ❖ All members of healthcare institutions recognise their obligations to render all possible and adequate care to every patient. There will be no discrimination on the basis of HIV status in matters of admissions and treatment
- ❖ Our hospitals are encouraged to establish diagnostic facilities, which will include those for testing for HIV and STD.
- ❖ Our health care institutions will provide healthcare services social and counselling support and spiritual and pastoral care to the people with HIV/AIDS. Every hospital will have at least one trained counsellor.
- ❖ All Catholic healthcare institutions will take adequate infection control measures (universal precautions) to the greatest possible extent.
- ❖ Each institution will have a designated person as contact/liaison person for all matters connected with HIV/AIDS. Larger institutions and dioceses will have HIV/AIDS committees.

3) Home Based Care

This is an integral part of caring. It is needed when the individual has developed AIDS or even during a bout of opportunistic infection, family members or anyone available provides home-based care. Home-based care includes treatment of common symptoms such as fever, diarrhoea, cough and other health problems related to HIV/AIDS. It is basically palliative in nature and includes maintaining proper nutrition and patient hygiene. Families and caregivers at home need to be trained in day-to-day care of the patient. The training should include aspects such as planning a balanced diet, principles of hygiene, disposal of soiled linen, etc.

4) Community based care

As there is no cure yet for HIV/AIDS, the only possible treatment is for opportunistic infection, which all Catholic healthcare facilities will extend to HIV/AIDS sufferers. This includes:

- ❖ Clinical Management for diagnosis, testing, rational treatment (including prophylactic interventions) and follow-up care.
- ❖ Nursing care to promote and maintain hygiene and nutrition, to assist the family in day-to-day care and to take necessary precautions.

9. ADVOCACY

In spite of the strong IEC campaign on HIV/AIDS there is still inadequate understanding of the serious implications of the disease among the Church personnel, Church leaders, professional agencies, teachers and administrators, not to speak of the medical and paramedical personnel engaged in the healthcare delivery system. A strong advocacy campaign needs to launched at all levels of the opinion and policy makers and service providers so as to make them understand and feel motivated about the need for immediate prevention of the disease and also for adoption of human and Christian approach towards those who have already been infected with HIV/AIDS.

There is a serious information gap about the causes of spread of the disease even among a large number of medical and paramedical personnel in Church-run institutions. This leads to situations of discrimination against HIV/AIDS-infected persons in hospitals, and dispensaries and work places, not to speak of the community at large. There is a strong need for advocacy, at all levels to eliminate such discrimination and over-reaction both by those who are holding offices and the general public.

In Church-related educational institutions, HIV/education should be imparted through both curricular and extra-curricular activities.

All Christian newspapers, and magazines and other print media should be used for conducting campaigns for social mobilization and awareness raising over prevention, and for sharing information and expertise. In general, the media should play a positive role in creating an enabling environment for HIV/AIDS prevention and control, and for the care of the HIV-infected people.

Church-related institutional management would initiate intensive advocacy and sensitization among doctors, nurses and other paramedical workers so that people living with HIV/AIDS are not discriminated against, stigmatized or denied necessary services. The Church expresses serious concern over instances of denial of medical treatment by doctors in their clinics, nursing homes and hospitals, which is causing enhanced stigmatization of the people living with HIV/AIDS.

1). Need For Networking

This global crisis of such great magnitude and perversity cannot be tackled by any one single agency, but through cooperation and collaboration of all: both government and non-governmental agencies are needed. The Church would be ready to cooperate and collaborate with the National AIDS Control Organization (NACO), State AIDS Society in various States, UN Agencies and other NGOs .

Each diocese and congregation is advised to formulate their plans and strategies within its areas of service in dialogue with all agencies committed to the cause: to combat HIV/AIDS spread, to attempt its containment, and to provide care and management for HIV/AIDS affected and infected people.

A. Ecumenical Networking

While we may differ in certain theological teachings and other Pastoral practices from our brothers and sisters who belong to other Christian churches, let us not forget that we are called by the same Lord, Jesus Christ to proclaim His Kingdom. Therefore, we are united in many common values and the tradition of Christian service. Many of these churches have also been active in responding to the AIDS pandemic. Networking with these churches can bring strength to our own Catholic efforts in this **field**.

B. Care and treatment of the patients

There is no cure; but there is no limit to care.

- Medical Care
- Nursing Care
- Emotional Support
- Financial Support
- Spiritual Support in grief and dying
- Support to the Family Members and Relatives

C. Pastoral Care

D. Rehabilitation

- Possibilities of jobs or income generation programmes for those who are living with HIV

- For children who are orphaned, possibilities for their education and settlement.

E. Living Positively with HIV

2) Issues Involved

- Medical
- Ethical
- Social
- Religious
- Humanitarian
- Discrimination
- Misconceptions
- Education & Training
- Documentation and Material Production

I. Care of the caregivers
II. Care
III. Agents of Implementation

i. Church Leaders (Bishops, CRI, Religious, priests & laity)
ii. Hospitals and Para-medicals; Associations
iii. Educational institutions; Welfare Units
iv. NGOs

3) Process of Implementation

- Circulation of the policy
- Pastoral Letters by Bishops
- Awareness building programmes:
  AIDS Day (Dec.1)
  Day for Orphans due to HIV (Dec. 28– Feast of Holy Infants)
- AIDS Desk
- Training Programmes (e.g. Certificate Course on "HIV & Family Education" by CBCI-IGNOU Chair on Health and Social Welfare)
- CHAI, St. John's, etc. working together
- Resource **mobilization**

- Expert Group at Diocesan, Regional & State level
- Inclusion in the Seminary curriculum, Nursing/Medical Syllabi
- Home-based care programmes and **personnel**

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The Church's Collective Response to HIV/AIDS
and
Scale-up Action in India
Report on Special Consultation of Bishops
And
Representatives of Major Health and Development Organizations

8-9 August 2003
St. John's Academy of Health Sciences
Bangalore, India

During a consultation supported by the Catholic Medical Mission Board (CMMB), of New York, USA, and held in Bangalore on 8-9 August 2003, members of the hierarchy and leaders of Catholic-sponsored health and social development services in India committed to a strategic and collaborative response to the rapidly worsening situation of HIV/AIDS in the country. Participation in this event included eleven bishops (presidents of the Regional Health Commissions associated with the Indian Episcopal Conference), officers and staff of the Health Commission at the Catholic Bishops' Conference of India (CBCI), the Catholic Health Association of India, Caritas India, the Sister doctors Forum of India, the Catholic Nurses guild of India (CNGI), as well as experts from Indira Ghandi Open University of India (Delhi), the Community Health Cell (Bangalore), Amala Cancer Research Centre (Kerala), and Amala Ayurveda Hospital (Kerala). Guests coming from outside the country included: Dr. Rabia Mathai, Global Director of Programs at CMMB; Rev. Robert J. Vitillo, Co-Chairperson of the Caritas Internationalis HIV/AIDS Task Force; Rev. Michael Perry, OFM, Policy Advisor for Africa, United States Conference of Catholic Bishops; Mr. Marc D'Silva, Catholic Relief Services; and Dr. Mario De Souza, Advisor to the Health Ministry in Oman.

In opening the session, Rev. Alex Vadakumthala, Executive Secretary of the CBCI Commission for Health, spoke of the continuing stigmatization and marginalization directed toward those living with or otherwise affected by HIV in India. He mentioned specifically the newspaper reports, in July 2003, about a woman in Andhra Pradesh woman who died in abominable circumstances and may even have been stoned to death when she returned to her home village after receiving a diagnosis of HIV infection. Subsequent to her death, her own family refused to re-claim her ashes at the crematorium. He also cited the case of two brothers in Kerala, whose parents died of AIDS-related illnesses, and who were ejected from school after the parents of their classmates refused to send their own children to the school unless these two orphans were expelled. Finally, some Catholic religious sisters adopted the boys and are providing for their education. Fr. Alex said that such ignorance and fear added to the motivation for this consultation, the major goal of which was to promote additional, collective action in response to HIV/AIDS in India.

In offering the first words of welcome, Bishop Ignatius Menezes, of the Diocese of Ajmer-Jaipur, said that no longer could one claim that HIV/AIDS is a problem of the West, since it has taken root in the East as well and that the Church must respond to this situation. In his words of welcome, Archbishop Concessao, of Delhi, who also serves as CBCI Vice President, said that Jesus embodied the compassion of the poor and suffering, and in particular of the least ones in society. In fact, these persons provided an opportunity to be served and thus, through them, Jesus could show what God was like – a compassionate savior who is accepting of all. The archbishop cited Jesus' approach to the lepers; any

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physical contact with them was unthinkable in Jesus' time, yet he touched them and, against the prevailing law, he recognized them, made them feel at home, and healed them. In this manner, Jesus produced a "counter culture". The Church serves as a sign and sacrament of Jesus' continuing presence in the world today. The presence of HIV/AIDS among us gives the Church an opportunity to exercise Jesus' ministry to and acceptance of people so affected as well as to reiterate its moral teaching based upon natural law. The archbishop pointed out that India has the dubious distinction of being the "AIDS capital" of the twenty-first century and insisted that the Church must help to prevent the spread of the virus and to care for those already affected.

The Global Epidemiology of HIV/AIDS – Current and Future Trends

Rev. Robert J. Vitillo pointed out the fact that the pandemic of AIDS is comparable in magnitude to the worst and most tragic pandemics in history; these have tended to infect between 20%-50% of certain elements in the population. He then citied some striking dimensions of this pandemic:

- Approximately 42 million people living with HIV/AIDS by the end of 2002
- 5 million new infections in 2002
- 3.1 million deaths due to AIDS in 2002
- Approximately 14,000 new HIV infections in 2002
    - More than 95% are in developing countries
    - 2000 in children under 15 years of age
    - of the remaining 12,000
        - almost 50% are among women
        - approximately 50% are among 15-24 year-olds

Fr. Vitillo identified sub-Saharan Africa as the most affected region at the present time – with 29.4 million people living with HIV/AIDS at the end of 2002. In four southern African countries, adult sero-prevalence rate exceeds 30%. Food crises in three of these countries (Lesotho, Swaziland, and Zimbabwe) are linked to the toll of HIV. AIDS causes twice as many deaths in the region than those caused by the second leading "killer disease" (lower respiratory infections) and almost 2.5 times the number of deaths caused by **malaria**.

The following historical perspective on the spread of HIV in Asia and Pacific[1] was offered:

- During the early to mid-1980s, there was extensive spread among men who engage in same-sex contact, especially in Australia, Japan, Malaysia, New Zealand, Singapore and Hong Kong
- During the mid- to late 1980s, high HIV prevalence was documented among other populations with high risk behavior (50% or more among female sex workers in Thailand and in parts of India, notably Mumbai)
- In addition, at the same time, there was HIV spread among Injecting Drug Users (IDUs) in Thailand, Northeast India, and the "Golden Triangle" area of China, Myanmar, and Thailand
- During the 1990s, in several South and South-east Asian countries (Cambodia, parts of India, Myanmar and Thailand), significant heterosexual transmission continued or was first noticed.

[1] *HIV/AIDS in Asia and the Pacific Region*, World Health Organization, 2001

- An explosive spread of HIV occurred within IDU populations (levels of more than 50% within 1-2 years in several provinces of China, north-east India, Malaysia, Myanmar, Pakistan, Thailand, and Vietnam, Indonesia, and Nepal.

Some key features about the current situation of HIV/AIDS in the region[2] were mentioned as follows:

- Almost 1 million people in this region acquired HIV during 2002 – a 10% increase since 2001 – bringing the estimated number of people living with HIV there to 7.2 million.
- China and India are experiencing serious, localized epidemics that are affecting millions of people.
- Although India's national adult HIV prevalence rate remains at less than 1%, it has an estimated 3.97 million living with HIV – the largest number in a single country with the exception of South Africa.
- The epidemic in China shows no signs of abating.
- Official estimates put the number of HIV-infected people there at 1 million; there was a 17% increase in new infections in the first six months of 2002.
- The country is marked by widening socioeconomic disparities and extensive migration (more than 100 million Chinese living outside their home regions) – these factors have strong influences on the spread of the epidemic.

Fr. Vitillo pointed out the potential for an increasing HIV burden in Asia by comparing the respective general population numbers and the distribution of adult HIV infection in Asia[3]:

	% of World's Population	Distribution of Adult HIV Infection
Asia and Pacific	60%	18%
Sub-Saharan Africa	8%	70%

He then sounded an alert concerning factors that could contribute to an increase in HIV within South Asia[4]:

- 54% of its population is under the age of 25 – the age of vulnerability for risk taking behavior
- There is ample evidence of sexual activity and of injecting drug use among young people
- in Maharashtra, a study of adolescent, married people indicated that 48% of boys had engaged in premarital sex
- in Nepal, HIV prevalence among IDUs increased from 2.2% in 1995 to nearly 50% in 1998
- Thousands of children live and work on the streets – many abused, marginalised, unaware of HIV risk

After reviewing HIV/AIDS trends in the other regions of the world, Fr. Vitillo expressed grave concern about the projected "Second Wave" of the pandemic at the beginning of the twenty-first century:

Five countries – Nigeria, Ethiopia, Russia, India, and China – will be burdened with some 50 to 75 million people living with **HIV**.

[2] UNAIDS Report, December 2002.
[3] *HIV/AIDS in Asia and the Pacific Region*, World Health Organization, 2001
[4] *South Asia: The HIV/AIDS Epidemic*, UNICEF, 2001.

- In Nigeria, life expectancy is expected to decrease to age 47, compared with 61 before the arrival of AIDS; and in Ethiopia, to 40, from 53 before the onset of disease.
- In addition to the increased health care costs, the burgeoning number of orphans due to the death to AIDS of one or both parents, other catastrophes forecast for these countries by 2010 include:
    - famines,
    - civil wars
    - economic reversals
    - collapse of social and political institutions

The presenter then detailed some of the impact of HIV/AIDS on social development and on the integrity of both families and individuals:

Impact on Population and Life Expectancy

- U.N. Population Division estimates that the population of the 45 most affected countries will be 97 million smaller in 2015 and that the world population will be 480 million smaller by 2050
- India alone will account for 47 million additional AIDS-related deaths and China will account for an additional 40 million such deaths.
- Life expectancy in Sub-Saharan Africa is the same as it was in tenth century Europe

Impact on the Family[5]

- A study in Côte d'Ivoire indicated that health-care costs rose by up to 400% when a family member had AIDS
- Households in both Thailand and Tanzania reported spending up to 50% more on funerals than on medical care
- Research in Tanzania showed that individuals' food consumption dropped by 15% in the poorest households after the death of an adult to HIV/AIDS

Staggering Increases in the number of Orphans bring the risk of a "lost generation

- with little or no education
- poor socialization
- social upheaval
- economic underclass

Education systems are collapsing[6]

- AIDS has an impact on both the availability and the use of schooling
- In Central African Republic and Swaziland, school enrollment is reported to have fallen by 20% and 36% due to AIDS and orphan hood, with girl children most affected
- In Guatemala, studies have shown that more than a third of children orphaned by HIV/AIDS drop out of **school**

[5] Source: UNAIDS Barcelona Report, 2002.

[6] *HIV/AIDS: Implications for Poverty Reduction.* United Nations Development Program Background Paper prepared for the UN General Assembly Special Session on HIV/AIDS, 25-27 June 2001.

Reactions to HIV/AIDS often cause stigmatization and marginalization

- Studies in Côte D'Ivoire and South Africa show that, in places with extremely high HIV prevalence, women refused testing or did not return for their results
- In southern Africa, a study on needle stick injuries found that nurses did not report the injuries because they did not want to be tested for HIV
- In a study on home-care, fewer that 1 in 10 people caring for an HIV patient acknowledged the disease affecting their loved one

Privacy and Confidentiality are often compromised

- Many people, including some clergy, have the false concept that HIV could be spread by casual means and think that HIV-infected need to be publicly identified in order to avoid infection
- Instead of adopting "universal" health care precautions - valid preventing spread of HIV and other blood-borne diseases, some health care workers think that HIV patients require special precautionary measures and thus disregard the patient's right to confidentiality

Women are severely affected

- Women are more vulnerable to HIV/AIDS because they have less secure employment, lower incomes, less access to formal social security, less entitlement to assets and savings, and little power to negotiate sexual contacts
- They are more likely to be poorly educated and have uncertain access to land, credit, and education
- Women-headed households are poorer and have less control over productive resources

Some simple math can save the developing world[7]

- Macroeconomist, Jeffrey Sachs, says that we could fight malaria, TB, and HIV, by providing medications, technology, and prevention funding to the poorest countries with only $27 billion per year; that is 1/1000 of the income of the "rich countries
- Sachs maintains that we could save 8 million lives per year if the "rich world" were willing to set aside 10 cents on every $1000

Major Learnings at the Present Stage of the Pandemic[8]

- The HIV/AIDS pandemic is still at an *early* development and its long-term evolution is still unclear.
- Some success in prevention activities (e.g., in Thailand and Uganda) has been achieved in particular countries - usually this has happened with a multi-sectoral approach and with active involvement of young people.
- A necessary component in this success has been community mobilization, including elimination of stigma, partnership between government and others in the community, and involvement of all sectors in the community.
- Access to comprehensive care and treatment for HIV/AIDS is not an optional luxury in global responses - this must be made available in *all* parts of the **world.**

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[7] *AIDS 2002 Today*, Newsletter of XIV International Conference on AIDS, 10 July 2002 and Jeffrey Sachs Senior Lecture at Barcelona, 11 July 2002.

[8] UNAIDS Barcelona 2002 Report

- It is crucial to address the economic, political, and cultural factors that render individuals and communities vulnerable to HIV/AIDS.
- While the lack of capacity and infrastructure must be addressed in developing countries, it should not be an obstacle to making comprehensive care and prevention available in all countries that show a commitment to an expanded response.

HIV/AIDS in India – Church's Responsibility

Dr. G.D. Ravindran, of St. John's Medical College Hospital, Bangalore, presented on this topic. The first case of HIV was detected in India in 1987. In the last 15 years, the epidemic has spread rapidly throughout the country. Today India has approximately 4 million people infected with HI V.

HIV increases the mortality and morbidity rates of the affected communities. It will increase the infant and under-five mortality. The number of orphans will increase; it also produces emotional trauma and discrimination among the infected individuals.

HIV/AIDS also has an economic impact. The work force of the country will be affected as will be young adults. National budget of health care is likely to increase as the demand for care increases. Poverty worsens inequality and increases human rights abuses.

89% of infections occur among the sexually active and economically productive age group of 18-40 years of age. 25% of HI V-infected are women. The disease has not spared children. The virus infects approximately 30,000 newborn children. At least 120,000 children have been orphaned by the AIDS-related deaths of one or both parents.

There are certain differences between the epidemic in India and in the Western world. The virus seen in India belongs to clade type C vs. clade B which is more prevalent in the West. Transmission through blood transfusions is decreasing. Transmission from mother-to-child is increasing. Intravenous drug use is a major source of transmission in India.

General awareness about the disease and about modes of transmission is low. Reproductive tract infections are on the increase. Changing social behavior patterns, sensationalism by the media, and peer pressure all contribute to the adoption of risky sexual behavior.

Large numbers of migrant workers tend to engage in high-risk behavior when they are away from their families. Economic necessity and gender inequality render sex workers vulnerable to acquiring the infection. In the Northeastern regions of the country, intravenous drug use also contributes to transmission of the disease.

Abuse of blood and blood products as well as unsafe blood bank procedures have helped to spreads HIV. Similarly, unsanitary conditions in ante-natal facilities have caused problems.

The central government of India established a National AIDS Committee in 1986 and launched the National AIDS control program in 1987. In 1992, the government established a new program **and**

changed the committee into a National AIDS control organization (NACO). It also formulated a policy that involved a multi-sectoral approach that included involvement of non-governmental organizations.

NACO implements its policies as well as its activities through the different state AIDS Cells/societies. Its activities involve program management, surveillance, research, information, education, and counseling activities. It also undertakes initiatives to ensure safe use of blood, reduction of sexually transmitted diseases (STDs), condom promotion, and interventions that can reduce the impact of the disease.

The Catholic Hospital Associations formulated a policy on HIV/AIDS in 1997. It has been conducting various training programs through its members. Catholic hospitals have been in the forefront of providing care for HIV/AIDS in the country. Catholic colleges have taken active part in the university programs on AIDS control.

Some recommended interventions to deal with the increase of HI V spread in India include the following:

1. Medical interventions like voluntary testing and counseling; integrated approach to health care such as that implemented by many Catholic hospitals in the country; provision of safe blood transfusions; treatment of opportunistic infections; de-stigmatizing people living with HIV/AIDS (PLWHAs); reduction of alcohol and drug abuse; adoption of universal precautions in the health care setting and safe disposal of medical waste.
2. Social interventions such as integration of HIV/AIDS education in the school curriculum from 3rd and 4th standard grades and gradual sophistication of curriculum content in later grades; promotion of AIDS days in parish youth programs; family education and support programs at the parish level; social welfare schemes to increase economic capacity and assist the unemployed; targeted work with certain groups engaging in high risk behavior, including commercial sex workers, IVDUs, and gay men.

Response of the Church in the United States to the Situation of HIV/AIDS

Fr. Michael Perry spoke of the two documents issued under the auspices of the Bishops' Conference of the United States. The first, *The Many Faces of AIDS,* was issued in 1987 by the Administrative Board of the Bishops' Conference. The second, *AIDS: A Call to Compassion and Responsibility* was issued by the plenary body of bishops. Both documents emphasize the need for an integrated response from the Church and for provision of services and advocacy on behalf of those living with HIV/AIDS.

In recent years, the International Justice Committee of the United States Conference of Catholic Bishops has made advocacy on HIV/AIDS as one of its top priorities. Focus of the advocacy efforts includes promotion of additional funding by the U.S. government for HIV/AIDS efforts in developing countries, insistence on provision of anti-retroviral medications at affordable prices for PLWHAs living in developing countries, and promotion of strategies to reduce stigma and discrimination against PLWHAs.

Catholic Relief Services, the overseas relief and development arm of the bishops of the United States has made a major commitment to fund HIV/AIDS efforts, especially in Africa, Asia, and Latin America.

CMMB AS A CATALYST FOR A FAITH-BASED RESPONSE TO HIV/AIDS,
by Dr. RABIA MATHAI, DrPH, MPH, MS, PhD, GLOBAL DIRECTOR OF PROGRAMS

CATHOLIC MEDICAL MISSION BOARD: A Global Leader in Faith-Based Organizations

- CMMB is a 75 year old US based FBO
- Exclusively providing healthcare to people in need worldwide
- Focusing on strengthening health of vulnerable children and women
- CMMB collaborates with in-country faith-based umbrella organizations like CBCI, CHAI, CARITAS INDIA, RELIGIOUS ORDERS and Technical resource and professional groups like ST. JOHN'S NAHS, SDF, CRI,CNGI, and CDC
- CMMB bases its programs on national priorities and guidelines, within WHO protocols

CMMB HIV/AIDS INITIATIVES

- CHOOSE TO CARE 84 Projects through Southern African Bishops Conference for HIV/AIDS prevention, care and support in South Africa, Swaziland, Namibia, Lesotho and Botswana

- BORN TO LIVE – PMTCT
  Global Initiative, including National Scale-up in Kenya

HIV/AIDS Religious Initiatives

- CMMB collaborates with umbrella, faith-based groups to build capacity of religious leadership and communities
- CMMB helps to strengthen faith-based health care infrastructure, such as in hospitals and other health care facilities

CHOOSE TO CARE: FOCUS

CAPACITY BUILDING AND INTERVENTIONS:

- HOME BASED CARE AND SUPPORT INCLUDING PEOPLE LIVING WITH HIV/AIDS AND AIDS ORPHANS thru Feb 2003: 160,000 home care patients, 3900 treated in hospice facilities, and 2700 AIDS orphans **assisted**

- PREVENTION EDUCATION FOR COMMUNITIES, ESPECIALLY ADOLESCENTS thru Feb 2003: 360,000 youth reached

- SENSITIZATION OF CHURCH LEADERSHIP AND CHURCH COMMUNITIES thru Feb 2003: 98% of SA diocese reached with HIV/AIDS community-based programs.

•RELIGIOUS INITIATIVE FOR SENSITIZATION OF CHURCH LEADERSHIP UNDER PLANNING

CMMB works with 350 FBO Partners in Global Initiatives in Over 100 Countries

:

CMMB's Preparatory Work in India

•Consultations with CBCI, CHAI, St. John's Medical College

•Meeting NACO and CDC officials with CBCI and CHAI

•Working on draft strategies with above organisations

•Supporting national PMTCT training for Catholic facilities

•Serving as a Catalyst for this meeting

CMMB stands ready to ...

•Work in collaboration with the co-sponsors of this meeting to promote an appropriate response to HIV/AIDS in India

•Respond to needs as they are identified in India (beginning with this meeting)

•Assist Indian partners with capacity-building

•Establish an in-country office and identify leadership for this office

•Support additional regional meetings and consultations as planned

Dr. Mathai ended her presentation by thanking all the participants for their excellent contributions to the discussion and by raising an urgent question: **What will be our next steps????**

HIV/AIDS and the Ethical Response of the Church

Rev. Dr. Thomas Kalam, Director of St. John's National Academy of Health Sciences, Bangalore, prepared an extensive paper on the ethical response to **HIV/AIDS.**

He said that Christ's view of illness (that it is "for God's glory" (John 11:14) and "so that God's works might be revealed" (John 9:3) must be the basis for a Christian ethics of HIV/AIDS.

He maintained that the ethics of HIV/AIDS cannot be confined to casuistry, even though this is a useful instrument in detailing Christian moral response to a range of difficulties. The ethics of HIVAIDS must be developed with reference to the ultimate aim of achieving the fullness of life and thus the glory of God.

Fr. Kalam insisted that the conjecture that AIDS might be God's punishment for sin must be ruled out at the very outset of our discussion. The virus can be transmitted in different ways, moral, immoral, and amoral. It is primarily an epidemiological issues rather than a moral one.

He then detailed different ways in which HIV/AIDS has become an occasion for the promotion of the fullness of life:

- By celebrating life when it is disrupted by HIV/AIDS
- In the positive living of people with HIV/AIDS
- In the cry of those with HIV/AIDS
- In the care given to people living with HIV/AIDS
- In the efforts for positive action for prevention and education

Fr. Kalam said that ethical conflicts arising from HIV/AIDS can be grouped under three areas:

1. In dealing with People affected by HIV/AIDS: This ethics should promote the care and treatment PLWHAs should get; it should guarantee strong action to protect individuals against discriminatory treatment or any form of persecution of ill treatment; it should protect the human dignity of the affected.

2. In dealing with the general public not affected: it should positively address the need to protect public health by helping to promote ways of preventing the spread of HIV/AIDS.

3. In dealing with enhancement of human life: it should enable everyone, both the infected and non-infected to "live positively" with this pandemic of HIV/AIDS. The quality of human life should be enhanced in the way we deal with HIV/AIDS.

In the matter of HIV/AIDS, the poles of ethical conflict are:

Public health vs. Fundamental rights of an individual
Utility (for many) vs. Liberty (for the few)

One has to strike a balance which, while protecting public health, will also protect individuals so that they will feel free to come forward for available treatment. Any one-sided and divisive approach that sets fundamental rights of individuals in opposition to public health, or vice versa, or which does not give hope to both the affected and non-affected cannot be considered as constructively ethical.

Use of Indian Traditional Drugs in HIVAIDS – A Scientific and Clinical Study

Drs. M. Kesavan and Kttan Tharakan presented joint papers on the use of traditional drugs in HIV/AIDS treatment. Findings of their studies indicate satisfactory relief of opportunistic infections and physical ailments in patients. Symptoms relieved included: fever, diarrhea, joint pain, itching, and partial relief of lymphadenopathy. Medication improved the life span of the patients. Patients with tuberculosis were referred for Western medical treatment as well.

Value-Based University Programs of Study on HIV and Family Education

Professor Gracious Thomas explained the Catholic Bishops' Conference of India (CBCI) and Indira Ghandi National Open University (IGNOU) signed a Memorandum of Understanding on February 29, 2000, to establish the IGNOU-CBCI Chair on "health and Social Welfare" at IGNOU.

One of the objectives in establishing this Chair was to develop and launch programs of study in the areas of HIV/AIDS and Family Education. The "Certificate in HIV and Family Education" (6-month study period) was established in January 2002. The Diploma on "HIV and Family Education" (1-year study period) was established in 2003. The main target audiences for these programs are school teachers, NGO staff, para-medics, and parents of adolescents. More than 2000 students are enrolled in these programs.

Currently IGNOU is involved in a massive HIV/AIDS Awareness Campaign. The university has developed a brochure entitled, *HIV Prevention Guide*, for its students; this is being mailed to 300,000 students and may eventually reach 1 million students this year. IGNOU has produced more than a dozen video films and audio programs that are broadcast through various outlets. IGNOU conducts regular teleconferences on this topic. The university also conducts awareness-raising seminars about HIV/AIDS.

Proposed Common Policy Statement on HIV/AIDS by the Church in India

A preliminary draft of this statement was presented by staff of the CBCI Health Desk. The participants complimented this effort and gave helpful suggestions for editing and change.

Plans for Future Activities

The participants made recommendations for future activities, including:

1. Prevention Education and Awareness-Raising about HIV/AIDS
    - Preparation of a Vision and Mission Statement to be issues by the Bishops of India
    - Training of Church leaders, especially bishops in a ½ seminar during the Plenary meeting of the bishops of India
    - Training of seminarians
    - Training of diocesan social service directors (by Caritas India)
    - Integration of HIV/AIDS education in school curricula
    - Designation of AIDS day on one Sunday of the year for awareness-raising in the parishes
    - Integration of HIV/AIDS education in pre-marital preparation courses
    - Train students, teachers, health care workers, men's and women's groups

2. Care and Support
    - Establish care centers as needed
    - Disseminate CHAI policy guidelines to medical staff
    - Include Post-Exposure Prophylaxis at all nursing stations in Catholic hospitals

- Offer Church-sponsored financial support to needy PLWHAs and their children

3. Fight Discrimination and Stigmatization
    1. Empower medical staff to use universal precautions with all patients, not just those living with HIV/AIDS

4. Pastoral Assistance
    - Train pastoral agents on pastoral care and counseling

5. Networking
    - CHAI to prepare protocols to all member organizations on how to access State AIDS society funding

6. Planning and Strategizing
    - Request religious congregations to include HIV/AIDS services in their respective charisms
    - Establish a central section with a technical team to monitor Church-sponsored activities and trends of the **pandemic**

Report Prepared by: Rev. Robert J. Vitillo, on August 29, 2003

will come as a separate decision outside the context of the group. The group is set up in such a way that it does not encourage sexual behavior per se. It is hoped simply that the mutual support resulting from participation in the group will influence the individual's choices as regards to the timing and manner of any possible future sexual behavior.

This seeking to influence a sexual act, should it take place, does introduce the element of cooperation. However, there is no expectation on the part of the group that the individual will or should engage in sexual behavior. Remoteness is also assured in the presence and purpose of support staff: to discuss clinical issues of infection, assure that the dignity of the topic is preserved, and offer the pastoral presence of the church.

On the other hand, it can be argued that the cooperative involvement of the clinic is through its facilitation of a mechanism meant to influence individuals to make decisions whether to engage in homosexual activity. Further, it is also meant to influence the decisions of those who decide for sexual activity regarding with whom, when, and in what manner. For the support group to be effective, it must have a direct influence on the participants' multifaceted decisions regarding sexual behavior. This will include influencing the person's decisions both to abstain from and engage in sexual activity. If the person chooses to engage in sexual activity, the hope of the group is that the decision will be with greater discipline than might otherwise be exercised. From this perspective, it can be argued that the cooperation is morally proximate.

I am not certain that the characterization of the mediate material cooperation as proximate or remote is always helpful, especially in cases like this in which the cooperation can be characterized as being either one or the other. The question is not so much whether the cooperation is proximate or remote, but whether morally permissible cooperation is prudent. That is to say, whatever proximity or remoteness is present, is it—in light of the moral gravity present, the end being sought, and the duress shaping the situation—reasonable to proceed?

Characterizing the cooperation as proximate or remote may be helpful in discerning the prudence of doing so, but the characterization itself is not definitive. Simply because the cooperation is remote will not necessarily mean it is prudent to proceed, and likewise the fact that it is proximate will not necessarily mean it is imprudent to do so. What is more important is that there be a comfortable fit with the cooperation and the identity/mission of the institution. In light of the church's teaching regarding the homosexual person, as distinct from the homosexual activity, its concern for the individual and common good, and the absence of more readily available means, it can be judged prudent to form the support group, however the moral distance is characterized.

Finally, there is the question of scandal. Scandal should not be an issue for those who understand the history and format of the group. The

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7. Pius XII, *Ca riesce*, *AAS* X

young people, including postponing the first sexual activity and, for those already active, nonpenetrative sex and the use of condoms for protected intercourse." One of the stated objectives of the organization was "controlling and containing the spread of HIV infection among a defined vulnerable target population, through education, awareness, and the promotion of safe sex." The sisters then sought the advice of some Catholic experts and eventually decided not to place their property at the service of this group.

This case is illustrative of one of the major dilemmas facing Catholic Church institutions in India in their response to the AIDS pandemic: To what degree may they be involved in ministry among people with AIDS, especially when their involvement necessarily includes cooperation with groups that do not share the same vision as the Catholic Church and, in fact, use means that the traditional teaching of the church considers immoral?

In this study we shall first look at the situation in India and then briefly see the response of the church before addressing the major ethical issues raised by this particular case.

The Indian Context

IT IS VERY hard to establish the extent of the spread of HIV/AIDS in India. The National AIDS Control Organization (NACO) reported that as of 31 March 1999, out of 3,457,080 samples screened, there were 7,012 cases of AIDS and 85,312 were confirmed HIV seropositive. The seropositivity rate is 24.68 per thousand. The epidemiological data indicate that the prevalence of HIV continues to increase and spread mostly through the heterosexual route, from the urban to the rural areas, and from the individuals practicing risk behaviors to the general population. Critics point out that these figures are flawed, because the samples do not cover all the states and the survey has been mainly limited to high risk groups—sexually active women attending prenatal clinics, and men and women attending clinics for sexually transmitted diseases. The figures refer to people tested and not to the entire population. But even making allowances for these drawbacks, the picture is grim. There is a great deal of under-diagnosis involved and the real figures are not showing up in hospital records.[1] Another study states that there are

1. For example, an analysis of Mumbai's mortality data for 1994 showed an abnormal increase in deaths due to tuberculosis, diarrhea, and hepatitis (infections common among HIV-positive people), especially among young adults and teenagers. *Express Magazine* (13 September 1998): 4.

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The Church's Response

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2. UNAIDS, Geneva, 1998.

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4. *The Times of India*, 13 June 1

5. Shalini Bharat, *Facing the Cha*
to HIV/AIDS in Mumbai, India (Mun

field of health care, is quite significant. It is estimated that the church hospitals, dispensaries, and health centers provide about 10 percent of the health care in the country. With the Governmental Health Care system in India proving grossly inadequate, the burden of looking after the needs of the poor often falls on voluntary agencies—those that belong to the church and other religious organizations as well as nongovernmental organizations (NGOs). At present the NGOs seem to be taking the initiative in responding to AIDS. On an institutional level the church has not done much. But with its modest resources, its contribution can only be limited. What is required, apart from ministering to people with AIDS who come to their institutions, is networking with governmental and other secular agencies.[6] The Catholic Hospital Association of India (CHAI) in its policy statement has in fact recommended working with other agencies. But it is precisely here the church faces a conflict. How is it to cooperate with agencies that promote responses not in keeping with the teaching of the church? More specifically, how does the church cooperate with agencies that make the use of prophylactics an essential part of their response to AIDS? These questions do not seem to have been addressed either by CHAI or by the bishops of India. A recent consultation of church bodies held in Delhi in April 1999 dealt with some of these issues with many participants, representing groups involved in ministry to people with AIDS, seeking direction and support from church leadership to respond to this thorny but urgent pastoral problem.

In its response to the AIDS crisis, the church has to combine prophetic witness to the truth with pastoral compassion. The compassionate face of the church in India has traditionally been revealed especially by the charitable hospitals, orphanages, hospices, and developmental activities that are mostly run by religious. The church also has the reputation of normally being the first to respond to major natural calamities. Yet in the face of the HIV/AIDS pandemic there has been a certain reluctance shown by church personnel to get involved.

Two reasons have been suggested by them in private discussions. First, there is a certain amount of discomfort and unease in relating to the HIV-infected persons because one is not comfortable with the subcultures to which many belong—the gay community, "commercial sex workers," drug addicts. Second, there is a conflict between the views of the church and the programs of other agencies, especially with regard to the use of condoms, which makes it difficult to get involved in this ministry.

6. Pope John Paul II has also stated that the struggle against AIDS calls for collaboration among all people. *Dolentium Hominum, Church, and Health in the World* 5.1 (1990) 1:6–9.

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The Issue of Condoms

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7. Carlo Caffarra, "AIDS
68–72.

Problems on the Level of Individuals and Institutions

THE GOVERNMENT HAS for many decades strongly advocated family planning. Apart from the objection to the use of coercion, the vast majority of Indians do not have any ethical objections to the use of contraception, sterilization, and even abortion. Hence, on an individual basis, it is not easy to convince people of the rightness of the Catholic position with regard to the use of condoms. In fact, it appears difficult at times to convince Catholics. There have been reports of religious distributing condoms as part of their ministry among commercial sex workers and people with AIDS. They seemed to justify this as a way of limiting the extent of evil when individuals refuse to desist from irresponsible moral behavior.[8]

There is also a problem on the institutional level. In the case cited at the beginning, we saw the difficulty in being associated with groups working for people with AIDS but promoting the distribution and use of condoms.[9] International funding agencies also often make the distribution of condoms one of the requisites for obtaining financial help. To what extent and in what manner can a Catholic or a Catholic institution get involved?

The response of the Catholic Church should be on two levels. It must bear witness to the inclusive nature of its compassion, protesting against discrimination by a broad policy of acceptance of people with AIDS and providing care. It must further be involved in the task of "responsibilization"—educating people to responsibility especially in the areas of prevention, transmission, and healing.[10]

Educating Individuals to Responsibility

IN THE TASK of educating people to responsibility, we must be clear about the content and limits of our teaching. In Catholic institutions one is bound by what the Catholic Church regards as a Catholic vision and a Catholic ethic.

8. At the National Consultation of Catholic Church Bodies mention was also made of such incidents as providing clean needles to drug addicts to prevent HIV infection.

9. This also seems to have been the view of Archbishop Roger Mahoney who withdrew permission for the use of church facilities for an AIDS education program which he discovered would promote the use of condoms. *Origins* 16.28 (1986): 506.

10. Marciano Vidal suggests that the two basic criteria of the ethics of AIDS are "responsibilization" and "nondiscrimination." See "The Christian Ethic: Help or Hindrance? The Ethical Aspects of AIDS," José Oscar Beozzo and Virgil Elizondo, eds., *Concilium: The Return of the Plague* (1997/75): 89–98.

In the light of this doctrine, How would one make a moral decision in the case given above? As James F. Keenan suggests, at least six questions must be answered to determine whether A can legitimately cooperate with B. "First, what is the object of A's activity? Second, is A's cooperation in B's illicit activity formal or merely material? Third, is the cooperation immediate or simply mediate? Fourth, is the cooperation proximate or simply remote? Fifth, does A have sufficient cause for acting? Sixth, is A's cooperation indispensable?"[13]

Applying this principle to the case given, we might draw the following conclusions:

1. In the matter of renting rooms for the NGO, we could say the object of the sisters' act would not in itself be immoral. They merely provide space for the care of people with AIDS.

2. The cooperation is not formal because they do not show approval of the use of prophylactics or intend the act. It is possible for them to detach their concern for people living with HIV/AIDS from the use and promotion of condoms which they do not intend. Such cooperation is only material.

3. Their cooperation is not immediate, since the object of their action is not the same as the object of the illicit activity, nor are they involved in any essential part of the illicit activity.

4. Further, the cooperation is remote from the illicit activity. The act of renting out space is radically different from the acts of the religious who decide to distribute condoms to commercial sex workers and people with AIDS.

5. Yet another question that is traditionally asked is whether there is a sufficiently grave reason for the cooperation. Taking into consideration the nature of the AIDS pandemic and the urgent need to provide care and prevent an epidemic in the interest of the common good, one could claim that there are sufficiently grave reasons.

6. We may also state that the cooperation is not indispensable to the performance of the immoral act.

7. But one final factor needs to be taken into account—namely, the danger of scandal. It is precisely this factor that seems to have prevented

permitting principle. It is a principle that we avoid as far as possible because cooperation in evil is regrettable. One of the purposes of the principle is to contain evil. The principle cannot be used mechanically, but has to be applied with human reasoning. James F. Keenan, "Institutional Cooperation and the Ethical and Religious Directives," *Linacre Quarterly* 64 (August 1997): 53–76.

13. James F. Keenan, "Prophylactics, Toleration, and Cooperation: Contemporary Problems and Traditional Principles," *International Philosophical Quarterly* 29 (1989): 209.

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morality. It is not. It is more an issue of social justice, involving human rights and the conflict between the rights of the individual and the protection of the common good. The Christian response must be on both the micro and the macro levels.

There is a need for the practice of what Vidal calls "nondiscrimination," stated more positively as the criterion of inclusion or solidarity. The starting point is the criterion of acceptance of the other whom I cannot "shut out" but whom I must "bring in" in a special way to the dynamic of solidarity of human actions.[15] India has had a long history of discrimination that included a practice known as "untouchability." Untouchability was formally abolished in the Indian Constitution, no. 17, but discrimination still continues. There is a danger of people with HIV/AIDS becoming the new untouchables. The reason is that the disease carries a social stigma. In the public perception persons living with HIV/AIDS are seen as having brought it on themselves by immoral behavior. As a result people with AIDS are discriminated against in the area of employment, housing, and access to health care. At times they are denied basic rights such as liberty, autonomy, and freedom of movement. This constitutes an attack on the foundations of justice based on the equal dignity of all human beings, and violates the claim to just and fair treatment irrespective of a person's physical condition or the cause of it.[16]

The Catholic Hospital Association of India (CHAI) has rightly decided that health care institutions have an obligation to establish a policy that guarantees optimum care, resists any form of discrimination, helps in promoting research, and provides educational and counseling support. As Dr. Edmund Pellegrino suggests, there is also a collective responsibility to reaffirm the obligation of all doctors to treat HIV infection, to take action against those who do not, and to support physicians who have become infected. The profession has great influence on society and should be an advocate for nondiscriminatory, compassionate, and competent care of all HIV-infected patients.[17]

Unfortunately, despite the guidelines of CHAI that state that no one must be denied admission or treatment in hospitals because they suffer from

15. Vidal, "Christian Ethics."

16. *Gaudium et Spes* clearly states that because of the dignity proper to human persons their rights and duties are universal and inalienable. It further declares that every form of discrimination, whether social or cultural, whether based on sex, race, color, social condition, language, or religion, is to be overcome and eradicated as contrary to God's will (no. 29). A similar statement can be found in the *Universal Declaration of Human Rights*.

17. Edmund Pellegrino, "Treatment Decisions and Ethics in HIV Infection," *Dolentium Hominum*, 116–17.

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18. Pellegrino, "Treatment

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allowed. But the fact that this often leads to further discrimination and denial of health care, and that at present there is no therapeutic benefit to the patient, indicates that there is no justification for such mandatory screening or testing.

Another area concerning justice is the allocation of resources. The exorbitant cost of providing care to people with AIDS places a strain on society. There is sometimes an objection made that society is not obliged to provide for people who have freely brought the disease on themselves through their behavior. However, this would also constitute unjust discrimination. Access to health care is a right for all persons. There is also a global dimension to be kept in mind. The distribution of resources for the treatment and care of AIDS patients and the prevention of HIV transmission has been extremely unequal. Although more than 80 percent of all HIV infections occur in less-affluent countries, they receive only a small portion of the international resources spent on HIV/AIDS. This raises a serious issue of distributive justice.[20]

As the study document of the WCC indicates, socio-economic and cultural contexts are determining factors in the spread of HIV/AIDS. The WHO currently estimates that nine out of ten people with HIV live in areas where poverty, the subordinate status of women and children, and discrimination are present.[21] Apart from its response to the immediate effects and causes of HIV/AIDS, the church, conscious of the link between poverty and AIDS, must continue to promote just and sustainable development. It also needs to pay attention to situations that increase vulnerability to AIDS—migrant labor, commercial sex activity, and the drug culture. Finally it must also stand up for the human rights of persons living with HIV/AIDS who are often denied their fundamental right to security, freedom of association, movement, and adequate health care.[22]

20. *Facing AIDS: The Challenge, the Church's Response*, WCC Study Document (Geneva: WCC Publications, 1997), 66.

21. *Facing AIDS*, 13. According to Dr. Elizabeth Reid, "it is critical to explore the relationship between economic, social, and cultural variables and the spread of HIV—who becomes infected with the virus and with what spatial distribution. Examples which have been identified as having a causal role in the spread of the virus include gender (more specifically the economic, social, and cultural lack of autonomy of women, which places them at risk of infection); poverty and social exclusion (the absence of economic, social, and political rights); and labor mobility (which is more than the physical mobility of persons and includes the effects on values and traditional structures associated with the processes of modernization). At the core of the transmission of HIV are issues of gender and poverty." Quoted in *Facing AIDS*, 14.

22. *Facing AIDS*, 95, 105.

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CHAI's Effort to Deal with HIV/AIDS

Involvement with HIV/AIDS work

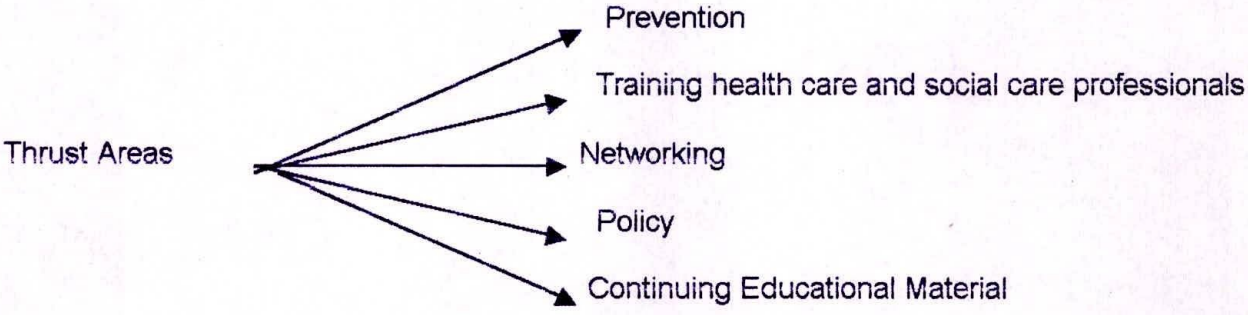
As HIV/AIDS was becoming a serious health and social problem, there was an urgent cry from all quarters of the church to respond to this grave situation. Since CHAI is the structural body responsible for health, everyone looked up to CHAI for guidance and direction on HIV/AIDS.

Milestones of CHAI's growth with specific focus on HIV/AIDS

1993	–	AIDS Desk was formed "Think-tank" group
1994		CHAI's Policy on HIV/AIDS
1995		CHAI's Plan on HIV/AIDS
1996 – 1997		Personnel from the member institutions were trained to plan and initiate actions in their regions
1998 – 2001		- Developed human resources in care and support. - Networking with like-minded organizations for policy lobbying and advocacy.
2002 – 2004		The quality of life of the persons infected & affected with HIV/ AIDS is enhanced through a process of specific interventions such as implementers forum & promoting access to parallel system of medicine.

Specific Areas of Involvement:

CHAI approached the situation at various **levels**



Prevention

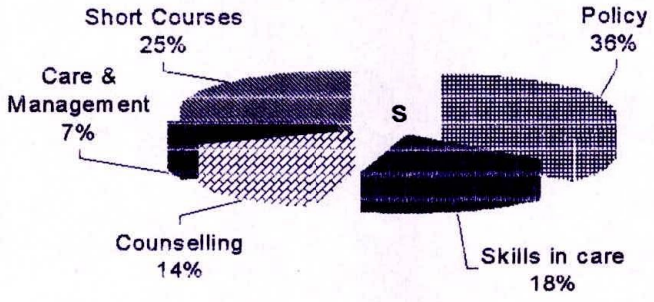
Prevention had been an utmost concern. CHAI had done pioneering work in the area of school health. Developed modules and innovative approaches for Life Skill Education in schools ad colleges with the collaboration of CRI in 1997-1999.

Now we have been invited by Andhra Pradesh State AIDS Control Society to be the nodal agency for the school health programme in the state of AP for the non-government schools.

Training

Training of the health care personnel with specific skills on prevention, counselling, care and management. About 650 persons have been trained and about 50% of them are directly involved in giving care while others have initiated activities along with their ongoing work.

Training Programmes & Participants trained



Networking
Networking with church related institutions, NGOs and Government agencies – such as APSACS for the school health programmes "Life Skills Education" and Drop-in Centers".

TB and Malaria Control Programme through the regional units. Training on microscopy through Government agency.

Collaborating and networking with other Churches for care and prevention Community Health Watch Groups.

Policy: Consultations were organized at Regional and National level to form policies.

1. *Common church policy*

Intensive efforts had been taken to network and collaborate with church bodies, church related institutions and NGO's to bring out a common church policy on HIV/AIDS. Prevention, care, management, counselling and training of personnel. This policy would be available in six months.

2. *Congregation and institution policy*

Policies to be made flexible to ensure that persons infected and affected are cared and supported. Consultations and discussions with 242 decision and policy makers of the member institutions were organized.

(St. Ann's of Luzen sought help in developing the policy and now they have started a center in Vijayawada, Andhra Pradesh for both men and women with HIV/AIDS).

Continuing Educational Material

Through our interventions, there was a felt need for scientific and updated information among our membership. Personnel who have been trained by us are updated with the recent developments with continuing educational material on HIV/AIDS and the concerns and issues. This material is sent once in four months.

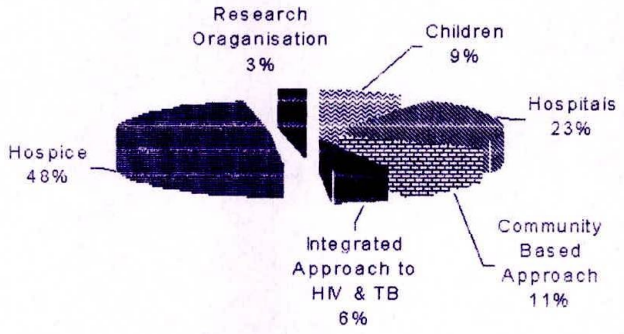
Impact

Nine years into HIV/AIDS work – we stop to look back and see if we have made a dent in the epidemic. Has our mission of Christian love reached to the forsaken one?

We feel content enough to say YES!! We made a dent in this epidemic through our love, service, and efforts.

The approaches and strategies used during the past nine years in the areas of prevention, training, networking, impact on the policies, and disseminating information enabled us to be instrumental in starting 35 organizations/ institutions in India for the care, support and management of persons infected and affected with HIV/AIDS.

Organisations working for HIV/AIDS



Back in 1993 when the challenge of HIV/AIDS was hurdled at us, there was not even a single church related institution for the care and support of these most neglected and rejected ones. But today we are glad to see 35 institutions giving these services. One young sister from Mumbai says that she feels it is enough if we can allow them to die in peace and dignity.

Institutional care has always brought criticism about the sustainability, feasibility and impact in the long run. However, when we look closely we found the impact the institutions have made:

- The institution facilitates acceptance in the community.
- The local community contributes in caring for persons with HIV/AIDS through volunteering to serve or meet their needs. Thereby through this process remove stigmatization.
- The organization facilitates to build back the lost relationships of the persons with their family and community.
- Promotes dignity of life.
- The experiences shared by our member institution working with HIV/AIDS have shown that institution/ organizations are instrumental in fostering community support in the course of time. (eg. Jyothi Terminal Care center)

The membership involved in HIV/AIDS works were initiated based on the needs of the people. The situation differs from state to state thus each organization is a unique model by itself. Some of them focus on children while others care for men and women.

Few approaches that have made difference.

Integrated Approach

Mukta Jeevan now has an integrated approach to communicable diseases. The pioneer institution by sisters of Helpers of Mary in Thane was started for the Leprosy patients. After the outbreak of HIV/AIDS as some of patients also are with HIV. The management adopted a mainstream approach to patient care. Patients whether with leprosy, TB or HIV/AIDS are isolated neither among themselves nor from their families and friends. The caregiver and visitors take universal precaution in the care and management of the inmates who live as a family there. There are men, women and children with and without infections.

The families are supported to earn their livelihood through various income generation programmes. The children are sent to the local **schools**.

Community Involvement

Jyothi Terminal Care Center - A hospice was started two years ago in Mumbai has about 40 inmates. There was a stiff resistance from the local community. They have even requested the hospice to be shifted. However, over a period of six months, the community observed that the patients were cared by the caregivers without fear or stigma. The carers also started going into the community and sensitizing them. The response was overwhelming.

The organization is now run solely on local contribution, which even includes food, clothing and medicine. The local community takes care of the dead. They perform the last rites according to the patient's wishes. The women folk of the community volunteer their services in the kitchens. A place, which was started as a hospice, has generated such a large community response.

Implementers Forum: A forum of organizations is envisaged at regional level of the members involved in HIV/AIDS related work. The main aim of the forum is to:

- Training and enhancement of skill development
- Establishing linkages/network with others working for HIV/AIDS
- Collaborate for specific issues such as gender sensitivity, care and support
- Updating and sharing of resources - material and man power.
- Support and care of the caregivers.

Some of our *learning and challenges* over the nine years are:

- As India is a vast country having different cultural, the problems presents and the approach needs to different.
- A significant finding is that the training programme enabled the members to address the concerns of the HIV/AIDS.
- There has been an attitudinal change among the membership and a considerable shift in the policy regarding admission for treatment.
- Some of the membership has made a shift from institutional care to community based care, which is foreseen as a positive development towards the mainstreaming of the persons infected and affected with AIDS.

New initiatives

- Based on our learning, the new initiatives envisaged are:
- Implementers forums
- Integration of HIV/AIDS to communicable diseases
- Research and promotion of parallel system of medicine
- Training on care and management
- Research documentation

Through the initiatives

- We hope to evolve care and support from the community-based organization and providing basic care and counselling at home.
- To establish much stronger network with national and international agencies working in this field to mobilize a massive effort against HIV/AIDS to meet this challenge adequately, efficiently and effectively.

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28. September 2000

Extract of the book

„Catholic Ethicists on HIV/AIDS Prevention"

edited by Rev. Fr. James F. Keenan; (ISBN 0 8264 1230 0)

The fundamental insight that lead to this book was recognising HIV/AIDS as a social problem. A coalition of authors has worked intensively to address the problematic, that certain moral positions adopted by Church personnel are at odds with some relatively effective HIV prevention measures, favoured by Catholic health workers involved in the pandemic. The intention of the book is to bring evidence that common Catholic moral tradition can help to constructively mediate the apparent clashes of values.

In the first part of the book, 26 cases from around the world are presented, highlighting the complexity of HIV prevention and illustrating the importance and relevance of local issues and concerns. On the other hand, the ability of the Catholic moral theological tradition is demonstrated to address HIV prevention.

Recognising the actual status and trends of the HIV/AIDS pandemic, makes it obvious, that addressing effective HIV prevention is not simply finding good arguments for prevention, but more importantly addressing the social problems that inhibit HIV prevention measures. As main social problems have to be mentioned, that:

a. women do not have adequate power in the face HIV/AIDS,
b. religious scrupulosity, neurotic anxiety and unjustified traditions inhibit effective prevention work,
c. the integrity of religious traditions needs to be respected,
d. even after 20 years of pandemic spread of HIV, homophobia remains virulent and vicious, and that
e. there is a profound difficulty in protecting children, in particular in relation to real issues of teenage sexual contact and drug use.

In the second part of the book, moral theologians from all over the world try to describe the progressive development of the moral tradition in the face of the challenges posed by HIV/AIDS.

Tradtion in Moral Theology

Marciano Vidal (C.Ss.R.) analyses the meaning of tradition in the field of moral theology and is concerned with developing criteria that govern progress within the Christian moral tradition. He refers to three documents of Church teachings: the Constitution *Dei Verbum* from Vatican Counsil II (1965), and John Paul II's encyclicals *'Veritatis Splendor'* (1993) and *'Centesimus Annus'* (1991).

He distinguishes between "apostolic" or constitutive tradition and post-apostolic or "Church" tradition (continuing tradition). The apostolic tradition comprises everything that serves to make people of God live their lives in holiness and to increase their faith. The moral content of tradition lacks a particular organ of verification. The Church, in her doctrine, life and worship perpetuates and transmits to every generation all that She herself is, all that She believes.

The tradition that comes from the Apostles makes progress in the Church, with the help of the Holy Spirit. The Constitution *Dei Verbum* describes the dynamic understanding of tradition as a living tradition of the Church. In the field of moral theology, many advances have been achieved in the history of the Church. Examples of the most outstanding ones in the last decades are the following:

Advances in Social Ethics

- Strengthening of the rights for religious freedom and freedom of conscience (Vatican II).
- The moral reappraisal of war, which shifted from the just war theory to finally the point of saying no to war.
- The formulation of solidarity as a new virtue and a new principle of social life.
- The acceptance of ethical, juridical category human rights.
- The preferential option for the poor which manifests the universality of the Churches being and mission.

Advances in personal ethics

- There is a holistic comprehension of human being as persons, in particular expressed in *Gaudium et Spes*.
- The value of human life has gained depth, especially in he morality of abortion, euthanasia, capital punishment and so forth.
- The understanding of the corporal dimension of the human condition has moved beyond the staturing biologists' consideration to distinctive personal comprehension.
- Human sexuality is placed today within the framework of an integral vision of person.

Advances and fundamental ethics

- The universal call to holiness implies that there is no longer a morality of sins, but the pursuit of the exalted vocation of the faithful in Christ (*Lumen Gentium*).
- The limits of the morality "of acts" have been overcome by accepting the complimentary category of fundamental choice.
- The sin of structures or structural sin is an advance in the formulation of objective and subjective group culpabilities.

Vatican II formulated principal factors of moral progress. Elements which have to be considered to achieve progress are the following:

- Continued analysis, to reach a more profound understanding of the Ministry of Christ.
- Ongoing interpretation of the "the signs of the times in the light of the gospel" .
- Considering the rich and diverse human experience, in particular in respect to experience of the past ages, from progress of the sciences and from the riches hidden in various cultures.

Moral Theology facing HIV/AIDS

Kevin Kelly describes the challenges for moral theology facing the new millennium in a time of AIDS. To help that the Church, the body of Christ, lives positively with AIDS, moral theologians need to have the courage and confidence to formulate and teach a positive and attractive person-centred sexual ethics, which is both truly human and truly Christian.

Its aim should be to help humans grow as loving and loved persons, whose loving is truly life-giving in the fullest sense. It must also be about enabling to find security in relationships of personal integrity, mutual trust and faithful commitment. There are two marks of the true Church in times of AIDS:

1. It should be a Church, which in its life and teaching offers a credible witness of its belief in the full and equal dignity of women, and which repudiates as contrary to the gospel any way of thinking or acting which implies that women are in any way of inferior status to men. Critical self-examination must be on the agenda of the Church.
2. It should be a Church which uses the full power of its authority and its influence to change and eradicate the basic causes of poverty in our world, especial the many factors which owe their continued existence to human agency and which constitute global structural injustice on a worldwide scale.

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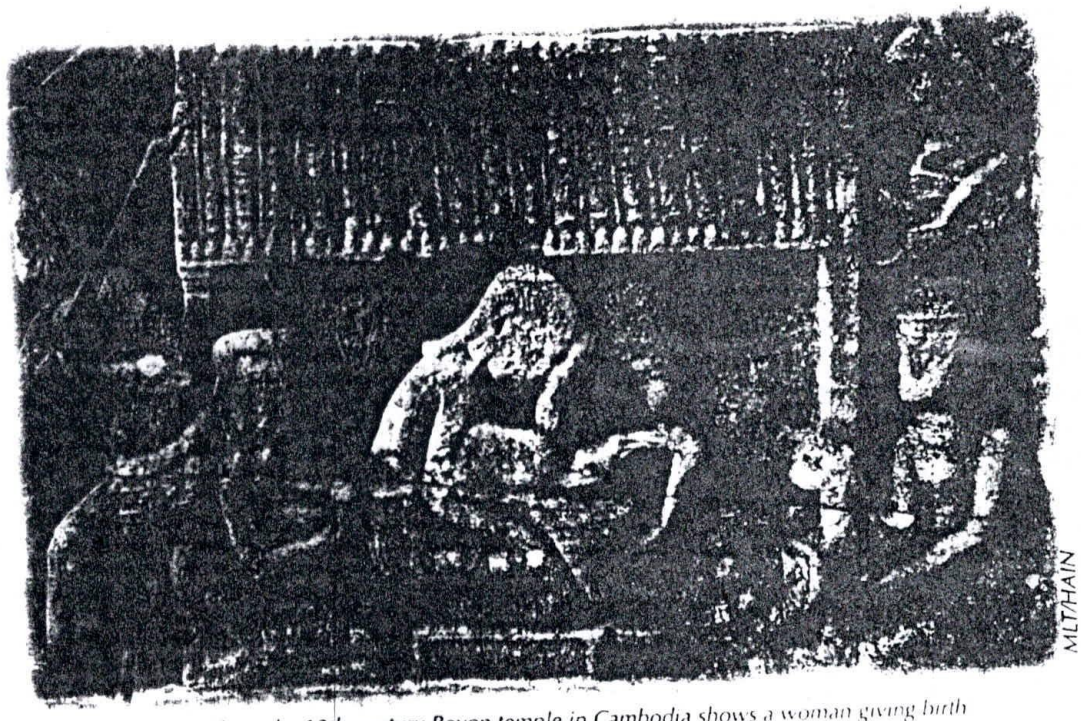
RELIGION AND HIV/AIDS



MLT/HAIN

This scene from the 12th century Bayon temple in Cambodia shows a woman giving birth

IN THIS ISSUE

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Religion has always been part of social life in Asia and the Pacific. The region is the birthplace of such world religions as Hinduism and Buddhism as well as many other smaller but significant religions, from Sikhism to Shinto. At the same time, the region has often been tolerant, welcoming religions from outside. Today, Asia includes the largest Islamic countries in the world — Indonesia, Bangladesh and Pakistan. Besides Islam, Christianity has also flourished in many countries in the region, to name a few, the Philippines, South Korea and the Pacific island nations.

For many Asians and Pacific islanders, religions are not just a matter of paying homage to the supernatural. They provide important ethical guidelines for living, for interpreting natural events including disasters and misfortune, and for coping with life's milestones, from birth through illness to death. They also often provide an anchor in a time of rapid social change, with religions not just surviving but thriving amid modernisation. In fact, in several countries in the region, religious fundamentalists – Hindu, Islamic, Christian – have a growing number of followers, offering a "return to traditions" as the solution to the problems of modernisation.

HIV/AIDS poses new challenges to religions. Because its main mode of transmission is sexual, HIV/AIDS intensifies the tensions that are present around sexuality. Many religions have had ambivalent attitudes toward sexuality. Religions have always been important forms of social control, especially in the area of sexuality. But many religions, especially in the past, also respected and even celebrated the powerful forces that come with sexuality, whether for reproduction or for eroticism.

The ambivalence continues today, and often creates problems for HIV/AIDS prevention and care. The epidemic is interpreted by some people as divine

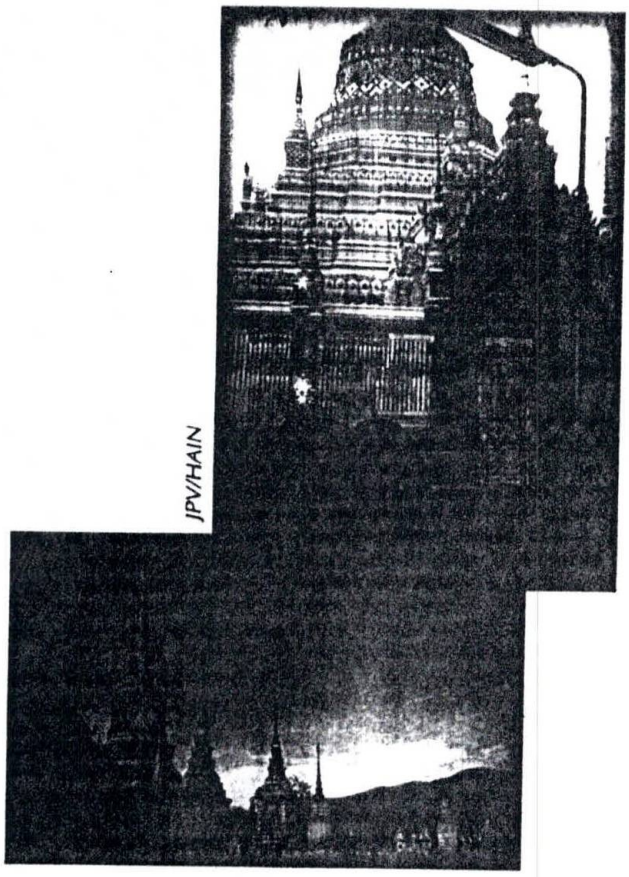
punishment for sexual transgressions, from premarital sex to homosexuality. The stigma posed by religion can be powerful. Governments and NGOs often avoid working with or supporting groups such as homosexuals or sex workers because they are seen as sinners who deserve to become infected. Some may even think of AIDS as a way of cleansing society of such "undesirables".

Even in countries where there are HIV prevention programmes to reach such sectors, the targets may themselves be socially inaccessible. Internalising what religions have said about their "sinful" behaviour, they remain marginalised, unreached by information and education campaigns.

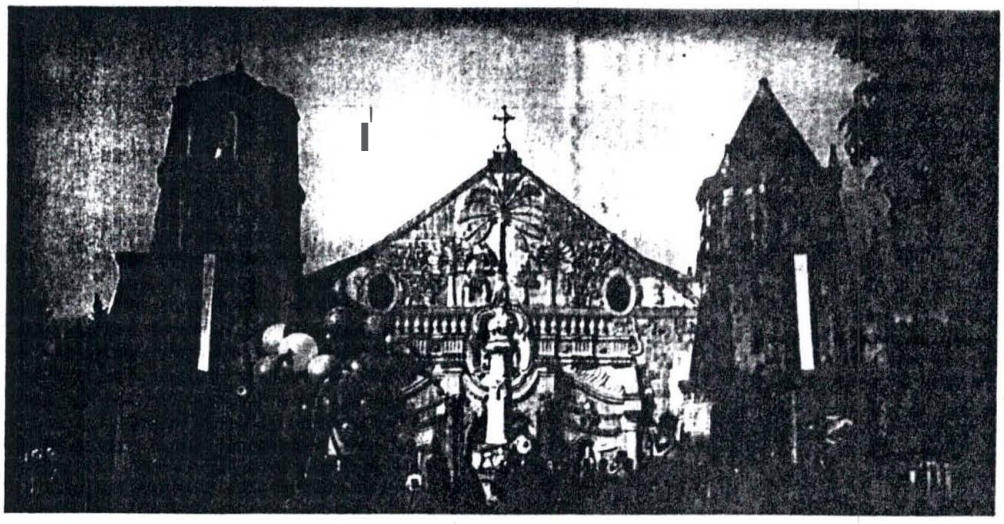
Religious stigma works most strongly against those who are infected with HIV, who may be left to fend for themselves. Again, governments may be reluctant to respond to the needs of people with HIV because they are seen as sinners. Religious prejudices, mixed with misconceptions about HIV/AIDS, become a dangerous and volatile mixture that sends many people to their deaths.

Fortunately, there has been ferment, too, among religious institutions, as people begin to question biases and prejudices. The responses have varied. In Thailand, as we see in an article by Noemi Leis, Buddhist monks are now at the frontlines providing care and support for people living with HIV, particularly those who are very ill and who are dying. Christian missionaries and lay workers are doing similar work in many parts of Asia, again mainly providing institutional care for the sick and dying. This includes many Catholic workers who may be reluctant to promote condoms as part of preventive education, but who are at least willing to minister to the needs of patients.

There are, too, religious thinkers who are tackling the very doctrinal bases for behaviour. The article in this issue by Masdar Mas'udi presents, in simple language, the rationale for a more secular approach in Islam toward the HIV/AIDS epidemic. He explains, for example, that condom use upholds Islam's premiere right, the right to life.


JPV/HAIN

Theologians have tried to tackle other ethical dilemmas brought about by the threat of HIV/AIDS. For example, some people may object to needle exchange programmes, where drug dependants are given new clean needles. The objections come about because the programmes are seen as tacit acceptance of the use of drugs, but religious ethicists will say that the needle exchange programmes constitute a lesser evil because it saves lives.



Other religious thinkers, notably Muslim and Christian, have contributed to the fight against HIV/AIDS by questioning the role of religious doctrines in reinforcing gender inequality, and the way this inequality contributes to women's vulnerability to HIV. Religious norms that force women to be passive may become a death sentence since they are then unable to protect themselves, even if they know their husbands or partners may have HIV.

The inclusion of religious groups in HIV/AIDS work can produce many benefits, some of which are explained below:

First, many religious institutions have formidable resources that can be tapped for HIV work. These religious institutions have their

own schools, hospitals, clinics and orphanages. While some of these institutions may be reluctant to discuss sexuality issues, or to promote condoms, they can at least be mobilised to provide other services, especially for care and support.

Second, religion plays such an integral role in people's lives that an HIV/AIDS prevention programme cannot be effective unless it deals with people's religious beliefs and practices. For example, government and NGOs need to look at how religious beliefs shape the relationships between men and women. If women see the risk of HIV/AIDS as unavoidable, as part of karma, then educational programmes will not be very effective. Religous beliefs and practices also play vital roles in the care and support of people with HIV. It is important to emphasise the suppportive aspects of religion.

Third, dialogues between religious institutions and groups working on HIV/AIDS can be mutually beneficial. Religions offer ethical frameworks to discuss many issues that have to be tackled in HIV/AIDS programmes. Some religious workers rightly object to programmes that only distribute condoms without encouraging people to discuss what is meant by "correct use". "Correct" is not just a matter of technical skills, but must also be based on notions of a mutual respect, and of sharing of responsibilities.

Conversely, people working in public health can bring up very practical case studies and challenges for religious leaders and thinkers to tackle. What does one do, for example, if a husband is infected and the wife is still free of HIV? Would they be asked to abstain from sex? Or would they be encouraged to use condoms, an option still not allowed among Roman Catholics?

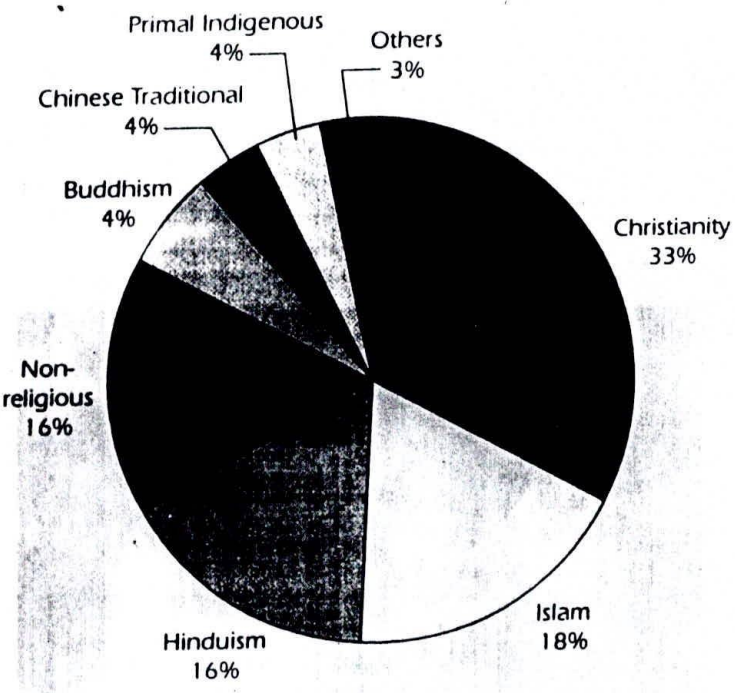
Sometimes, the implementation of HIV prevention programmes raises ethical issues that need dialogues. What happens, for example, when a Catholic physician goes around claiming that condoms do not prevent HIV/AIDS? Would that not be violating religious injunctions on speaking the truth, and on preserving life?

Dialogues open people's minds. When religious workers listen to NGOs and government workers doing HIV prevention, they begin to see the potential impact of HIV/AIDS on society, and the need for such measures as sex education. Likewise, religious workers are needed to remind medical people – often jaded by their routines – to respect human dignity and human rights.

Often, there is a fear that such dialogues will lead to compromises when in fact they can lead to new richer partnerships.

— *Michael L. Tan, HAIN*

Major Religions of the World



Source: http://www.adherents.com

& SOUL

Religion can influence a woman's reproductive health, whether positively or adversely. As the Women's Feature Services (WFS) puts it, "Religion is an experience so personal, yet so political, that it tends to affect many aspects of women's lives, including reproductive health."

To highlight the role of religion and to raise related issues, a series of inter-faith discussions on women, religion and reproductive health are currently being held in the Philippines. The multi-media programme, aptly called "Body and Soul", was developed by the WFS. The discussions present perspectives from the Catholic, Protestant and Islam religions, which are the predominant religions in the Philippines. Four multi-media discussion forums have been held, and the papers presented at each forum have been compiled and published into booklets. The discussions have focused on the following themes:

- Frameworks on Religion and Reproductive Health
- Condoms and Religion
- Adolescent Sexuality
- Population

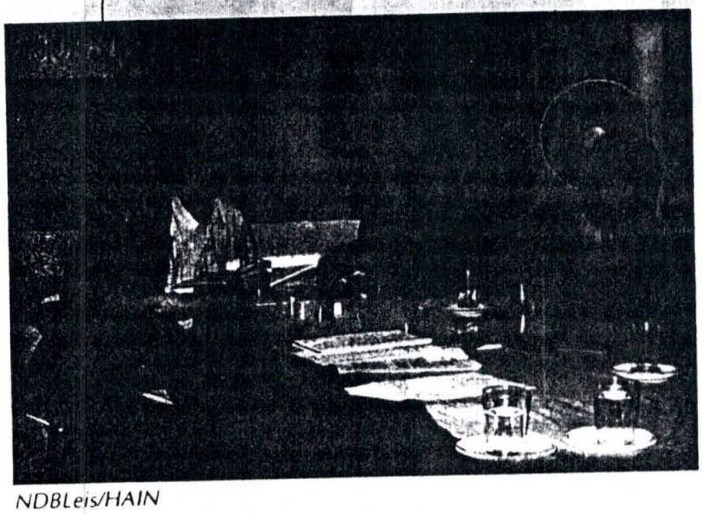
(Please see page 8 for contact details of WFS)

Buddhist Monks:

RESPONDING TO HIV/AIDS

The Buddhist monks have become a very important stakeholder in the fight against HIV/AIDS and are now recognised as a strong partner in HIV/AIDS work especially through their spiritual guidance.

Monks and health workers planning future HIV/AIDS activities



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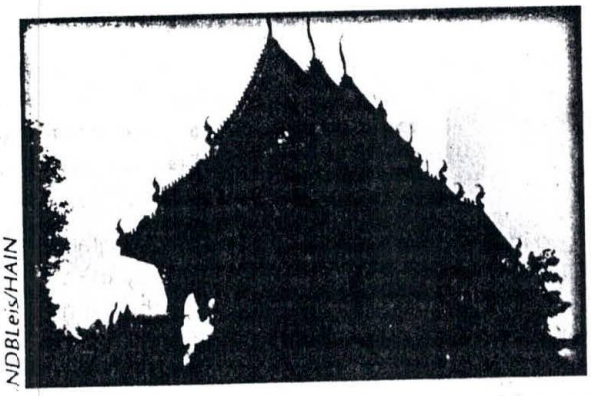

NDBLeis/HAIN

A Buddhist temple in Chiang Rai, Thailand

Ten years ago, Mae Chan hospital in Chiang Rai, Thailand first encountered cases of HIV. It was at this time that the HIV/AIDS epidemic was rapidly spreading in Thailand, particularly in the northern area which shares borders with Cambodia and Laos.

The hospital staff, however, found it difficult to talk about HIV/AIDS with the patients. Likewise, persons with HIV/AIDS (PHAs) who were admitted to the hospital did not discuss their thoughts and feelings with the hospital staff. Instead, the patients were going to the Buddhist monks for counselling and spiritual guidance.

The health workers at the hospital then realised the monks played an important role in people's lives, and decided to explore ways they could work with the monks. Although the monks were hesitant when HIV/AIDS was first discussed, they became more open and receptive to the idea as the number of HIV cases increased, and their friends and family members became infected. Wanting to know more about a disease which was fast becoming a problem for their communities, the monks then approached the hospital staff. Gradually, the monks and health workers started to work together. Since then, the Mae Chan District Hospital and the Buddhist monks have worked together for the prevention of HIV/AIDS while providing care and support for those who are already infected.

WORKING TOGETHER

Today, Mae Chan hospital has a meditation room where patients can read, listen to tapes of Buddhist teachings, meditate or have a one-on-one counselling session with monks. If the patient cannot walk, the monk stays at the bedside. An audiocassette tape of Buddhist teachings is aired on the hospital's sound system so that all the patients can listen.

In addition to their work in the hospital setting, the Buddhist monks also provide community support. The temples have become a venue for several activities for PHAs and their relatives. They do meditations, yoga, exercises, herbal sauna, food preparation and even income generating projects such as making herbal medicines. The monks conduct home visits as well to talk to those who are infected and affected.

Several community therapy centres have been established in Chiang Rai to provide a venue for community interaction. Community members who are not HIV positive go to the centre and provide an informal social support system for the PHAs in the community. The monks regularly visit the community therapy centre to conduct information campaigns and to provide care and support services.

The monks emphasise meditating before doing activities such as counselling or treatment. Health workers, PHAs, and their families

THE BUDDHIST AIDS PROJECT

With its goal of linking together Buddhist communities in different countries, the Buddhist AIDS Project (BAP) maximises the use of information technology to reach a wide audience.

In the past, many of the information resources on HIV/AIDS and Buddhism have not been easy to find. BAP is working to change that situation. Through its website, BAP provides easy access to information resources.

The project aims to provide free information and referral on:

- current HIV/AIDS information, with links to local, national and international resources
- Buddhist teachings, practice centres and events
- complementary alternative medicine services

The website also contains the BAP Library of Articles, which is a list of information materials on HIV/AIDS, Buddhism, spirituality, medicine, research findings, conference reports and announcements, among others.

Moreover, the BAP website serves as a virtual gathering place where many people have made themselves available for those seeking life enhancing practices that can strengthen the response to changing physical, mental, and spiritual challenges.

BAP serves persons living with HIV/AIDS, including family, friends, caregivers, as well as people who are HIV negative. The project provides information on HIV/AIDS and alternative health care to its clientele.

While focusing on the San Francisco Bay Area, BAP offers worldwide information and referral services, responding to requests through e-mail and phone. Recently, BAP has assisted community service projects in Thailand and Cambodia. They also offer study and support groups on basic Buddhist teachings and practice.

BAP is a non-profit project of the Buddhist Peace Fellowship. Established in 1987, it is now based in San Francisco, USA. BAP is run by about 30 volunteer physicians, body workers, counsellors, mediation instructors and others. BAP also welcomes interested volunteers who are willing to share their time and skills.

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http://www.buddhistaidsproject.org

are also encouraged to meditate.

In conducting educational activities, the monks use Buddhist teachings on moral conducts for human behaviour. There are five moral conducts in Buddhism:

- Do not destroy life
- Do not take what is not given
- Abstain from sexual misconduct
- Abstain from falsehood
- Abstain from intoxicants

The monks do not prohibit condom use. However, they leave its discussion to lay educators in the hospital.

Aside from social, spiritual, and emotional support, monks also provide PHAs their basic needs such as food, clothing, soap, and others.

The monks conduct their own fundraising activities and are not dependent on the hospital for funding. The Buddhist community has traditionally supported the monks, who walk through the streets in the morning carrying bowls where people can put their donations.

There are also Buddhist festivals when people go to the temples to bring gifts for the monks. The gifts are usually money, food, clothes, and other items. These gifts are then shared with their community.

It is interesting to note that monks have also learned to write to international agencies for funding, and they have been quite successful in generating funds.

Every month, the health workers from the hospital meet with monks to provide them updates on HIV/AIDS and give information materials. During these meetings they also talk about future plans and fund raising activities.

LESSONS LEARNED

Both the hospital workers and the monks agree that their efforts complement each other, and that they should go on working together in providing HIV/AIDS education as well as care and support services.

The participation of PHAs as well as the non-positive community is also important.

The community therapy centre provides not only social support but also lessens the impact of stigma. The PHAs have become more visible in the community without experiencing discrimination from other community members. Disclosure for PHAs about their HIV-status is thus not a very sensitive issue.

The Buddhist monks have become a very important stakeholder in the fight against HIV/AIDS and are now recognised as a strong partner in HIV/AIDS work especially through their spiritual guidance.

Explaining the Buddhist response to HIV/AIDS, Supakit, the head monk in Mae Chan district observes, "Imagine that HIV/AIDS is a glass, and you break the glass so that there are many small pieces. Each of us can pick up a piece. This is easy to do because it is only a small piece of glass that we have to pick up. We must all work together to pick up the little pieces so that we will solve the problem".

— *Noemi D. Bayoneta-Leis, HAIN*

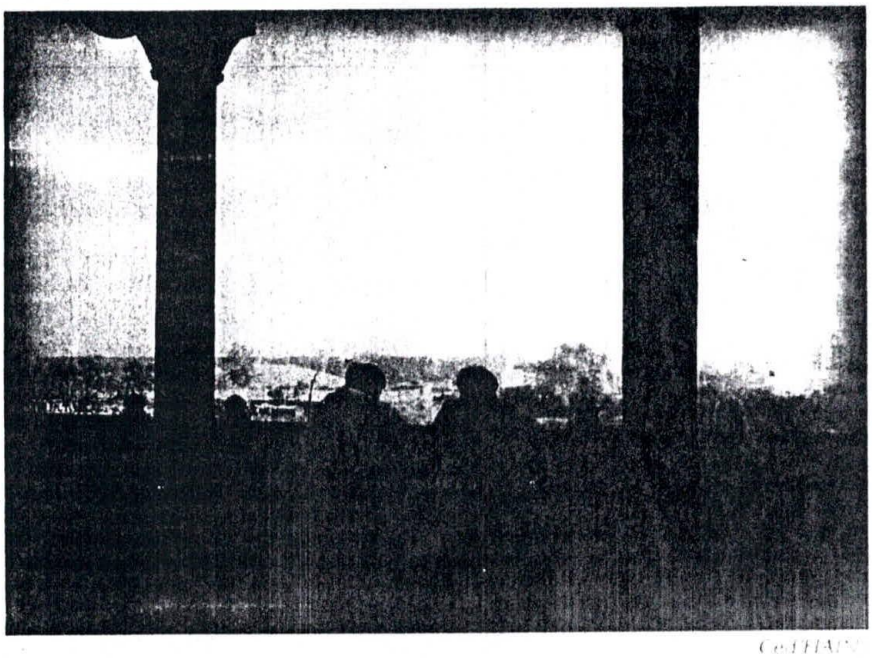
Acknowledgements: The author would like to acknowledge the assistance provided by Ms. Jeap Pinitsuwon and Dr. Supalert Nedsuwan of Mae Chan Hospital and Monks Supakit, Sommai, Niwit, Supat Monahir, Pairov, Muangvisan from Temple Muang Klang.

HIV/AIDS:

BETWEEN TWO PARADIGMS

No epidemic in the world today attracts as much attention, publication, debate and controversy as HIV/AIDS. There are many reasons for this, including HIV/AIDS being incurable and deadly. Another factor which contributes to more public attention to HIV/AIDS is that its main method of transmission is sexual. This has brought about heated debate and controversy between two paradigms: the religious and secular paradigms. The religious paradigm claims to be rooted in the sacred texts while the secular paradigm is rooted in the realities of the world.

Within the framework of the religious paradigm, particularly the more conservative ones, human beings have no other way to differentiate the good (*al-hasan*) from the evil (*al-qabih*), except through divine revelation. Using this perspective, advocates of the religious paradigm view the HIV/AIDS epidemic as a blessing in disguise. This looks at HIV/AIDS as a curse and punishment from God for humanity's disobedience. Using this line of argument, religious conservatives condemn the use of condoms because this is seen as justifying illicit sexual relations, i.e., disobedience to God. Some religious conservatives even go to the extent of saying there should be no room for compassion for those affected by the virus because they are sinners. According to conservatives, the only way to prevent HIV/AIDS is to return to the demands of religion and faith.



Those advocating a secular paradigm say that "good" is defined as something useful for humanity and "truth" is something that can be proven empirically. This saying explicitly recognises the necessity of looking at the material bases of one's faith. If so, the religious people should not look at the human life only from the formal religious perspective, but from the reality of material life. As the Prophet Muahammad says, "*Kaada al-faqru an yakuna kufran*: poverty can bring about somebody to disbelieve."

Responding to conservatives, secularists say that no one can positively prove that HIV/AIDS is a curse sent by God to punish human beings for disobeying God's will. Secularists ask how one can justify isolation or "excommunication" of those in great suffering. Is it not those who are ill who need, even more, God's love?

On the argument that HIV/AIDS is caused by sin, secularists point out that transmission can also occur within the *halal* (lawful) sexual relationship between a husband and wife. Moreover, HIV transmission also occurs through blood transfusions and from a mother to child.

Secularists point out that according to Islamic teaching, there are five human rights: the right to life, the right to believe, the right to have knowledge, the right to have property and the right to have clan identity (*nasab*). Of these five rights, the right to life is the most important. For the secularists then, condom use upholds this premier right to life.

In the context of a married couple where one of them has been infected with HIV, can one allow sexual relations to occur without any protection? Does that not mean we are putting them in danger, with fatal consequences? Or must couples with one infected with HIV be separated forever?

We have seen many cases of women working in brothels who become infected with HIV. Would it not be moral to offer the use of condoms to protect themselves, their client, and their family? We understand that *zina* (illicit sexual relations) is a religious sin, particularly for those already married. But is not *zina* without protection (i.e., without the use condoms) an even greater sin because it allows a deadly virus to be transmitted?

These critical questions are difficult to answer by the *ulama* holding the very formalistic and conservative religious paradigm. A moral and ethical perspective concept built on the authority of doctrine without being based on empirical reality tends to become empty words.

On the other hand, modern humanity must also be aware of the dangers of a morality without a transcendental dimension because there is the risk of losing one's orientation. An exchange of views, where each side is open to the insights of the other, is clearly needed if we are to work out a program of understanding and action.

— *Masdar F. Mas'udi*

Director of The Indonesian Society for Pesantren and Community Development, Jakarta, Indonesia

Religious Leaders Speak Out on HIV/AIDS

"... the magnitude of AIDS epidemic problem in the ASEAN region is increasing significantly. The increase has to be controlled in time, otherwise, religious, social and economic development in the region will be hindered and disparities within and between ASEAN Member Countries will increase accordingly,

... every individual has the right to have an appropriate and right information on HIV/AIDS. Without having the information nobody will be able to prevent HIV infection,

... all Muslim Leaders in all ASEAN Member Countries need to be properly trained to use the IEC instruments and methods. The well-trained Muslim leaders will then play their important role in HIV/AIDS campaign in their respective community.

— The Jakarta Declaration of Islamic Religious Leaders December 1998

"To Tibetan physicians, AIDS is really something new, and the immediate cause is negative: sexual liberty... such a major illness or major negative event also has a karmic cause, no doubt. But I think AIDS also has a positive aspect. It has helped to promote some kind of self-discipline."

— The Dalai Lama, 1994

"Perhaps the AIDS crisis is God's way of challenging us to care for one another, to support the dying and to appreciate the gift of life. AIDS need not be merely a crisis: it could also be a God-given opportunity for moral and spiritual growth, a time to review our assumption about sin and morality. The modern epidemic of AIDS calls for a pastoral response."

— Bishops of Southern Africa June 1990

"God loves you all, without distinction, without limit. He loves those of you who are elderly, who feel the burden of the years. He loves those of you who are sick, those who are suffering from AIDS. He loves the relatives and friends of the sick and those who care for them. He loves us all with an unconditional and everlasting love."

— Pope John Paul II, California September 1997

"For us, an encounter with people infected with HIV/AIDS should be a moment of grace - and opportunity for us to be Christ's compassionate presence to them as well as to experience His presence in them."

— Bishops' Conference of the Philippines, 1993

Tree of Hope

Located in New South Wales, Australia, the Tree of Hope is a centre for HIV-positive women and men, and their partners, family, friends, and care-givers. The Centre offers Personal Care – composed of emotional, spiritual and social support. Upon request, the Catholic nuns who operate the Centre visit persons with HIV/AIDS (PHAs) and their loved ones at home or in the hospital. The Centre is open from Mondays to Fridays during the daytime, and the answering machine is left on during the hours that the Centre is unattended.

Sisters in Islam

Sisters in Islam (SIS) is a group of professional Muslim women committed to promoting the rights of women within the religious framework. To attain its objectives, SIS embarks on activities in four programme areas:

- Research and interpretation of textual sources of Islam
- Advocacy for policy and law reform
- Awareness raising and public education
- Strategic planning and policy formulation

(Please see page 8 for contact details of SIS)

AIDS and Muslim Communities: Opening Up by S Ali. Summary of an international meeting in Karachi to explore the relationship of Muslim religious and political concepts with HIV transmission, medical care, and human rights. AIDS/STD Health Promotion Exchange 1996(2):13-6. Available from HAIN.

AIDS and the Muslim Communities—A Personal View/AIDS and the Muslim Communities—Challenging the Myths. Leaflets in English, Gujrati, Urdu, Arabic, Farsi, Gengali and Turkish available from The Naz Project, Palinswick House, 241 King St., London W6 9LP, UK.

Body & Soul: a Multimedia Discussion on Women, Religion & Reproductive Health, 2000. A collection of papers presented in several interfaith dialogues related to reproductive health. Four booklets are available on diferent themes, namely: Frameworks on Religion and Reproductive Health; Adolescent Sexuality; Population; and Condoms and Religion. For orders, write to Women's Feature Service (WFS) Philippines, 313-E Katipunan Ave., Quezon City, Philippines. wfs@pacific.net.ph

Catholic Ethicists on HIV/AIDS Prevention, 2000. James Keenan (editor). A collection of essays and case studies discussing HIV/AIDS prevention from a Catholic perspective, drawing on theology, philosophy and ethics. It includes a good selection of 26 case studies, based on real-life situations from different countries – developed and developing — with a discussion of options. Available for US$24.95 (Paperback) from Continuum International Publishing Group, Inc., 370 Lexington Ave., New York, NY 10017, USA; or £15.99 from Continuum International Publishing Group Ltd., Wellington House, 125 Strand, London WC2R0BB; Or visit their website: http://www.continuum-books.com

The Church Responds to HIV/AIDS : a Caritas Internationalis Dossier, 1996. A selection of statements on HIV/AIDS by Catholic Church leaders such as Pope John Paul II, bishops' conferences and other church groups. The booklet presents the stand of the Church based on its teachings and as shown by pronouncements of Church officials. Available for £1.50 from CAFOD, Romero Close, Stockwell Road, London SW9 9TY, UK. ISBN 1 871 549 639

Friends for Life by R Manning. Describes a Buddhist monk's initiatives in establishing Friends for Life, a hospice for PHAs in the outskirts of Chiang Mai, Thailand. AIDS Action Asia Pacific edition Jul-Sep 1995 (28):11.Available from HAIN.

A Guide to HIV/AIDS Pastoral Counselling. Explains the process of HIV/AIDS counselling, provides basic information for pastors on the topic and features case studies. Available in English, French, Spanish, Portuguese at US$10, surface mail. Free to developing countries from CMC-Churches' Action for Health, World Council of Churches, P.O. Box 2100, 1211 Geneva 2, Switzerland. dgs@wcc-coe.org

Handle with Care: a Handbook for Care Teams Serving People with AIDS by RH Sunderland and EE Shelp. A step-by-step guide for congregations that wish to organise care teams to serve people with HIV/AIDS. Contact Foundation for Interfaith Research and Ministry, PO Box 205528, Houston, Texas, USA.

Islam, Reproductive Health and Women's Rights. Zainah Anwar and Rashidah Abdullah (editors). 2000. A collection of papers presented at a recent conference on Islam and reproductive health. The papers were prepared by theologians, academicians and NGO workers. They discuss Islamic teachings — drawing from the Quran and hadith — and its relationship to reproductive health and rights, on issues ranging from HIV prevention to gender relations. Available for US$20 (RM40) plus postage cost which is 25% of the total order for surface mail and 100% of total order for airmail. Write to SIS Forum (Malaysia) Berhad, Sisters in Islam, JKR No. 851, Jalan Dewan Bahasa, 50640 Kuala Lumpur, Malaysia. Tel: (603) 242 6121/24[illegible] 3705, Fax: (603) 248 3601. Write to sis@*sisfora po.my* or visit *http://www.sistersinislam.org.my*

The Jakarta Declaration is the result of the First HIV/AIDS ASEAN Regional Workshop of Islamic Religious Leaders held November 30-December 3, 1998. The Declaration sets forth the rationale for the involvement of Muslims in the regional response to HIV/AIDS. It also includes a Plan of Action which presents objectives, activities, and recommendations identified at the workshop. Posted on SEA-AIDS – Message 1707. Copies available from HAIN.

Knowledge, Attitudes, and Behavior: Cambodia's Monks, Nuns Fill Gap for AIDS Patients, 1997. Describes the HIV/AIDS situation in Cambodia and how the religious community such as the Buddhist monks and nuns help PHAs by providing care and support Available from HAIN.

Learning About AIDS: a Manual for Pastors and Teachers. Available in English and French, US$2. Free to developing countries from Churches' Action for Health, World Council of Churches, P.O. Box 2100, 12[illegible] Geneva 2, Switzerland.

Religion, Ethnicity and Sex Education: Exploring the Issues. A briefing pack, presents seven religious perspectives on sexuality, sex education and gender. £15.50 Order from Book Sales, National Children's Bureau, 8 Wakley St., London EC1V 7QE, UK

Spiritual Aspects of Health Care by D Stoter. A reference for health workers on how to respond when grief and anger make communication very difficult. Guides the health worker in meeting the spiritual and religious needs of patients. Available from Mosby, Times Mirror International Publishers Ltd., Lynton Hse., 7-12 Tavistock Square, London WC1H 9LB, UK. ISBN 0 7234 1955 8

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Tolerant Signals: The Vatican's new insights on condoms for H.I.V. prevention

By Jon D. Fuller and James F. Keenan

America, September 23, 2000

Jon D. Fuller, S.J., M.D., is an associate professor of medicine at Boston University School of Medicine and assistant director of the Adult Clinical AIDS Program at Boston Medical Center. James F. Keenan, S.J., is a professor of moral theology at Weston Jesuit School of Theology in Cambridge, Mass., and recently edited *Catholic Ethicists on HIV/AIDS Prevention* (Continuum, 2000) with the assistance of Father Fuller, Lisa Sowle Cahill and Kevin Kelly.

Monsignor Jacques Suaudeau of the Pontifical Council for the Family recently published "Prophylactics or Family Values? Stopping the Spread of HIV/AIDS" in the weekly edition of L'Osservatore Romano (4/19). Here we find important signals of what many have suspected all along: that while individual bishops and archbishops have occasionally repudiated local H.I.V. prevention programs that include the distribution of prophylactics (more commonly referred to as condoms), the Roman curia is more tolerant on the matter.

Monsignor Suaudeau reports that the Catholic Church has been accused of "lacking a sense of reality and of being irresponsible about the H.I.V.-AIDS epidemic in Africa because of its position regarding the use of prophylactics to prevent sexual contamination." In response, Suaudeau introduces a distinction between prevention (attacking a problem at its roots) and containment (interventions to lessen the impact of a problem). Against malaria, for instance, containment efforts have been of limited success because truly preventive efforts (such as eliminating all mosquito larvae) are so difficult. In contrast, in the case of typhoid fever, prevention was achieved because public health officials aimed to correct the mistaken attitude that care did not need to be taken about sources of drinking water.

With that distinction in mind, Suaudeau advances his thesis regarding prevention: "Family values guarantee true human victory. Wherever there is true education in the values of the family, of fidelity, of marital chastity, the true meaning of the mutual gift of self...man will achieve a human victory, even over this terrible phenomenon." He adds: "If people really want to prevent AIDS, they must be convinced to change their sexual behavior, which is the principal cause of the infection's spread. Until a real effort is made in this regard, no true prevention will be achieved. The prophylactic is one of the ways to 'contain' the sexual transmission of H.I.V.-AIDS, that is, to limit its transmission."

After citing apparently conflicting data about the reliability of prophylactics, the author backs away from the issue and claims, "In any case, the church's position on the prevention of H.I.V.-AIDS is not at this technical health care level." Instead, he argues, the church is concerned about the root of the problem, that is, respect for human sexuality. Here he also mentions the "condition of women" as well as poverty, political instability, unemployment, the growth of prostitution, the condition of refugees, civil wars and urban crowding of the poor as critical factors that fuel the transmission of

H.I.V. in the developing world.

After a strong endorsement of sexual abstinence, the author applies his distinction to two very important populations: commercial sex workers in Thailand and the general population of Uganda. He notes that in Thailand "the use of condoms had particularly good results for these people with regard to the prevention [we would have thought he would have written "containment"] of sexually transmitted diseases." He adds, "The use of prophylactics in these circumstances is actually a 'lesser evil,' but it cannot be proposed as a model of humanization and development." He wonders, therefore, why authorities did not examine why there was growth in the Thai prostitution industry in the first place. He calls attention to more comprehensive approaches in Uganda. While recognizing that "sexually active men and women use prophylactics more frequently," the factors he finds more important include a delay in the age of first intercourse among both men and women and a decrease in sexual relations outside of marriage.

Monsignor Suaudeau's article conveys important insights about Vatican curial thinking on H.I.V. prevention. First, the article is not simply disseminated in the Pontifical Council's own newsletter. Publication in L'Osservatore, the official newspaper of the Curia, is a sign that the article represents a broad constituency of curial thinking. Second, it rightly endorses abstinence and the proper understanding of Christian sexuality as the evidently most safe and most human preventive approach against H.I.V. transmission. Third, it does not attack the endorsement, promotion, distribution or use of prophylactics. Rather, it introduces a distinction between containment and prevention and claims only that prophylactics alone are inadequate prevention. Fourth, while noting that further studies regarding the adequacy of prophylactic usage for H.I.V. prevention are still needed, it does not categorically deny their effectiveness. Fifth, it acknowledges the positive function that prophylactics have played in two populations critically affected by the H.I.V. epidemic. Sixth, it recognizes the use of prophylactics as a lesser evil, an important principle used to describe morally permissible though regrettable action. Finally, it concludes by recognizing the need for more fundamentally human, life-enhancing programs to prevent H.I.V. transmission.

While many readers may be surprised by the article's tolerance, we are not. Admittedly, the Vatican has intervened otherwise, as in 1988, when the Congregation for the Doctrine of the Faith raised questions about the U.S. Catholic Conference's pastoral letter The Many Faces of AIDS: A Gospel Response (1987), and again in 1995, when the same congregation acted against a resource pack on H.I.V. education published with an imprimatur by the archbishop of St. Andrews and Edinburgh. However, health care workers and moral theologians have encountered an implicit tolerance from the Roman Curia when they have first asserted church teaching on sexuality and subsequently addressed the prophylactic issue. For instance, more than 25 moral theologians have published articles claiming that without undermining church teaching, church leaders do not have to oppose but may support the distribution of prophylactics within an educational program that first underlines church teaching on sexuality. These arguments are made by invoking moral principles like those of "lesser evil," "cooperation," "toleration" and "double effect." By these arguments, moralists around the world now recognize a theological consensus on the legitimacy of various H.I.V. preventive efforts.

Without known interference, the Vatican has allowed theologians to achieve this consensus. Vatican curial officials now seem willing publicly to recognize the legitimacy of the theologians' arguments. Hesitant local ordinaries will in turn, we hope, note Monsignor Suaudeau's tolerant signals and more easily listen to the prudent counsel of their own health care and pastoral workers and their moral theologians.

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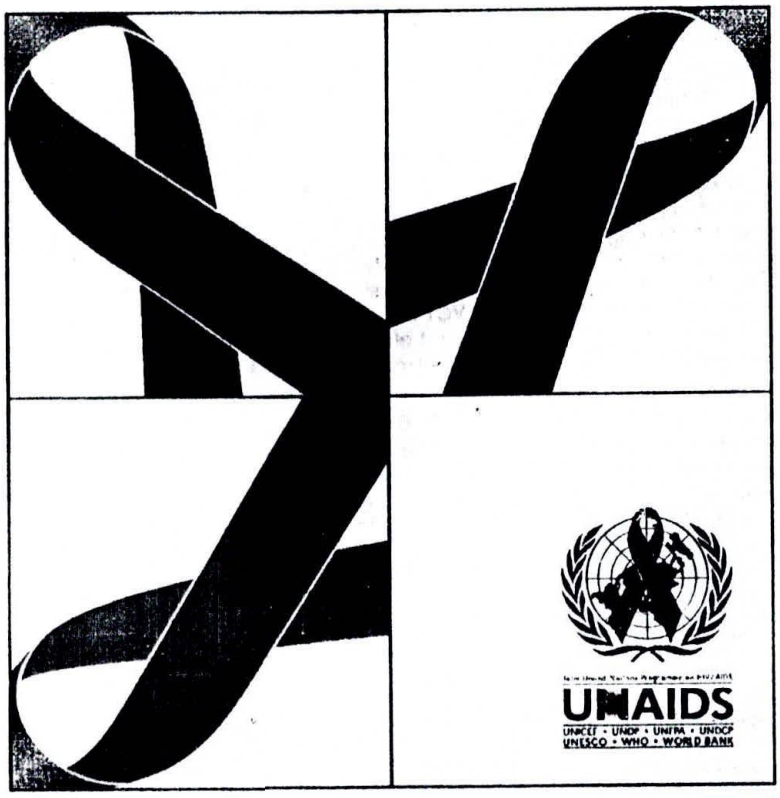
Voluntary Counselling and Testing (VCT)



UNAIDS
Technical update

May 2000

UNAIDS Best Practice Collection

At a Glance

HIV voluntary counselling and testing (VCT) has been shown to have a role in both HIV prevention and, for people with HIV infection, as an entry point to care. VCT provides people with an opportunity to learn and accept their HIV serostatus in a confidential environment with counselling and referral for ongoing emotional support and medical care. People who have been tested seropositive can benefit from earlier appropriate medical care and interventions to treat and/or prevent HIV-associated illnesses. Pregnant women who are aware of their seropositive status can prevent transmission to their infants. Knowledge of HIV serostatus can also help people to make decisions to protect themselves and their sexual partners from infection. A recent study has indicated that VCT may be a relatively cost-effective intervention in preventing HIV transmission.

There are several challenges related to the establishment and expansion of VCT services:

- **Limited access to VCT.** Many of the countries most severely affected by HIV are also among the poorest countries. Establishing VCT services is often not seen as a priority because of cost, lack of laboratory and medical infrastructure and lack of trained staff. This has resulted in VCT being unavailable to most people in high-prevalence countries. It is important to document the benefits of VCT in order to promote and expand access to it.
- **Improving the effectiveness of VCT.** Innovative ways can be developed to reduce the costs of VCT by using cheaper and more efficient HIV testing methods and strategies. Improving Information, Education and Communication (IEC) to advocate the benefits of VCT and raising community awareness may lessen the time required for pre-test counselling. Integrating VCT into other health and social services may also improve access and effectiveness and reduce cost. Social financing of VCT services has also been shown to be an effective approach in some settings.
- **Overcoming barriers to testing.** In some countries where VCT services have been established there has also been a reluctance of people to attend for testing. This may be because of denial and of the stigma and discrimination that people who test seropositive may face, and the lack of perceived benefits of testing. To overcome the barriers to establishing VCT services it is important to demonstrate its effectiveness and to challenge stigma and discrimination so that people are no longer reluctant to be tested. The role of VCT as a part of comprehensive health care, with links to and from other essential health care services (such as tuberculosis services and antenatal care), must be acknowledged. The structure of VCT services should be flexible and reflect an understanding of the needs of the communities they serve. Services should be easily accessible and closely linked with community organizations that can provide care and support resources beyond those offered by VCT services alone.
- **Publicizing the benefits of VCT.** Until recently, there was a paucity of data indicating that VCT may be important in changing sexual behaviour and a cost effective intervention in reducing HIV transmission. However, there are now studies available showing that VCT is a cost-effective intervention in preventing HIV transmission and that VCT gives seropositive people earlier access to medical care, preventive therapies and the opportunity to prevent mother-to-child transmission of HIV.
- **Understanding the needs of specific client groups.** VCT services should be developed to provide services for vulnerable or hard-to-reach groups. Community participation and involvement of people living with HIV is essential if these services are to be acceptable and relevant.

UNAIDS *Best Practice* materials

The Joint United Nations Programme on HIV/AIDS (UNAIDS) publishes materials on subjects of relevance to HIV infection and AIDS, the causes and consequences of the epidemic, and best practices in AIDS prevention, care and support. A *Best Practice* Collection on any one subject typically includes a short publication for journalists and community leaders (Point of View); a technical summary of the issues, challenges and solutions (Technical Update); case studies from around the world (*Best Practice* Case Studies); a set of presentation graphics; and a listing of Key Materials (reports, articles, books, audiovisuals, etc.) on the subject. These documents are updated as necessary.

Technical Updates and Points of View are published in English, French, Russian and Spanish. Single copies of Best Practice materials are available free from UNAIDS Information Centres. To find the closest one, visit the UNAIDS website (http://www.unaids.org), contact UNAIDS by email (unaids@unaids.org) or telephone (+41 22 791 4651), or write to the UNAIDS Information Centre, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

Voluntary Counselling and Testing (VCT). UNAIDS Technical update
English original, May 2000
I. UNAIDS II. Series

1. Voluntary workers
2. Counselling
3. AIDS serodiagnosis

UNAIDS, Geneva WC 503.6

Background

What is VCT?

Voluntary HIV counselling and testing (VCT) is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential.

UNAIDS policy statement on VCT[1]

VCT has a vital role to play within a comprehensive range of measures for HIV/AIDS prevention and support, and should be encouraged. The potential benefits of testing and counselling for the individual include improved health status through good nutritional advice and earlier access to care and treatment/prevention for HIV-related illness; emotional support; better ability to cope with HIV-related anxiety; awareness of safer options for reproduction and infant feeding; and motivation to initiate or maintain safer sexual and drug-related behaviours. Other benefits include safer blood donation.

UNAIDS therefore encourages countries to establish national policies along the following lines:

- Make good-quality, voluntary and confidential HIV testing and counselling available and accessible
- Ensure informed consent and confidentiality in clinical care, research, the donation of blood, blood products or organs, and other situations where an individual's identity will be linked to his or her HIV test results.
- Strengthen quality assurance and safeguards on potential abuse before licensing commercial HIV home collection and home self-tests.
- Encourage community involvement in sentinel surveillance and epidemiological surveys.
- Discourage mandatory testing.

Elements of VCT HIV counselling

HIV counselling has been defined as "a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour."[2] The objectives of HIV counselling are the prevention of HIV transmission and the emotional support of those who wish to consider HIV testing, both to help them make a decision about whether or not to be tested, and to provide support and facilitated decision-making following testing. With the consent of the client, counselling can be extended to spouses and/or other sexual partners and other supportive family members or trusted friends where appropriate. Counsellors may come from a variety of backgrounds including health care workers, social workers, lay volunteers, people living with HIV, members of the community such as a teachers, village elders, or religious workers/leaders.

HIV counselling can be carried out anywhere that provides an environment that ensures confidentiality and allows for private discussion of sexual matters and personal worries. Counselling must be flexible and focused on the individual client's specific needs and situation.

In some settings HIV counselling is available without testing. This may help promote changes in sexual risk behaviour. In one rural area, community-based counselling significantly increased rates of condom use among adults.[3]

Voluntary testing

HIV testing may have far-reaching implications and consequences for the person being tested. Although there are important benefits to knowing one's HIV status, HIV is, in many communities, a stigmatizing condition, and this can lead to negative outcomes for some people following testing. Stigma may actively prevent people accessing care, gaining support, and preventing onward transmission. That is why UNAIDS stipulates testing should be voluntary, and VCT should take place in collaboration with stigma-reducing activities.

Confidentiality

Many people are afraid to seek HIV services because they fear stigma and discrimination from their families and community. VCT services should therefore always preserve individuals' needs for confidentiality. Trust between the counsellor and client enhances adherence to care, and discussion of HIV prevention. In circumstances where people who test seropositive may face discrimination, violence and abuse it is important that confidentiality be guaranteed. In some circumstances the person

1 *UNAIDS.* Policy statement on HIV testing and counselling. *Geneva, UNAIDS, 1997 (see for full statement).*
2 *WHO.* Counselling for HIV/AIDS: A key to caring. For policy makers, planners and implementers of counselling activities. *Geneva, World Health Organization/GPA, 1994.*
3 *Mugula F et al.* A community-based counselling service as a potential outlet for condom distribution. *Abstract WoD834, 9th International Conference of AIDS and STD in Africa. Kampala, Uganda, 1995.*

requesting VCT will ask for a partner, relative or friend to be present. This shared confidentiality is appropriate and often very beneficial.

The counselling process

The VCT process consists of pre-test, post-test and follow-up counselling. HIV counselling can be adapted to the needs of the client/s and can be for individuals, couples, families and children and should be adapted to the needs and capacities of the settings in which it is to be delivered. The content and approach may vary considerably for men and women and with various groups, such as counselling for young people, men who have sex with men (MSM), injecting drug users (IDUs) or sex workers. Content and approaches may also reflect the context of the intervention, e.g. counselling associated with specific interventions such as tuberculosis preventive therapy (TBPT) and interventions to prevent mother-to-child transmission of HIV (MTCT).

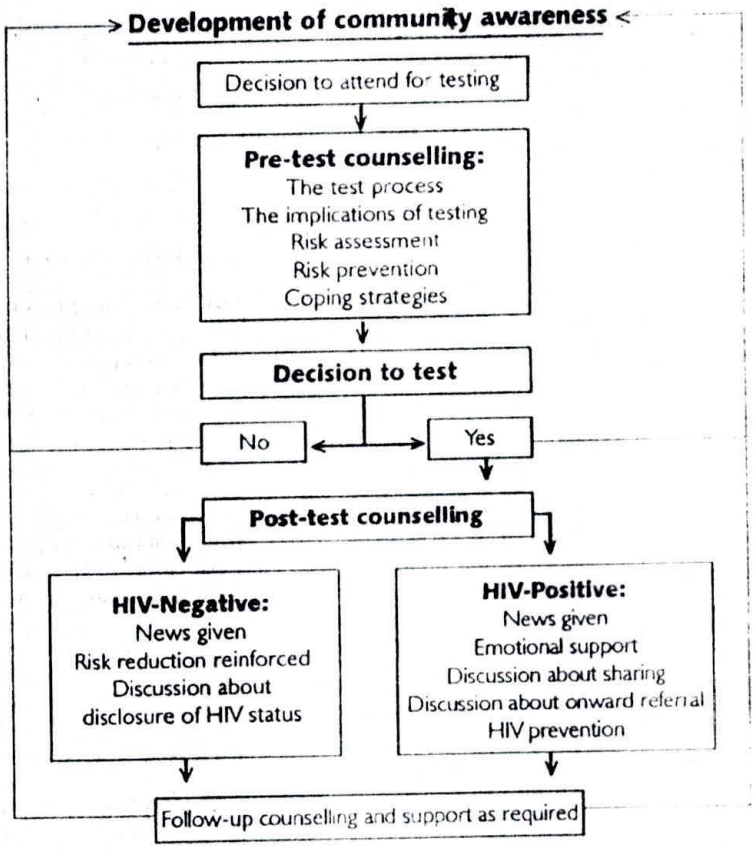
Establishing good rapport and showing respect and understanding will make problem-solving easier in difficult circumstances. The manner in which news of HIV serostatus is given is very important in facilitating adjustment to news of HIV infection.

Counselling as part of VCT ideally involves at least two sessions (pre-test counselling and post-test counselling). More sessions can be offered before or after the test, or during the time the client is waiting for test results.

Pre-test counselling

HIV counselling should be offered before taking an HIV test. Ideally the counsellor prepares the client for the test by explaining what an HIV test is, as well as by correcting myths and misinformation about

Figure 1: Pre-test and Post-test Counselling



HIV/AIDS. The counsellor may also discuss the client's personal risk profile, including discussions of sexuality, relationships, possible sex and/or drug-related behaviours that increase risk of infection, and HIV prevention methods. The counsellor discusses the implications of knowing one's serostatus, and ways to cope with that new information. Some of the information about HIV and VCT can be provided to groups. This has been used to reduce costs and can be backed up by providing written material. It is important, however, that everyone requesting VCT has access to individual counselling before being tested.

People who do not want pre-test counselling should not be prevented from taking a voluntary HIV test (for example people who have had VCT may request testing but not wish to have further pre-test counselling). However, informed consent from the person being tested is usually a minimum ethical requirement before an HIV test.

Post-test counselling

Post-test counselling should always be offered. The main goal of this counselling session is to help clients understand their test results and initiate adaptation to their seropositive or negative status.

When the test is seropositive, the counsellor tells the client the result clearly and sensitively, providing emotional support and discussing how he/she will cope. During this

session the counsellor must ensure that the person has immediate emotional support from a partner, relative or friend. When the client is ready, the counsellor may offer information on referral services that may help clients accept their HIV status and adopt a positive outlook. Sharing a seropositive result with a partner or trusted family member or friend is often beneficial and some clients may wish someone to be with them and participate in the counselling. Prevention of HIV transmission to uninfected or untested sexual partner/s must also be discussed. Sharing one's HIV status with a sexual partner is important to enable the use of safer sex practices, and should be encouraged. However, it may not always be possible, especially for women who face abuse or abandonment if known to be seropositive.

Counselling is also important when the test result is negative. While the client is likely to feel relief, the counsellor must emphasize several points. Counsellors need to discuss changes in behaviour that can help the client stay HIV-negative, such as safer sex practices including condom use and other methods of risk reduction. The counsellor must also motivate the client to adopt and sustain new, safer practices and provide encouragement for these behaviour changes. This may mean referring the client to ongoing counselling, support groups or specialized care services.

During the "window period" (approximately 4-6 weeks immediately after a person is infected), antibodies to HIV are not always detectable. Thus, a negative result received during this time may not mean the client is definitely uninfected, and the client should consider taking the test again in 1-3 months.

Counselling, care, and support after VCT

VCT services should offer the opportunity for continued counselling to people whether they are seropositive or seronegative. For seropositive people, counselling should be available as an integral part of ongoing care and support services. Counselling, care, and support should also be offered to people who may not be infected, but whom HIV affects, such as the family and friends of those living with HIV.[4]

HIV testing

The diagnosis of HIV has traditionally been made by detecting antibodies against HIV. There has been a rapid evolution in diagnostic technology since the first HIV antibody tests became commercially available in 1985. Today a wide range of different HIV antibody tests are available, including ELISA tests based on different principles, and many newer simple and rapid HIV tests.[5] Most tests detect antibodies to HIV in serum or plasma, but tests are also available that use whole blood, dried bloodspots, saliva and urine.[6]

VCT as an entry point to prevention and care

VCT is an important entry-point to both HIV prevention and HIV-related care. People who test seropositive can have early access to a wide range of services including medical care, ongoing emotional support and social support. People who test seronegative can have counselling, guidance and support to help them remain negative.

Entry point to medical care

Health care services may refer people, particularly those with symptomatic disease, to VCT, to aid with further management. Collaboration and cross-referral can ensure that people with HIV receive appropriate medical care, including home care and supportive and palliative care. There are benefits of other health care services, such as tuberculosis services, working in close collaboration with VCT services. People attending VCT can be screened for clinical TB and treated appropriately, or offered TBPT if TB screening is negative, and TB services can refer people to VCT. This may be particularly important in countries where dual infection is common, with up to 70% of people with TB also having HIV infection, and TB being a major cause of morbidity and mortality in people with HIV.[7] Prevention or early treatment of TB in people with HIV can be a cheap and effective intervention.

Entry point for preventing mother-to-child transmission of HIV infection (PMTCT) interventions

Increasing numbers of countries are now offering interventions to PMTCT. VCT is offered within the antenatal setting or close links are formed with VCT services. It is important that women receiving VCT in this setting have adequate time to discuss their

4 WHO. Source Book for HIV/AIDS Counselling Training. Geneva, WHO/GPA, 1994.

5 WHO. The importance of simple and rapid tests in HIV diagnostics: WHO recommendations, Weekly Epidemiological Record 73 (42):321-328, October 1998.

6 UNAIDS. HIV testing methods: UNAIDS Technical Update. Geneva, UNAIDS, November 1997.

7 Elliott A et al. The impact of HIV on tuberculosis in Zambia: a cross sectional study. British Medical Journal, 1990, 301: 412-415.

own needs and not just those concerned with PMTCT, and that there are links with services which can provide ongoing support and care for women with HIV.

When counselling women in the antenatal setting for PMTCT interventions, special consideration should be given to:

- counselling about infant feeding options
- counselling about all available PMTCT options
- family planning counselling
- for seropositive women, referral for ongoing medical and emotional support
- for negative women, counselling about prevention of HIV infection during pregnancy and breast-feeding
- counselling on the advantages and disadvantages of disclosure, particularly to her partner
- involving the partner in counselling and decision-making

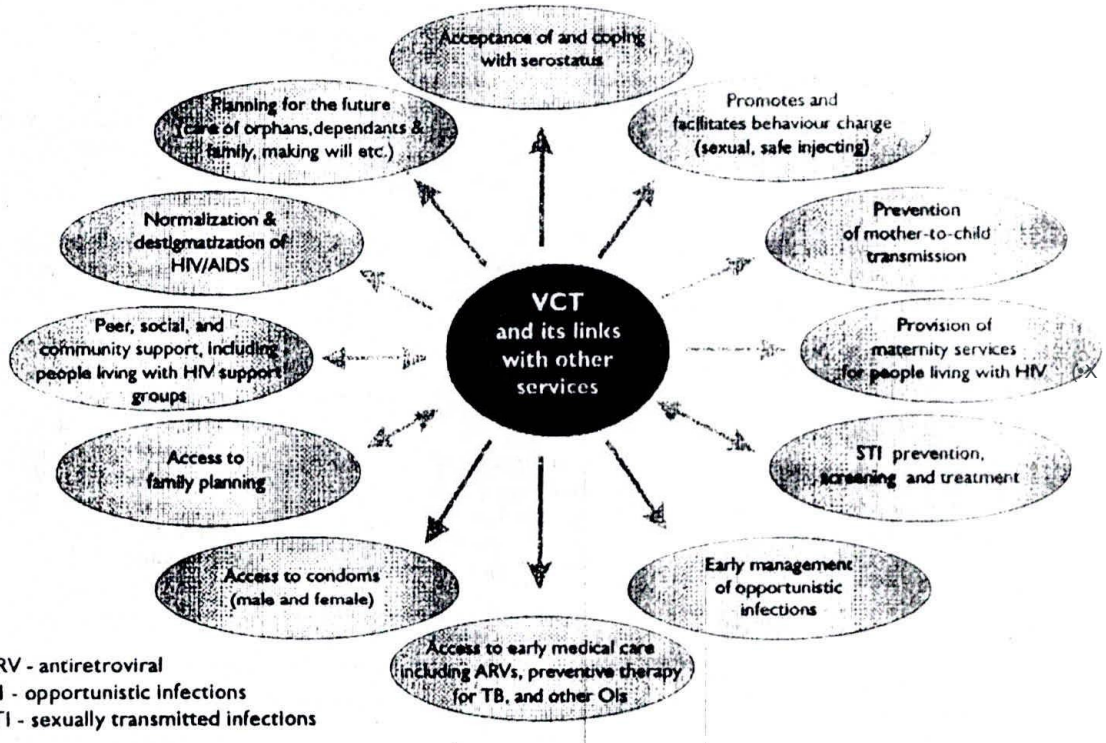
Entry point for ongoing emotional and spiritual care

Although the immediate emotional needs of people following VCT may be met by the counselling service some people will require longer-term support and care. Counsellors will need to be aware of all services available for people following testing. These may include spiritual services, traditional medical practitioners and support groups for people living with HIV.

Entry point for social support

One of the benefits of VCT is that it can help people with HIV to make plans for their future and the future of their dependants. HIV counsellors should be knowledgeable about legal and social services available to help people with these decisions. Material and financial support is sometimes requested, and counsellors need to be aware of any available services, although these are often limited in developing countries.

Figure 2: VCT as an entry point for prevention and care



ARV - antiretroviral
OI - opportunistic infections
STI - sexually transmitted infections

The Challenges

Limited access to VCT

VCT has not been seen as a priority in HIV care and prevention programmes in many developing countries and has therefore often not been widely available. Reasons for this include:

- complexity of the intervention
- the relatively high costs of its various components
- the lack of evidence of its effectiveness in reducing HIV transmission
- the lack of evidence of its cost-effectiveness as measured by number of cases of HIV averted

It is sometimes difficult to measure the impact of counselling on behaviour change. It is understandable that VCT will often not have an easily measurable effect, because of the complexity of sexual behaviour and relationships, and factors which affect these, such as gender inequalities, and lack of empowerment of women in many high-prevalence settings. In countries where resources are very limited VCT services may, therefore, not obtain priority in government planning, and counselling may not receive the official approval, resources, and support it needs to be implemented effectively. Decision-makers may also question the benefit of providing counselling and testing services in places where clinical care options are limited.

Improving effectiveness of VCT

Even where VCT is considered important, its widespread implementation is often limited by lack of funding, infrastructure, trained and designated staff, clear policies on staffing and service sustainability. Counsellors often have other roles within a health care system – such as nursing or social work – which reduce the time available for counselling as a part of HIV testing. Without adequate staffing levels and policies guaranteeing counselling as a priority, pre-test and post-test counselling are often not delivered at all, or are done so hurriedly that clients are not given the time and attention they need.

Inadequate preparation of the settings in which VCT services are offered may also be a problem. This may result in insufficient privacy during counselling sessions, inconvenient opening times or difficult physical access. Clients may feel intimidated by reception staff or have fears regarding the confidentiality of their test results.

Burnout – emotional exhaustion that results when a counsellor has reached his or her limit to deal with HIV and its related emotional stress – may result in rapid turnover of counsellors. This is especially true in high-prevalence areas, where the "breaking of bad news" may occur several times a day. Effective VCT services must find ways to ensure ongoing support and supervision of counsellors and help them to cope with burnout and remain motivated.

Overcoming barriers to VCT

Although VCT is becoming increasingly available in developing and middle-income countries, there is still great reluctance for many people to be tested. There are several possible contributing factors that must be addressed if VCT is to have an important role in HIV prevention and care:

Stigma HIV is highly stigmatized in many countries and people with HIV may experience social rejection and discrimination.[8] In low-prevalence countries, or places where HIV is seen as a problem of marginalized groups, rejection by families or communities may be a common reaction. This fear of rejection or stigma is a common reason for declining testing.

Gender inequalities The need for protection and support of vulnerable women who test seropositive must be considered when developing VCT services. In Zambia, women said that it was thought to be shameful to have HIV and if they were known to be seropositive, they worried that they would suffer discrimination. Studies from Kenya have also shown that women may be particularly vulnerable following VCT and in some cases have lost their homes and children or have been beaten or abused by their husbands/partners if their status became known.[9]

Discrimination In some countries people with HIV are subject to discrimination at work or in education. Unless legislation is in place to prevent this some people will be reluctant to undergo VCT.

Publicizing benefits of VCT

Even in areas where VCT services are available, uptake of services is often poor. A common barrier to VCT is the lack of perceived benefit.[10] If VCT is linked with medical care, and effort is made

8 Karim Q., Karim S., Soldan K., Zondi M. (1995) Reducing the stigma of HIV infection among South African sex workers: socioeconomic and gender barriers. American Journal of Public Health 85 (11): 1521-5

9 Temmerman M et al. The right not to know HIV-test results. Lancet, 1994, 345:696-697.

10 Buggaley R. et al. Barriers to HIV counselling and testing (VCT) in Chawama, 1995, Lusaka, Zambia, 9th International Conference on AIDS and STDs in Africa, December 1995.

to improve medical services for people with HIV, this will help to reduce this barrier to testing. Offering interventions to prevent MTCT can also be recognized as a major benefit of VCT.

Understanding the needs of specific client groups

The HIV epidemic does not affect all sectors of society equally, or in the same way within countries or cities. Some groups are particularly vulnerable to HIV for a variety of reasons including age, profession or specific risk behaviours. For example in the former Soviet Union HIV is largely a problem among IDUs and the HIV prevalence in the general population is low. It may therefore be appropriate to provide specific resources for VCT for IDUs rather than provide a comprehensive service for the general population. VCT services which are acceptable to one group – for example, to men who purchase the services of commercial sex workers – may not be acceptable for other groups, such as the sex workers themselves. Rapid assessment techniques for analysing potential client needs in a given area may exist, and are relatively inexpensive and simple to carry out. However, there may not be adequate and locally available management expertise for creating effective services in response to the findings of an assessment.

Expanding access to VCT

For VCT services to be promoted and developed it is important to document their usefulness in:

- Reducing HIV transmission
- Improving access to medical and social care
- Facilitating MTCT interventions
- Improving coping for people with HIV

Several studies have demonstrated that VCT can prevent HIV transmission among serodiscordant couples. There have also been some studies showing significant behaviour change in individuals following VCT. A recent multi-site study conducted in Kenya, United Republic of Tanzania and Trinidad has provided data on the role of VCT in HIV prevention and its cost-effectiveness compared with other HIV prevention interventions.[11] This study demonstrated that VCT significantly reduced sexual risk behaviour – specifically, unprotected sex with non-primary partners, with commercial sex workers, and among couples who have been tested and counselled together. Furthermore VCT did not increase the occurrence of negative effects such as stigmatization or disintegration of relationships. The study also showed that VCT could be cost-effective in terms of the cost per HIV infection averted. The cost per client for VCT was $29 in the United Republic of Tanzania and $27 in Kenya, and was more cost-effective when targeted to HIV-positive persons, couples, and women.

There are several examples where VCT has been shown to help people access appropriate medical and social services.[12]

In industrialized countries VCT enables people to access antiretrovirals (ARVs) earlier and therefore decrease HIV-associated morbidity. In developing countries PLHA can have access to TBPT and targeted health care.

If pregnant women are to have access to interventions to prevent MTCT it is important that they know and understand their HIV status. VCT associated with MTCT interventions has been shown to be acceptable in some settings.[13] However, barriers to VCT services in antenatal clinics exist where associated ongoing care and support are not available for pregnant women.

Reducing the costs of VCT

The cost of HIV testing has been reduced significantly over the past decade, as cheaper testing methods are manufactured. Simple/rapid testing enables testing to be carried out without laboratory facilities and equipment or highly trained personnel. These factors could enable HIV testing to be made more widely available and can be suitable for rural areas and sites outside capital cities.

Innovative approaches can be devised to help make the counselling component of VCT less labour-intensive. Group education prior to pre-test counselling can shorten the length of time required for one-to-one counselling, and hence reduce costs. Sometimes counselling can be carried out by trained volunteers or lay people and this may also reduce costs. However, if volunteers or lay counsellors are employed adequate training, supervision and support must be ensured, otherwise counsellors may leave and burnout

11 *Sweat ML et al. Cost-effectiveness of voluntary HIV-1 counselling and testing in reducing sexual transmission of HIV in Nairobi, Kenya and Dar Es Salaam, Tanzania: the voluntary HIV-1 counselling and testing efficacy study. Lancet, 2000, July.*

12 *WHO. TASO Uganda, the inside story: Participatory evaluation of HIV/AIDS counselling, medical and social services, 1993-1994. Geneva, WHO/Global Programme on AIDS,1995.*

13 *Bhat G et al. Same day HIV voluntary counselling and testing improves overall acceptability among prenatal women in Zambia, 1998. Abstract no. 33283, XII international Conference on HIV/AIDS, Geneva, Switzerland.*

will be common.

Integrating VCT services into other existing health and social services may also help to reduce costs and make services available to a wider range of people.

Cost sharing has been used in some countries to help provide a more sustainable service. In Uganda, where the AIDS information centre provides VCT, clients are expected to pay a share of the costs. One day a week is set aside for free testing, to enable people who are unable to pay to still have access to VCT. When this was introduced it did not lead to a decline in testing.

Social marketing of VCT has also been proposed as a way of increasing access to sustainable VCT services and has been successfully implemented in Zimbabwe.

Challenging stigma and improving education and awareness

In countries where stigma and discrimination have been challenged with political and financial commitment, VCT has been an important component of the process. However, in many communities HIV remains a stigmatizing problem and VCT is not recognized as being an important part of HIV prevention and care. Societal attitude towards HIV can have a strong impact on individual choices, and if people known to have HIV face discrimination and stigma, VCT is unlikely to be a popular intervention. Stigma and discrimination must be challenged by government and in communities.

Greater involvement of people living with HIV/AIDS in developing and promoting VCT and providing education and awareness about its benefits can be important in providing a more relevant service.

Legislation to protect the rights of people living with HIV in employment and education and to prevent discrimination, need to be in place if people are to feel comfortable and secure about seeking VCT. Mandatory testing should also be discouraged.

Although there are public health benefits of partner notification, making this a compulsory component of VCT has not been shown to be helpful, and may lead to discrimination of the infected partner.

Promotion of the benefits of VCT

The benefits of VCT are often not widely known and understood. Promotion of the advantages of VCT should be an integral part of HIV education programmes and included in IEC materials.

VCT without associated support and care services has been shown to be unpopular in many settings. An explicit policy of care and support for people following VCT should be developed in conjunction with VCT.

If VCT services are to be effective, some important considerations include:

- The location and opening hours of the service should reflect the needs of the particular community. VCT has been carried out in STI clinics, hospital outpatient departments and hospital wards, but also in centres specially dedicated to HIV counselling.[14] VCT services for sex workers, as well as condom supplies, are sometimes offered in the vicinity of nightclubs and operate at night.[15]
- Counselling sessions need to be monitored to ensure that they are of high quality and that informed consent is always sought and counselling offered before a client takes an HIV test.
- Counselling should be integrated into other services, including STI, antenatal and family planning clinics. Community-based counselling services should be initiated and expanded.
- A referral system should be developed in consultation with NGOs, community-based organizations, hospital directors and other service managers, as well as with networks of people living with HIV and AIDS. Regular meetings among service providers should be held to review and improve the referral system.
- Counsellors need adequate training and ongoing support and supervision to ensure that they give good-quality counselling and can cope with their stresses and avoid burnout. Development of tools for monitoring the quality and content of counselling and counsellor needs would be useful.

14 *Sititrai W and Williams G. Candles of Hope: The AIDS Programme of the Thai Red Cross Society. London, TALC (Strategies for Hope No. 9), 1994.*

15 *Laga M., et al. Condom promotion, sexually transmitted disease treatment and declining incidence of HIV-1 infection in female Zairian sex workers* Lancet, *1994, 344(8917):246-8.*

If VCT services are to be effective, some important considerations include: (con't.)

- Innovative ways of scaling up VCT services and making them more accessible and available should be explored. Interventions to prevent MTCT have provided an important impetus to make VCT more widely available for women and their partners. Pre-test group information can reduce the costs and staff needed for VCT, but individual or couple counselling should also be available.
- New testing methods such as simple/rapid testing will make VCT more available, especially in rural areas and where laboratory facilities do not exist. Quality control, basic training and supply systems need to be organized to ensure that these services are delivered safely and appropriately.
- Home testing and self-testing are likely to be more commonly used. This will provide greater access to VCT for people who are reluctant to attend formal VCT services. However, it is important that adequate information about and provision of follow-up support services are available.
- Linkages to crisis support, follow-up counselling and care for those testing seropositive, and strategies to enable people who test seronegative to stay negative, should be developed.

Development of VCT for specific groups

When VCT services are being developed consideration should be given to the different needs of the people attending and the communities for which the VCT services are designed.

VCT for prevention of mother-to-child transmission

Counselling and testing can benefit women who are or who want to become pregnant. Ideally, women should have access to VCT before they become pregnant so that they can make informed decisions about pregnancy and family planning. For women who test seropositive, counselling can help them decide whether or not to have children, and help explore family planning options. For women who are already pregnant and who test seropositive, counsellors can help them make decisions about terminating their pregnancy if abortion is a safe, legal and acceptable option. For women who choose to continue with their pregnancy, counsellors can discuss the use of interventions, such as short-course zidovudine (ZDV, also known as AZT), to reduce the risk of transmitting HIV to the unborn child, if this is available. Infant feeding choices can also be discussed.[16] Where possible, and when the woman agrees, partners should be involved in counselling sessions in which decisions about their present and future children are being discussed and made.

Counselling services for women should not be confined to those associated with MTCT interventions. Services should reflect the multiple roles and responsibilities of women and embrace a comprehensive approach to meet the health needs of seropositive women.

VCT for couples

Counselling and testing can be provided to couples who wish to attend sessions together before and after testing. This has been shown to be a successful approach in some countries.[17,18] During pre-test counselling couples can discuss what they propose to do depending on their test results and thus help prepare the couple for their results. Post-test counselling helps the couple understand their HIV test results. If a couple has serodiscordant test results this can pose difficult challenges in the relationship. Counselling can help the couple overcome feelings of anger or resentment (which in some cases can lead to violence, particularly against women). Counselling is important to help couples accept safer sex practices to prevent transmission to the uninfected partner.

Couple counselling for HIV can also be provided as part of pre-marital counselling, and can continue after the testing is completed.

VCT for children

In many countries, HIV increasingly affects children. Children may themselves be

16 *UNAIDS.* Mother-to-child transmission of HIV/AIDS: UNAIDS Technical Update. *Geneva, UNAIDS, October 1998.*

17 *Allen S et al. Confidential HIV testing and condom promotion in Africa.* JAMA, *1992, 8:3338-3343.*

18 *Allen S, Serufilira A, Gruber V Pregnancy and contraceptive use among urban Rwandan women after HIV counselling and testing.* American Journal of Public Health, *1993, 83:705-10.*

infected, or they may be part of a family in which one or both of the parents are either infected or have died of AIDS.

When children have clinical signs suggestive of possible HIV infection, VCT can provide a confirmatory diagnosis. The counselling sessions may include both the parents and the child. HIV-positive children have special counselling needs such as understanding and coping with their own illness, dealing with discrimination by other children or adults, and coping with the illness and deaths of other HIV-infected family members. HIV-negative children who are affected by HIV through the illness of a parent or sibling also have special counselling needs, such as coping with the emotional trauma of seeing their loved ones ill or dying and dealing with social stigma related to HIV. Older children may need counselling related to developmental issues (such as sexuality and the avoidance of risk behaviours) or coping with and healing from childhood sexual abuse that has put them at risk for HIV infection. In all cases, counselling provided to children should use age-appropriate educational and counselling methods.

VCT for young people

Teenagers are often particularly vulnerable to HIV infection. For VCT services to be effective for young people they must take into account the emotional and social contexts of young people's lives, such as the strong influence of peer pressure (e.g. to take drugs or alcohol) and development of sexual and social identities. They must also be "user-friendly", offered in non threatening, safe, easily accessible environments. Counselling should be age-appropriate, using examples of situations that are familiar and relevant to youth, and language that is non-technical and easily understood.

Anonymous VCT services may be preferable for some young people. However, different countries and cultures may have their own legal requirements and social expectations that prevent young people from accessing VCT services without parental consent or notification. Although VCT services must always take into account any relevant laws regarding the rights and autonomy of minors and the responsibilities of parents for their children, they must also remember that the dignity and confidentiality of the young persons must be protected and respected.

VCT for injecting drug users

Services targeting injecting drug users (IDUs) must take into account several factors. Injecting drug use is a practice that is illegal and socially stigmatized in many cultures. Because many drug users have experienced social stigma and unpleasant encounters with the law, they may distrust or fear government-based or hospital-based social services. VCT services that are part of such institutions may, therefore, be unlikely to attract drug-using clients. Examples of more successful VCT programmes for drug users are those coordinated with existing HIV prevention and social service outreach programmes that go to the places that drug users frequent. Often, the outreach workers are former drug users themselves, so they can understand the drug culture's particular social norms and values. Also, because they have already established trust with the drug using community, counselling and prevention messages delivered by such outreach workers are often perceived as being more credible. Such outreach workers, when trained as HIV counsellors, can explain HIV testing and the importance of knowing one's status in terms with which the drug users are familiar and which they can accept.

While HIV counsellors should discuss risk reduction with their clients at both pre- and post-test, they should also understand that IDUs may not be willing or able to change certain behaviours, such as their drug use or having unprotected sex. In these cases, HIV counsellors should discuss safer methods of practising these behaviours – such as not sharing needles or sterilizing needles and syringes before sharing – in order to prevent the clients from becoming infected or spreading their HIV infection to others.

Counselling for sex workers

VCT for commercial sex workers need to be sensitive to the problems of stigma and illegality associated with commercial sex in many societies. Sex work is usually the client's livelihood and thus stopping some or all risk behaviours may reduce the sex worker's ability to earn a living. Furthermore, sex workers may be under considerable pressure to perform especially risky activities (e.g. sex without a condom), either through financial inducement or coercion by a pimp or client. Counsellors must understand these issues, and help the sex worker find ways to work around or reduce the obstacles they face when trying to reduce their risk. In some cases, counsellors may want to work closely with community organizations that empower and support sex workers' desire to keep themselves healthy and safe.

Selected Key Materials

Baggaley R et al. *HIV counselling and testing in Zambia: The Kara Counselling experience.* SAFAIDS, 1998 6 (2):2-9.

Kamenga MC et al. *The voluntary HIV-1 counselling and testing efficacy study: Design and methods.* AIDS and Behaviour, 2000, 4(1): 5-14.

Mugula F et al. *A community-based counselling service as a potential outlet for condom distribution.* Abstract WeD834, 9th International Conference on AIDS and STD in Africa, Kampala, Uganda, 1995.

Sittitrai W and Williams G. *Candles of Hope: The AIDS Programme of the Thai Red Cross Society,* London, TALC (Strategies for Hope No. 9), 1994.

Sweat ML et al. *Cost-effectiveness of voluntary HIV-1 counselling and testing in reducing sexual transmission of HIV in Nairobi, Kenya and Dar Es Salaam, Tanzania: the voluntary HIV-1 counselling and testing efficacy study.* Lancet, 2000, July.

UNAIDS. *Caring for Carers, managing stress in those who care for people with HIV and AIDS.* UNAIDS, Best Practice Collection. Case Study. Geneva, UNAIDS, May 2000.

UNAIDS. *Knowlege is power,* UNAIDS, Best Practice Collection. Case Study. Geneva, UNAIDS, June 1999.

UNAIDS. *Mother-to-child transmission of HIV.* UNAIDS, Best Practice Collection. Technical Update. Geneva, UNAIDS, October 1998.

UNAIDS. *UNAIDS policy on HIV testing and counselling.* Geneva, UNAIDS, 1997. UNAIDS/97.2. Statement encouraging increased access to voluntary HIV testing and counselling services that feature informed consent and confidentiality, quality assurance, and safeguards against potential abuse.

UNAIDS. *Tools for evaluating HIV voluntary counselling and testing.* UNAIDS, Best Practice Collection. Key Material. Geneva, UNAIDS, May 2000.

WHO. *Counselling for HIV/AIDS: A key to caring.* Geneva, World Health Organization, Global Programme on AIDS, 1995. WHO/GPA/TCO/HCS/95.15. Explores programmatic and policy issues with regard to planning and setting up counselling services. Describes counselling in the context of an overall response to the epidemic, and ways counselling is organized.

WHO. Revised recommendations for the selection and use of HIV antibody tests. *Weekly Epidemiological Record* (1997) 72:81-83.

WHO. *Source book for HIV/AIDS counselling training.* Geneva, World Health Organization, Global Programme on AIDS 1994. WHO/GPA/TCO/HCS/94.9. Intended for use in training counsellors. Deals with initial training and refresher courses for those needing to act as counsellors in the course of their professional duties (e.g. health care providers) and for those specialized in counselling.

WHO. The importance of simple/rapid assays in HIV testing. *Weekly Epidemiological Record* (1998) 73:321-327.

THE LUTHERAN WORLD FEDERATION

A COMMUNION OF CHURCHES – EINE KIRCHENGEMEINSCHAFT – UNA COMUNIÓN DE IGLESIAS – UNE COMMUNION D'ÉGLISES
LUTHERISCHER WELTBUND – FEDERACIÓN LUTERANA MUNDIAL – FÉDÉRATION LUTHÉRIENNE MONDIALE

2005 Christmas Message from the LWF President

Dear Sisters and Brothers in the worldwide Lutheran communion,

"Do not be afraid." So began the angel's announcement of Jesus' birth. It was also Gabriel's greeting to a bewildered Mary, "Do not be afraid." To the grieving women at Jesus' tomb, angels again declared, "Do not be afraid." To exiles in Babylon who felt forsaken by God comes the announcement, "Be strong, do not fear!" (Isaiah 35:4)

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To be human is to have fears. Fear has permeated life in this past year and haunting images will remain with us. Children fear abandonment as their parents die from HIV/AIDS. Parents clutch their children, terrified there will not be food enough to keep

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death and disease away. People struggle for survival in the midst of natural disasters. Others seek safety from violence. All know the reality of fear.

We know the reality of fear, but fear must not become our defining reality. When fear becomes our orientation to the world, we either withdraw in isolation or lash out in acts of aggression. Fear hardens lives, dares not acknowledge failures, and closes borders. Fear leaves us cynical, immobilized, and turned in upon ourselves.

The angel says, "Do not be afraid. For see, I am bringing you good news of great joy for all the people: to you is born this day in the city of David a Savior, who is the Messiah, the Lord."

God sends messengers to hold back the walls of fear. We can then hear the good news of God's love in Christ Jesus for the whole creation. We entrust our lives to God's promise. Faith rather than fear defines us.

Faith frees us to confess our bondage to sin and to accept God's gift of forgiveness. Faith calls us to take up our cross and follow Jesus into our suffering world. Faith compels us to bear witness to the signs of God's reign of justice, mercy, and peace. As one writer said, "Faith quells our fears, but never our courage." We receive the future, trusting in the power and promise of Christ's death and resurrection.

May our voices in the communion of the Lutheran World Federation be joined with the chorus of every time and every place as we joyfully sing:

Glory to God in the highest heaven,
and on earth peace
among those whom [God] favors.

In God's grace,

Bishop Mark S. Hanson
President, The Lutheran World Federation

November 2005

** This year's Christmas card, titled "Hope", was designed by fifteen-year-old Ramez Odeh from Bethlehem. Ramez attends the Lutheran Dar Al-Kalima School in Bethlehem, West* ***Bank.***

PRACTICAL INFORMATION

Practical information

Admission

Applicants are accepted on the basis of their previous studies and experience

- an academic degree or equivalent,
- at least three years of professional experience in humanitarian, social, development or human rights related fields.

Language

Courses are taught in both French and English.
Participants must speak and write one language correctly and have a good knowledge (passiv) of the other language.

Selection procedure

Applicants are selected on the basis of their application file.
The number of participants is limited.

Costs

- Tuition fees
  Whole programme : CHF 15'000.- Per module: CHF 4'000.-
- Living expenses in Geneva
  Housing, transport, food, insurance, etc. vary between CHF 1'500.- to 2'000.- per month. Participants must find their own sources of finance.
  Information on Geneva can be found on the following website :
  http://www.geneve.ch/portail/

Certification

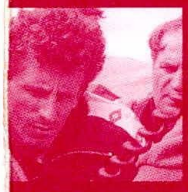
Participants who have fulfilled the requirements outlined in the program's rules and regulations will be awarded the Diplôme de formation continue en Action humanitaire /Master's in Humanitarian Action by the University of Geneva. Upon request, attestation may be obtained for each module successfully passed.

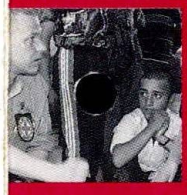
Application

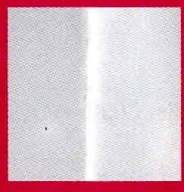
The application form can be found on the website of the program :
http://www.unige.ch/ppah
Complete files must be received before 15 September 2004.

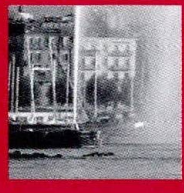
Information

Action humanitaire - ppAH
Université de Genève UNI MAIL
40, bd du Pont d'Arve / CH-1211 Genève 4
Tel : +41 22 379 89 32 Fax : +41 22 379 89 39
Email : ppah@unige.ch http://www.unige.ch/ppah









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THE HUMANITARIAN ACTION PLURIFACULTY P

A training program:

- in partnership with several humanitarian organizations,
- designed for professionals,
- to analyse contemporary situations and conceive strategies for **tomorrow**.

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Objective

To take advantage of the academic context to master the conceptual and methodological tools that are indispensable in order to address the great humanitarian challenges of our time.

Pedagogical methods

In our approach to teaching, we emphasize interactivity and a critical and independent examination of the meaning of humanitarian action and how it is carried out.

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Faculty staff from Universities of Geneva, Switzerland and Europe as well as experts from international organizations and NGOs actively involved in humanitarian action.

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A one year cours
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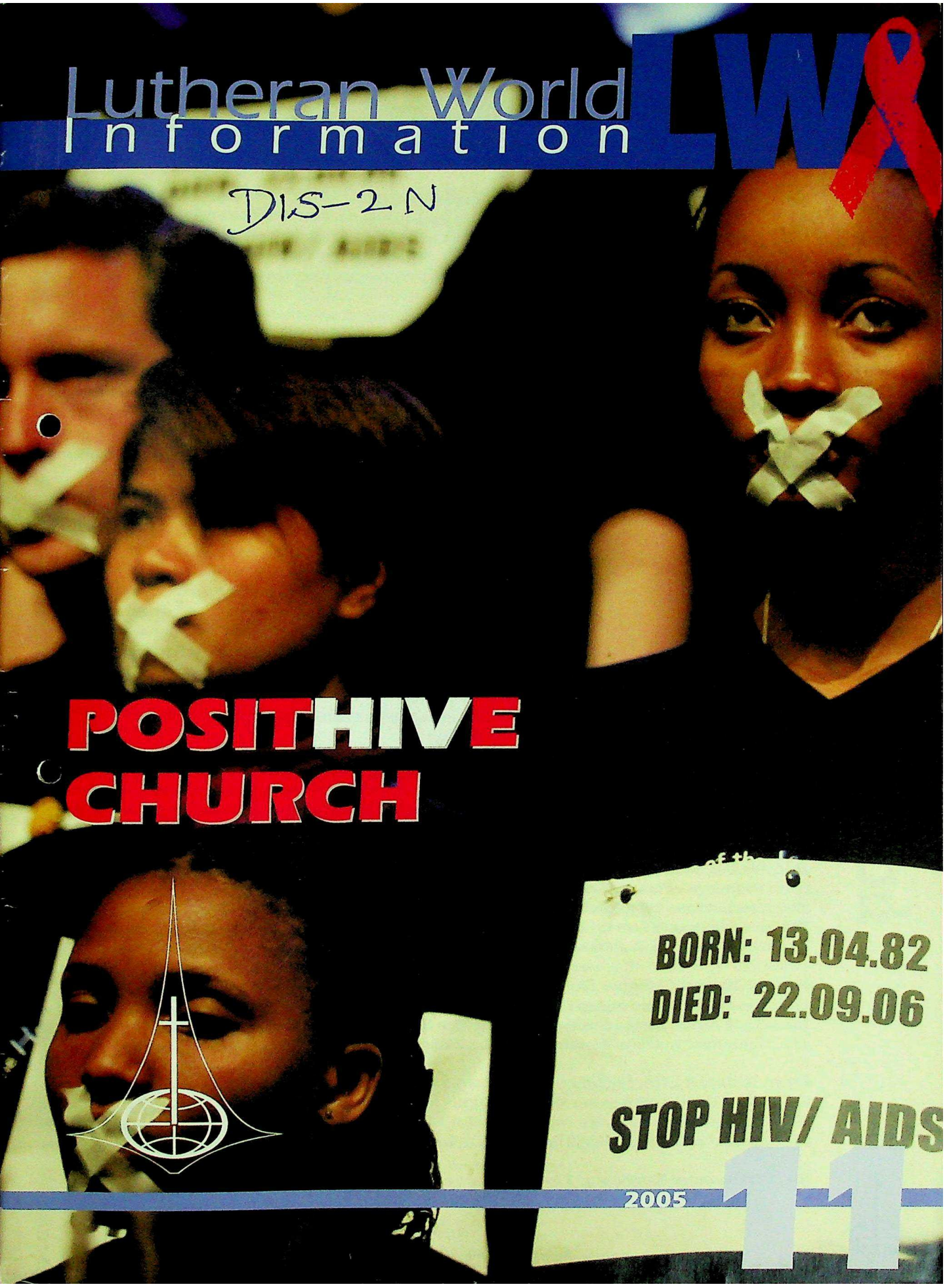


POSITHIVE CHURCH

2005 1

Contents

FOREWORD

When the Lutheran World Federation (LWF) launched its HIV/AIDS campaign over three years ago, I particularly commended the then member church leaders for collectively taking a historic step. They committed the churches to a process of seeking solutions, which looked beyond the capacity of "our cultures" and those of the "theological traditions of our churches."

The commitments made by the African member church leaders have been echoed in Asia, Europe, Latin America and North America. They are witness to the fact that while churches have provided care and support for people living with HIV/AIDS for more than two decades, the church leadership has too often contributed to stigmatization and discrimination; churches have not always been safe or welcome places for people living with, or affected, by HIV/AIDS.

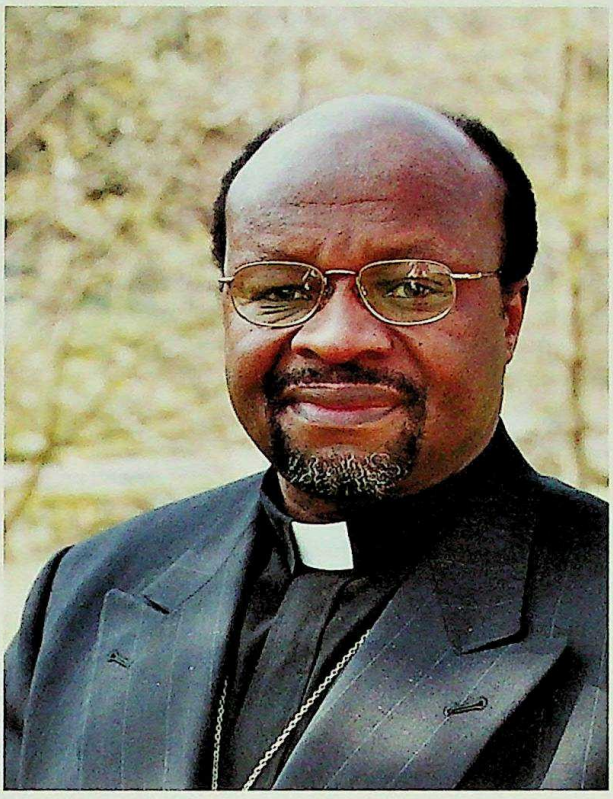
As a communion, we agreed to "prioritize life" by breaking the silence and secrecy surrounding HIV/AIDS, and by publicly acknowledging that "the church itself has AIDS." We prioritized the opening up of our churches, homes, institutions and hearts, and the creation of opportunities for all those living with HIV/AIDS.

But as members of the LWF communion accompany each other in a concerted global response to the pandemic, many questions still abound. We may not have all the answers, but we do need to continuously focus on them as they continue to challenge us.

Are We Theologically Equipped?

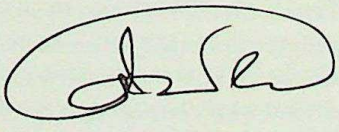
When can it be truly said that church leadership is competent, and committed, to deal with the challenges of AIDS? Is there a common understanding of theology with respect to AIDS, which is both contextual and contemporary? Are we theologically equipped to deal with the question of suffering, with stigma and discrimination, which originate from faith and culture-related judgement? Are we a caring and healing community? Are we using our resources in the congregations to alleviate the suffering through pastoral care and diaconic action? Are we through our actions, including advocacy at the global and international level, already part of the solution? Or are we still part of the problem?

AIDS work will continue to be a dynamic and challenging field. It is extremely demanding for professional staff, and for the thousands of volunteers involved. But I am encouraged by the numerous efforts of the churches and the Department for World Service field programs in HIV/AIDS response worldwide. The ecumenical initiatives, collaboration with civil society, and governmental and non-governmental bodies will continue to be important components of the fight against a pandemic that threatens to be of ever-increasing magnitude in years to come.



LWF General Secretary, Rev. Dr Ishmael Noko. © LWF/H. Putsman

As we mark World AIDS Day on 1 December 2005, I encourage you to carefully read the concerns shared in this special issue of *Lutheran World Information (LWI)* titled "**POSITHIVE CHURCH**." I particularly want to thank those persons, including those living with HIV/AIDS, who have shared their hope and inspiring experiences, reminding all of us of our obligations as integral members of this "positive" community. Their concerns represent a significant part of the challenges facing the Lutheran communion's response to HIV/AIDS in the different regions of the world. They remind us of our obligation "For the Healing of the World," as stated in the theme of the July 2003 LWF Tenth Assembly. *(535 words)*

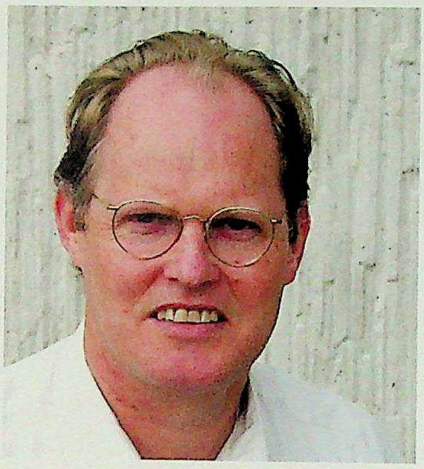


Rev. Dr Ishmael Noko
General Secretary
The Lutheran World Federation

Response to HIV/AIDS Demands Competent Expression of Being Church

When part of the body of Christ suffers, the whole body suffers.

Churches of the Lutheran communion are called to respond to the AIDS pandemic because—the Church itself has HIV/AIDS. The disease, and its effects, are not only outside the church but also among us, sending a significant challenge to the whole communion. In most congregations, there are individuals or families who, in some way, are affected by HIV/AIDS. In some Lutheran World Federation (LWF) member churches, the effects are not yet very visible. In others, they are a reality in daily funerals, orphaned children, and the breakdown of social and economic systems. The whole of the LWF communion shares in this shocking reality, which is changing the nature of life as previously known, and challenging what it means to be Church.



Mr Jacob Koos Schep, LWF/DMD Secretary for Project Implementation and Monitoring. © LWF/H. Putsman

For the LWF, a communion of churches that has been focusing on HIV/AIDS since the early 1980s, responding to the pandemic is not just a matter of designing and implementing more AIDS projects. It demands that the LWF become AIDS competent in its very expression of being Church. Upon the request of individual member churches, and the LWF Council, a global LWF campaign against HIV/AIDS was launched in 2002 with the aim to motivate, strengthen and support LWF member churches to respond more actively and courageously to the urgent pandemic of HIV/AIDS. Its action plan titled "Compassion, Conversion, Care – Responding as Churches to the HIV/AIDS Pandemic," was designed to ensure an integrated approach to the complex and diverse challenges posed by the pandemic.

Churches Have Expressed their Commitment

Initially, churches could be project holders of AIDS projects, but the clergy remained silent on the related sexual and relationship issues. So the LWF specifically focussed on empowering church leadership to break the silence, and to guide all workers within the churches to confront all related questions with courage and confidence. In four regional church leadership consultations in Africa, Asia, Europe and Latin America, participants expressed their commitment to fighting HIV/AIDS, and drew up specific action plans, which are currently being implemented. Many member churches have followed through on their commitment. But there are some processes in need of further accompaniment.

The LWF AIDS campaign has received tremendous support from LWF funding partners (for project follow-up), and from the Global Fund to Fight AIDS, Tuberculosis and Malaria, for consultations and the accompanying expertise. In Africa and Latin America, the LWF now has a regional consultant to assist and coordinate follow-up work.

The reporting requirements linked to the Global Fund's support facilitate the LWF's task of setting realistic expectations of its action. The Federation works with 15 bespoke indicators, which aim to reflect whether what is planned is achieved. In regional action plans, emphasis is put on the need for clarity in theology, and on the importance of church leadership courageously guiding pastors and congregations to change and adjust to the reality of AIDS. Development of criteria for this particular quality of leadership is underway.

New Alliances, Strengthened Capacity

Preparation of the first five chapters of an LWF AIDS manual is under way. It is aimed at equipping all church workers in high-risk countries with cutting-edge information and pastoral and other practical tools, to alleviate the suffering of those affected by AIDS. Direct cooperation between the LWF Department for World Service offices and member churches' AIDS coordinators is being established in order to create strong networks, and mutual encouragement. At the same time, member churches are being encouraged to forge strong ecumenical relations in this field, and to plan and implement their AIDS ministry with the many other actors in their nations. Fine examples of new alliances and strengthened capacity are emerging.

It is widely acknowledged that faith-based organizations have a crucial contribution to make to the fight against HIV/AIDS. As such, the AIDS pandemic provides an opportunity to churches to prove their relevance to society. *(655 words)*

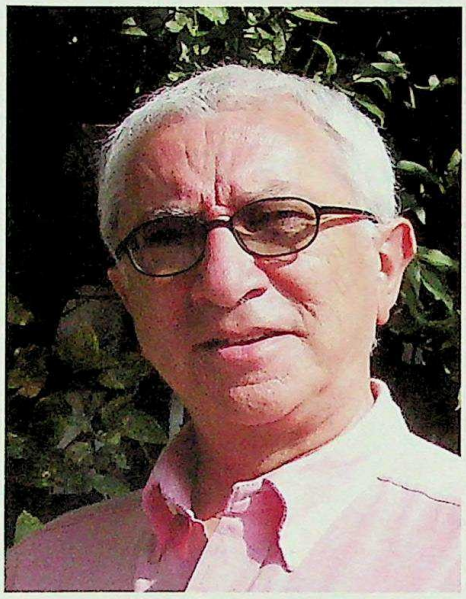
By Mr Jacob Koos Schep, Secretary for Project Implementation and Monitoring, LWF Department for Mission and Development (DMD).

CHALLENGING THE CHURCHES' POSITION ON HIV/AIDS

Breaking the silence on HIV/AIDS calls for a critical analysis of the church communion that the Lutheran World Federation is called to be—positive, inclusive and open, a church of the cross that has the courage to tell the truth. While the global AIDS statistics accentuate the epidemic's impact on Sub-Saharan Africa, the church's urgent intervention is required in other regions, where the pandemic could be as explosive.

Rev. Lisandro Orlov (Argentina) and Dr Sheila Shyamprasad (India) share their insights on the theological and social challenges for the churches.

The Gospel Will Always Be a Scandal for Human Beings



Rev. Lisandro Orlov, United Evangelical Lutheran Church, Argentina. © Ecumenical Advocacy Alliance

The context in which Jesus tells the parable of the prodigal son (Luke 15: 11–32) is important. He has to justify eating—a sign of communion—with sinners and swindlers (publicans). This story has two aims: to show the love of God, which overcomes anything we may realize, even theologically; and the logical and cautious reaction of the pious when faced with the irrationality of God's inclusive love.[1]

In this narration taken from everyday life, the father's incomprehensible and irrational love reflects the deep love of God. Jesus justifies the preaching of the good news to the despised and abandoned. The younger son claims *(vs 11–13)* his part of the inheritance in accordance with the Old Testament rules. He takes the money and emigrates to another country. Apparently, this young man was not married, which provides a clue about his age, as men married between 18 and 20 years old. He is like the young adults we encounter in our work with people living with HIV/AIDS. The young man squanders the inheritance and his brother would add the fact of women, who one could imagine were commercial sex workers or those in idolatry, and thus linked to gods of foreign temples.

(vs 14–19) The young man had not taken into account the frequent famines that occurred in Palestine and other regions of the world at that time. During this economic crisis, he had to tend impure animals and as a result, he was in no condition to celebrate Sabbath. Anyway, if he wanted to eat the pods that the pigs ate, he would have had to steal them, because as stated in the text, no one gave him anything. Then, he prepared a good speech that is not an apology, but an explanation so that he could work as a hired laborer in his father's home, as he had nothing left to claim. In the religious eyes of the time, we encounter a situation of idolatry and ritual impurity. This description prepares us for the father's inexplicable love.

Incomprehensible, Irrational Love

(vs 20–24) From a distance, the father sees his son, and simply feels moved. The father's first gesture is to run in public—in itself surprising, because in this cultural context, it was not common for a person of a certain social status to do that especially in front of his servants, even if one was in a hurry. This is a humiliating situation of a father disposing of his pride and dignity to meet his son. We are called to go out to encounter those who are excluded and marginalized from our churches and society disposing of both our personal and institutional pride.

The second gesture is as surprising—the father hugs and kisses his son. These are signs of reconciliation and peace. Let us forget the moral judgments. The son begins his speech but the father is not ready to listen, his heart is enjoying the feast of this encounter. He then asks the servants to bring clothes, a ring and sandals, which are symbolic elements. **New clothes,** indicate the arrival of a time of salvation. The son is accorded all honors as if by divine right that was his place. The **ring** sealed property documents, indicating a generous sharing of all goods. **Sandals** are the sign of free people, as slaves went bare-footed. The incomprehensible and irrational love of this father reflects the deep love of God.

These three situations emphasize a pastoral accompaniment to people affected by HIV/AIDS. They

are the foundation for a message that will open the doors of our hearts and our minds because they are the visible signs of willingness to reconciliation. Are we as churches, ready to act in the same way?

(vs 25–32) In all work with people living with HIV/AIDS, the strongest criticism often comes from those closest to us in affection, conviction and community. Criticism about the generosity of the father comes from the family itself. The elder son excludes himself from the feast of reconciliation. But the father insists on calling him son, and then continues that it "is just" and necessary to celebrate because the one who had been excluded had now found a home. We will never know how the elder brother responded to the father's invitation. This is an open-ended situation, like our attitude today. What will our churches do?

We as Christian communities often behave like the elder brother. There is no doubt the gospel will always be a scandal for human beings, and God's love always goes beyond our thoughts, values and moral values. The churches' pastoral actions should never loose this scandalous air. *(788 words)*

By Rev. Lisandro Orlov, regional coordinator of the LWF HIV/AIDS campaign in the Latin American region. Orlov, a pastor of the United Evangelical Lutheran Church, Argentina, is also director of a shelter for people living with HIV/AIDS in Buenos Aires, Argentina.

[1] Joachim Jeremias: "Les paraboles de Jésus," Livre de Vie, p. 184ff.

Insights into the Asian Epidemic – A Call to Churches

The tragedy and devastation caused by HIV/AIDS in Africa is well known to many people in that continent and outside. Out of the estimated 40 million people living with HIV/AIDS worldwide, 60 percent—over 25 million—are in Sub-Saharan Africa. Some governments there have declared HIV/AIDS a national disaster, and many more have set up AIDS coordination bodies in efforts to raise awareness about the pandemic, reduce the number of new infections, and provide care and support including treatment to people living with HIV and AIDS (PLWHA).

Dr Sheila Shyamprasad, LWF consultant for HIV/AIDS programs and projects. © Private

However, there is little realization that the world is set for a similar scenario in Asia with seven million PLWHA, and some 500,000 people dying every year from AIDS. Although Asia has the highest increase of new HIV infections, there is little hue or cry. Instead, all one hears is deafening silence.

One reason for this indifference and complacency is a false sense of security and comfort in the low HIV prevalence in the population. Less than one percent of India's one billion people is infected compared to 36.5 percent in the Southern African nation of Botswana, with a population of around 1.6 million people. Asians are of the opinion that the percentage will never rise to the critical levels in many African countries. But when such figures are translated into numbers, Botswana's 350,000 PLWHA are 15 times less than India's 5.3 million infected people. If HIV were to take hold in China, India and Indonesia, which account for 40 percent of humanity, the consequences could be disastrous.

Many Churches Not Yet Involved

The majority of churches in Asia are not yet involved in HIV/AIDS ministry because they do not realize the enormity and gravity of the situation, or if they do, they feel this is not the place for the churches. Another fallacious thinking is the misguided belief that the Asian culture of collectivism, hard work and strong family morals will render Asians non-vulnerable and will protect them from homosexuality, prostitution and polygamy. There is widespread assumption that HIV and AIDS affects only those who indulge in homosexual practice, injecting drug use or promiscuous sex, but little realization that the virus has moved into the general population.

There is an increasing number of new infections among monogamous women and their children. In Cambodia, seven monogamous women are infected by their husbands everyday. The much-talked-about ABC strategy of prevention (Abstinence, Be faithful, Condoms) does not work for women in monogamous relationships as they have no negotiating power when it comes to sex. Although homosexuality is not evident as in the West, other cultural practices like temple prostitutes, commercial sex work by married women who work from their homes to supplement family income, a large transgender community, and the easy access to drugs, all hinder the effective implementation of prevention efforts in Asia. Cultural taboos about sex and sexuality in Asian society prevent open discussion especially with the youth.

Inaccessible Treatment

While Asian countries battle to prevent new infections, the infected continue to die due to lack of treatment. Although India produces some of the cheapest antiretroviral medication, around 90 percent of its infected population cannot afford it. Another challenge is the availability of many drugs in the region's open market. Unethical practices prevail with under prescriptions, irregular treatment and lack of proper patient education. These factors may well lead to viral resistance, which is a frightening thought, as the drugs will then have no effect on the virus and no treatment will be of any use.

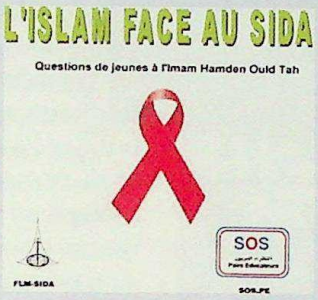
More injustice could be done when the Intellectual Property Rights Agreement goes into force, prohibiting India and other countries from manufacturing affordable new AIDS drugs. The availability in the Asian market of expensive drugs manufactured in the West could only result in the deaths of millions.

Churches need to be aware of these facts and rise to meet the challenge of speaking out about HIV/AIDS, reaching out to those infected and affected, especially the marginalized and outcast. Churches are called also to challenge unjust practices and processes that devalue humanity and deny the fundamental rights to information, health and care. The HIV/AIDS crisis is a unique opportunity for the church to prove its witness to the world.

The AIDS Desk of the United Evangelical Lutheran Church in India (UELCI) which brings together 11 Lutheran churches, has been one such witness. A pioneer in HIV/AIDS activities in India with 17 years of involvement and activities ranging from prevention education, advocacy to medical care and widow support, the UELCI has shown the way forward to other churches in the region. *(770 words)*

By Dr Sheila Shyamprasad, LWF consultant for HIV/AIDS programs and projects, Department for Mission and Development. Prior to joining the LWF in 2005, Shyamprasad worked for several years as project coordinator of the Lutheran Health and Medical Board at the UELCI AIDS Desk.

LWF Documentary – L'Islam face au sida (Islam and AIDS)



In 2003, the Lutheran World Federation (LWF) Department for World Service (DWS) program in Mauritania produced a 10-minute documentary "**L'Islam face au sida – Questions des jeunes à l'Imam Hamden Ould Tah**" (Islam and AIDS – Young People's Questions to Imam Hamden Ould Tah).

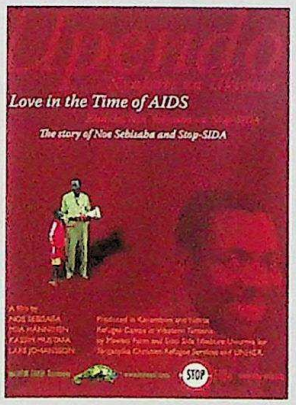
DWS Mauritania produced the documentary in collaboration with the SOS/Pairs Educateurs youth association, a group of young Mauritanians using peer education to fight HIV/AIDS.

The documentary's target group is young people, a category that is still struggling with unanswered questions, many of which are taboo subjects in the Islamic Republic of Mauritania. These include the use of condoms; so-called "breast brothers/sisters" [the custom whereby a woman would give her child to another woman to be breast-fed, with the aim to make the two children 'brother and sister']; HIV testing; whether an HIV-infected man can become an Imam or get married, and so on.

Determining the Islamic position on HIV/AIDS and its related issues is important as religious leaders are well listened to in the northwest African country. Imam Hamden Ould Tah is president of the Mauritanian High Islamic Council, and a renowned personality both nationally and internationally.

The documentary can be ordered by writing to **info@lutheranworld.org** or The Lutheran World Federation, P.O. Box 2100, CH-1211 Geneva 2, Switzerland, Tel. +41/22-791 61 11, Fax +41/22-791 66 29. *(227 words)*

Upendo – Nyakati za Ukimwi (Love in the Time of AIDS)



"Within being a refugee and within AIDS, I have found a life of love, truth and freedom," says Noe Sebisaba, who became the first refugee in the Kanembwa and Nduta Refugee camps in Western Tanzania to declare that he was living with HIV.

The 56-minute film, **Upendo – Nyakati za Ukimwi**, in DVD format, gives the story of Sebisaba, who was thought confused by some and condemned by others for bringing shame to his family. But the youth understood and admired his courage. Five years later, their organization has some 1,000 members in the refugee camps in Western Tanzania and is regarded as one of the most effective community-based AIDS initiatives in Africa.

The film in Kiswahili and Rundi dialogue with subtitles in English and French, was produced by Maweni Farm and Stop Sida Nkebure Umumva group for the Tanganyika Christian Refugee Service (TCRS), the LWF Department for World Service (DWS) program in Tanzania, and for the United Nations High Commissioner for Refugees (UNHCR).

As a UNHCR and World Food Program implementing partner, TCRS provides camp management for 130,000 Burundian refugees in camps in Kibondo District, advocates for refugee rights and welfare, promotes refugee self-reliance, group empowerment, peace and reconciliation. *(209 words)*

More information about *Upendo – Nyakati za Ukimwi* at **www.maweni.com**

Prophetic Diakonia and HIV/AIDS – Voices from the Regions

From the different parts of the global Lutheran communion, Colombia to the USA; Cambodia to South Africa; whether it is HIV/AIDS radio programs to marginalized groups; or religious leaders and volunteer activists fighting for PLWHA's right to information, medication and education; there is a wide scope of positive initiatives. Still, a lot remains to be done, challenging the global Lutheran communion to speak out more and engage further.

Africa

Cameroon: Demystifying HIV/AIDS Through Radio Programs

The struggle against HIV/AIDS, for some populations today, is truly valiant. The critical situation in Africa, the most affected continent, challenges the media, partners and information promulgators to promote training, awareness raising and dialogue.

Among these media, *Sawtu Linjiila (SL)* ["Radio Voice of the Gospel"], a program of the Evangelical Lutheran Church of Cameroon (EELC) is by no means least. In its permanent quest to demystify HIV/AIDS, reduce stigma and break the taboos surrounding the pandemic, *SL* has this year produced some 20 radio programs, aiming to teach, and raise awareness among, mothers and youth who would not normally benefit from information about HIV/AIDS.

Sawtu Linjiila presenter, Ms Asta Mouwabouna, goes on air with the "Health Magazine." © Sawtu Linjiila

Listeners can tune in to programs that include explanations about how HIV can be transmitted, the importance of testing, guidance with respect to care, and constructive ways of living with the patient and the disease. In collaboration with health professionals, *SL* has also given abundant advice on breast-feeding and balanced nutrition for mothers. The programs, produced in the Fulani language have been broadcast by eight national and international radio stations.

The EELC for its part, has set up a "Project to Combat HIV/AIDS." EELC President, Rev. Dr Thomas Nyiwe, says: "Many positive things have happened since the project's launching. AIDS has been considerably demystified. The church's message has gone across well." However, in spite of all efforts so far, much still remains to be done. "The goal of our work is to see complete eradication of this scourge called AIDS. Perhaps we'll have to work, pray and wait for a long time yet. Our greatest challenge is to keep up the fight," he adds.

Cameroon's National Committee to Combat AIDS estimates one out of 16 young people aged from 15 to 24 to be HIV infected. In spite of numerous awareness-raising campaigns conducted by the national body since its founding in 1987, the epidemic has continued to spread.

HIV prevalence in the sexually active population was estimated at 7.2 percent in 1998, against 0.5 percent in 1992. In addition, the number of declared AIDS cases exceeded 20,419 between 1985 and 1998, one third of those occurring in 1998 alone. The nationwide prevalence is 11 percent, and 17 percent in Adamaoua province, where *SL* is located. *(375 words)*

By Mr Thomas Magadji, director of Sawtu Linjiila, Cameroon.

Eritrean Church Provides Home-Based Care and Alternative Skills for Sex Workers

The AIDS pandemic in Eritrea is unfolding in the midst of a post-conflict situation. Aware of the increasing HIV prevalence, currently estimated at around 2.7 percent (UNAIDS) among adults, the Evangelical Church of Eritrea (ECE) has, since 1994, committed itself to the prevention, care and rehabilitation of people infected and affected by HIV/AIDS.

The ECE's focus includes awareness building about HIV transmission and prevention through workshops and seminars in church congregations. The target group is the general populace, with special care to include the deaf.

When the number of HIV/AIDS cases exceeded the capacity for institutional hospitalization, a home-based care initiative was begun in July 2002. Twenty volunteers were trained in collaboration with the Ministry of Health in Eritrea. There are currently 90 beneficiaries receiving holistic care at home. The services include

nursing care; counseling; psychosocial and spiritual support; follow up of treatment and referrals; nutrition and sanitation education; and childcare.

To reduce heterosexual sexual transmission of HIV by commercial sex workers, the ECE started skills training and a rehabilitation scheme to encourage alternative businesses. From 2002 to mid-2005, over 150 commercial sex workers had been trained in embroidery, tailoring, design and weaving.

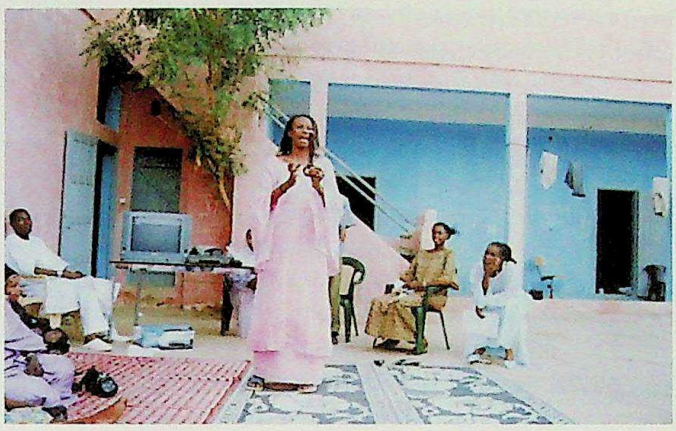
Through another project, profit from the sale of agricultural products currently supports HIV/AIDS orphans in 38 families. In addition, food supplies received from the World Food Program and the government's Eritrean Relief and Refugee Commission are distributed each month to people infected and affected by HIV/AIDS.

The 12,000-member ECE is a national organization started in 1966. Its holistic mission throughout the country includes evangelism, medical care, education and social services. *(274 words)*

A report of the ECE Health Services and HIV/AIDS Project.

HIV Prevention among Sex Workers in the Islamic Republic of Mauritania

When the Lutheran World Federation (LWF) Department for World Service (DWS) program started HIV/AIDS work among female sex workers in Mauritania in 2002, the focus was put on awareness-raising activities. Through peer education, key information on HIV prevention was spread in the capital, Nouakchott, in the port of Nouadhibou, and in Rosso, a border town on the bank of the River Senegal, to women discreetly identified in public as "vulnerable."



LWF/DWS Mauritania promotes HIV/AIDS awareness through educational theater, drama, music and other public media. © LWF/DWS Mauritania

Consequently, 42 women volunteered to have an HIV test. Eleven of them tested positive, i.e., 26 percent of a non-representative sample. Looking after HIV-positive people was not among LWF/DWS Mauritania's initial objectives, but the country program decided to support these women until other partner organizations could take over.

The LWF has also taken part in distributing sizable quantities of condoms, considering this a priority, as there seems to be no systematic source of protection available for sexual relations. Further, because of the lack of information on modes of transmission, and ways to prevent infection, an important factor in the continuation of risky behavior is the difficulty the female sex workers have in gaining access to condoms, either via distribution or because of cost. Beneficiary women have responded positively to this initiative. They however note, there will always be a woman who accepts to engage in unprotected sex to earn a higher fee.

Such interventions remain sensitive to the illegal character of prostitution in the strongly Islamic society. But the efforts of the LWF, a pioneer in working with sex workers in the country, are approved and encouraged by Mauritania's National Executive Secretariat for the Struggle against AIDS, the national institution coordinating a national HIV/AIDS campaign.

The LWF is currently preparing to test a system of partnership with small units that provide care in the field of sexually transmitted infections, in order to develop services to assist sex workers. The units are located in the more densely populated districts of Nouakchott. A long-term objective of the LWF is to raise enough funds to develop income-generating activities for the women through micro-credit, and training in vocational skills. *(356 words)*

By Ms Amel Daddah, HIV/AIDS coordinator, LWF/DWS Mauritania.

Seeking a Constructive Response to HIV/AIDS – Personal Reflections

No one wants to be near you, touch you, talk to you or even offer any help. You are all alone, as if you were in solitary confinement. Friends and family turn their backs on you. And that's not all. Being HIV-positive you have to live with many symptoms and infections, such as diarrhea, fever, skin disorders, tuberculosis and pneumonia, just to mention a few.

Then comes the stigma and discrimination. Disclosing your status is like opening a can of worms, the news spreads like wildfire. When you walk down the street, people laugh and point at you. Often, you wish you were dead.

The majority of HIV-affected and infected members of our societies die of the loneliness and isolation associated with the HIV/AIDS pandemic. Sexual promiscuity has become the most common explanation for HIV infection and AIDS-related illnesses, but this does not answer all questions including that of a faithful spouse infected by his/her partner. What about an infant being born HIV-positive and the many other innocent cases?

People living with HIV/AIDS (PLWHA) encounter different experiences in the church, especially in an African context where it is taboo to openly talk about sexuality. I never disclosed my status after I saw how another PLWHA was treated. The congregation nearly split into two groups—the supportive and non-supportive. Some said she had to leave because she would bring a curse on the church. So we decided to leave.

The church's task in situations dealing with HIV/AIDS should be to equip congregational members, and the community at large, with knowledge that promotes a constructive response to HIV/AIDS. *(274 words)*

By Mr Dumisani Dlamini, originally from Swaziland, now living in Johannesburg, South Africa. He is a support group member of the Evangelical Lutheran Church in Southern Africa Diakonia AIDS Ministry.

Asia

Cambodia: Buddhist Monks Join Volunteers in HIV/AIDS Care

With a 2.6 percent HIV adult prevalence rate, down from 4 percent in the late 1990s, Cambodia is one of the countries most affected by HIV/AIDS in South East Asia. Unprotected sex with commercial sex workers remains the most common means of HIV transmission.

Concerted efforts to fight the pandemic comprise political commitment, a strong response from civil society, and a wide range of health ministry activities, including a law that obliges legal brothels to insist on condom use by all female sex workers. But there are critical gaps in HIV/AIDS knowledge; stigma and fear prevail at household and community levels.

Through the District AIDS Committees (DAC), whose members are drawn from across public offices and civil society, volunteer activities are coordinated through networks such as youth associations, village health workers, monks, traditional healers and home-based care teams. The Lutheran World Federation (LWF) Department for World Service (DWS) Cambodia country program provides capacity building to DAC in the context of its Integrated Rural Development through Empowerment Project.

A bi-monthly meeting of a local health committee. Participants who include a Buddhist monk, village HIV/AIDS volunteer, couple/youth peer educators and a traditional healer, discuss issues related to HIV/AIDS education and identify coping strategies for the next two-months' activities. © LWF/DWS Cambodia

In the fight against the pandemic, Buddhist monks have become an important volunteer group. In the context of Buddhist ceremonies such as Pchum Ben (ancestor's day) and Khmer New Year in the pagoda, the monks use the temples to provide meditation, counseling, spiritual support, herbal medicines and fund raising for people living with HIV/AIDS (PLWHA) and orphans. A pagoda's congregation comprises some 1,250 to 2,000 people drawn from five to eight villages.

Mr Sin Samay (left) and Mr Son Siveth (right). © LWF/DWS Cambodia

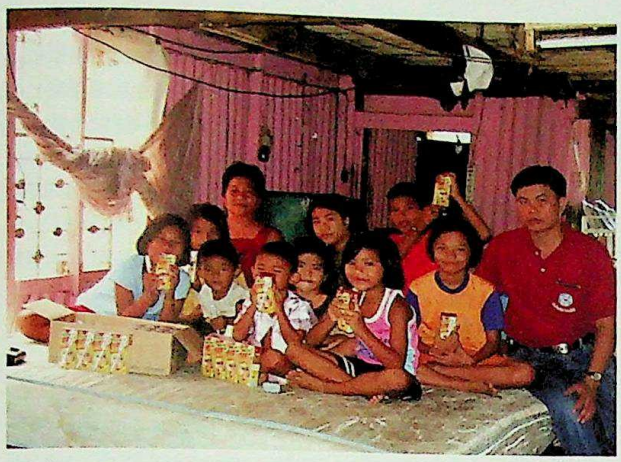
Cambodia's 95 percent Buddhist population has great respect for the monks. The spiritual leaders' involvement in HIV/AIDS care and support has impacted the social and behavioral practices of entire communities. It has led to a significant reduction of risky sexual behavior and decreased discrimination and stigmatization of PLWHA. A growing number of people are voluntarily seeking counseling and blood testing, and are involved in local fund raising for PLWHA support. The communities have begun to follow their spiritual leaders' example and have increased local resource mobilization to support HIV/AIDS activities. *(337 words)*

By Mr Sin Samay, health and HIV/AIDS coordinator, and Mr Son Siveth, planning and monitoring system officer with LWF/DWS Cambodia.

Thailand: "Move Her to Another School"

"Please move her to another school. We cannot take the risk that other children may become infected. Who will take responsibility then?" When staff of the AIDS support center of the Evangelical Lutheran Church in Thailand (ELCT) visited the elementary school where ten-year-old Lek goes to school, the headmaster told them to take her somewhere else. He even offered to pay them to move her.

She is an HIV-infected AIDS orphan, her parents having died almost four years ago. Lek and her older siblings live with their grandmother, who can hardly



Lek (second from left, back row) at home with her grandmother and other children in the community during a visit by the ELCT AIDS support center. Mr Suthiphat Akrananthaphong (extreme right) is a staff member of the Thai Lutheran church AIDS center. © ELCT Diakonia Department

provide for their basic requirements. Daily, the children go to the temple to ask for food.

Lek has been seeing a doctor for as long as she can remember. "It is nothing serious, you will soon get better," family members often tell her. She receives medication for AIDS opportunistic infections through a government program targeting poor people. Antiretroviral treatment could be possible if she would have the money to pay for it, or if she would be lucky enough to be enrolled in a special government program targeting only the most vulnerable for such treatment.

Although not abandoned by her family, Lek still has to bear the brunt of HIV/AIDS stigma. This cheerful young girl would like to freely play with her school mates, but the teachers are particularly concerned. This is a common situation that many HIV-infected children in Thailand have to face. Unfortunately, a considerable number also quit school because of rejection.

The ELCT AIDS support center endeavors to raise HIV/AIDS awareness through training and seminars. It also tries to build understanding among people living with HIV/AIDS, their relatives and communities by providing counsel, practical help and paying home visits.

An ELCT team regularly visits Lek and her family. She has an ELCT scholarship for education, and support for regular medical follow up. Equally important is ELCT's encouragement to the whole family, especially in the fight against discrimination in society. What most people living with HIV/AIDS fear most is not the infection or illnesses associated with the pandemic, but abandonment by those close to them. HIV/AIDS work is not just about dealing with the infected and affected, it must involve the whole community.

(372 words)

By Ms Leena Helle, ELCT Diakonia Department.

Ms Leena Helle, director, ELCT Diakonia Department. © Private

Europe

Life Is a Human Right! Says German Lobby Group

"Life Is a Human Right!" is the slogan used by Action against AIDS in its German and international campaigns for the last three years. The alliance brings together more than 90 church and civil society organizations that work together on HIV/AIDS related issues in cooperation with over 250 grassroots initiatives.

Action against AIDS was proposed in connection with the founding of the Geneva-based Ecumenical Advocacy Alliance (EAA) in December 2000. Based on agreed political goals for campaigns, members of the German network challenge the government to put more effort in combating HIV/AIDS. They appeal to the pharmaceutical industry to enable fair access to vital medication for people infected with HIV in developing countries.

Its current campaign "Pills not Profit," calls on leading producers of AIDS medication to contribute to improving treatment opportunities in poorer countries. Empty medicine packs bearing signatures and citizens' demands are intended to show pharmaceutical companies that they must still do a lot more. Over 30,000 signed medicine packs have been sent to various offices since the current campaign started in May 2005. The aim is to collect at least 100,000 signed packs by 15 July 2006, which will then be handed over to six designated companies in August 2006 in Berlin. It is a call to reduce medication costs, urgently develop treatment therapy for children, and forego patent rights in

Action against AIDS "Pills not Profit" campaign for children's medication. © Action against AIDS

poorer countries in order to support local production of essential medication.

Action against AIDS has a coordination office that liaises with co-sponsors and other supporters of its numerous advocacy and awareness-raising activities. With assistance from organizations at the federal and global level, the alliance does media work including newsletters, and campaigns. Its members lobby politicians in discussions and demonstrations.

Ms Katja Roll © Private

With no funding from governments or the business community, the alliance's survival is based on the commitment of groups and organizations, including several Lutheran churches and their related networks in Germany, that support the campaign "Life is a Human Right!"

(333 words)

By Ms Katja Roll, political coordinator, Action against AIDS.

Finnish Ambassador of Hope Sees "Nothing Shameful in Being Ill"

My name is Kari Tuhkanen, executive secretary of the Finnish Body Positive Association (FBPA). Founded in 1989, FBPA is a peer organization and the only association for people living with HIV/AIDS in Finland. We focus on improving the quality of life and care for HIV-positive persons and their loved ones, and preventing marginalization and discrimination.

I became infected with HIV in 1995. Due to difficulties with my treatment procedures, I had to resign from my dancing profession in 1997, and receive disability pension. After several years of voluntary work and self education in HIV, I am now back to paid work. Finland has less than 2,000 cases and an adult prevalence rate of about 0.1 percent.

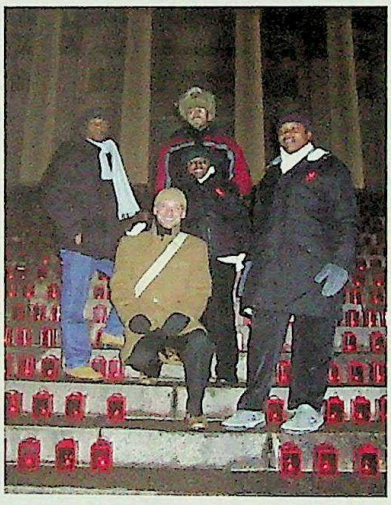
Since 2002, I have been an Ambassador of Hope in the Finnish-African network, Churches United in the Struggle against HIV/AIDS in Southern and Eastern Africa (*CUAHA). On World AIDS Day, 1 December 2004, my CUAHA African Ambassadors of Hope colleagues visited Finland. Our role is to give a face to HIV and spread the message of hope where it is most needed. We want to show it is possible to live positively with HIV.

For me, AIDS is a chronic illness that requires commitment and careful follow-up of treatment. But this is not yet possible worldwide. Only a fraction of the millions of HIV-infected persons have access to treatment, leaving thousands to die from AIDS-related illnesses daily.

Our individual behavior has an impact on our health and that of others. One of the most important aspects of responsible behavior to prevent further infection is HIV testing. One cannot rely on a symptomatic diagnosis as there might not be any visible symptoms, so testing remains the most reliable way.

Concerted efforts are needed from governments and religious and secular communities to prevent new infections and extend proper care to all those who need it.

I wish strength for all those living and struggling with HIV, and tolerance for each and everyone. AIDS is an illness. There is nothing shameful in being ill.



FBPA executive secretary, Mr Kari Tuhkanen (left, front row) and his African Ambassadors of Hope colleagues during the 2004 World AIDS Day commemorations in Finland © Private

(347 words)

*CUAHA's membership includes several member churches of the Lutheran World Federation and Department for World Service field programs, as well as Finnish partner organizations.

By Mr Kari Tuhkanen, FBPA executive secretary.

Russia: Protecting the Rights, Health of People Living with HIV/AIDS

Sverdlovsk region with its capital Ekaterinburg is one of the Russian regions with the highest number of HIV-infected persons. Eight years ago, when our non-governmental organization (NGO) "New Times" began its work, there were only eight registered HIV cases in the city. Now, there are more than 1,000.

Like many other cities in Russia, Ekaterinburg was not at all prepared for the quick spread of the infection. There was a lack of state prevention programs, of specialists trained in counseling, and of NGOs working in this field. There also was fear and hostility toward people living with HIV. They were often discriminated against, and medical care was low in quality.

Injecting drug users were the first group of people to be hit by HIV infection, which is why we began with harm reduction. Then we started training programs for teachers, psychologists, doctors, nurses and social workers. Unfortunately, HIV spread very quickly to other parts of the population. Most infections now originate from heterosexual transmission. Early on, only 20 percent of HIV-positive people were women. This number has now risen to 40 percent. So far, more than 1,000 children have been born to HIV-positive mothers.

Our organization's aim is to protect the rights and health of People Living with HIV/AIDS (PLWHA). We also collaborate with governmental organizations,

other NGOs and civil society including churches, in the fight against the pandemic and decreasing its impact.

With support from German Protestant aid agency, "Brot für die Welt," we started the project "Psychosocial Support Service for PLWHA," in 2004 , which benefits some 400 people.

The project provides the following services:

- Support center for women and children, with special care for HIV infected children with, a birth preparation program, and a psychosocial program for young families;
- Medical services for individual health care;
- Support for HIV-positive prisoners, including assistance to find a new job and generally adapt to life after their release;
- Social support service for HIV-positive injecting drug users;

"New Times" director, Dr Marina Khalidova (second from right) and colleagues carrying out HIV/AIDS work in Ekaterinburg. © "New Times"

- Psychological care and involvement in a self-help group, including a so-called "Social and Lonely Hearts Club."

(356 words)

By Dr Marina Khalidova, "New Times" director since 1998. Khalidova graduated from medical school in 1985 and worked in state medical institutions for 15 years.

Latin America and the Caribbean

Justice, Conversion and Integration: A Latin American Perspective

"Justice, Conversion and Integration," is how the Lutheran World Federation (LWF) member churches in the Latin America region translated "Compassion, Conversion, Care," LWF's 2002 call to its churches to respond to the HIV/AIDS pandemic worldwide.

In a closing statement of their regional consultation in Catia la Mar, Venezuela, 18–21 March 2003, Latin American LWF member churches said the word compassion needs to be translated as "justice." It had become evident from the testimonies of people living with HIV/AIDS (PLWHA) that they wanted neither pity nor compassion. Rather, they looked to the church for moral support as they struggled to defend their human rights and recover their wounded dignity.

Conversion, the churches agreed, must take the form of daily action that reveals the importance of the living church in a constant renewal process. The PLWHA stressed the need for a church that moves away from declaring repentance to others as a matter of law, to one that examines its theological concepts and pastoral practices[1]. Such conversion called for a closer connection between what is meant by HIV/AIDS and Lutheran identity—an identity profoundly evangelical, "because we understand that our mission is to ring out the Good News of God's and therefore the Church's unconditional acceptance of all God's children."

In Latin America, the word care should be rendered "integration," as the churches' actions cannot be compartmentalized or taken in isolation, but rather, must be centered on the individual, so as to arrive at more all-embracing responses[2]. The churches insisted also on the integration PLWHA.

"After some 20 years of this pandemic, we cannot ask those living with HIV/AIDS and society at large to be patient and grant us more time. Time is up! The Church must respond now," the regional consultation affirmed. *(298 words)*

By Rev. Martin Junge, LWF Area Secretary for Latin America and the Caribbean region.

[1] "You, then, that teach others, will you not teach yourself? While you preach against stealing, do you steal?" (Romans 2:21)

[2] "The Spirit of the Lord is upon me, because he has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free, to proclaim the year of the Lord's favor." (Luke 4: 18-19)

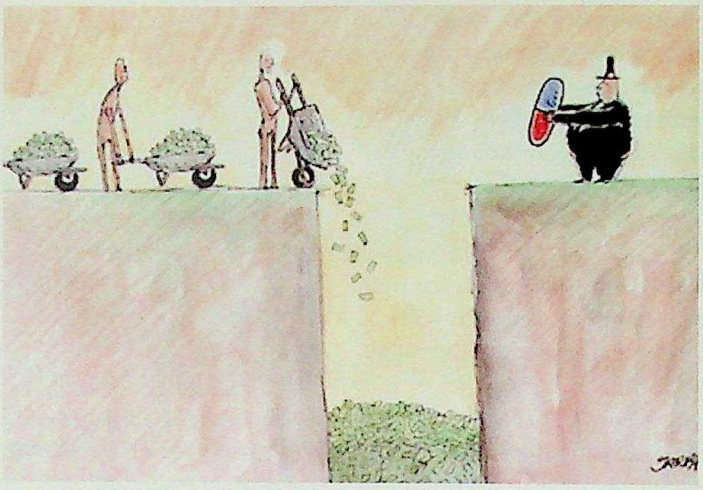
Social Movements Play Vital Role in Brazil's Fight against AIDS

The fight against AIDS is a fight against social prejudices and stigma. It is also a fight for equality, access to medicine, human rights and, above all, acknowledgement that good health is a fundamental right of every citizen.

Brazil was the first developing country to provide free, universal access to antiretroviral treatment (ARV) on the public health service. This political achievement grew out of active public participation

in government affairs, both non-governmental and private.

As a result of policies developed by social movements, prevention methods and medical aid have increased since the 1990s. This has brought an improvement in the quality of life, as well as a drop in the mortality rate and number of opportunistic infections of people living with HIV/AIDS and/or those being treated for the virus.



This cartoon by Jarbas Domingos won the Treatment Category award during the 2004 First Humor International Festival on Sexually Transmitted Diseases and HIV/AIDS in Brazil. It depicts developing countries' dependency on Northern pharmaceutical companies for AIDS drugs. The festival was organized by Brazil's Ministry of Health and the Graphic Arts Memorial Institute. © Jarbas Domingo

These policies target the most vulnerable sectors of society. A decline in the number of new infections has been possible through education and behavioral intervention programs, as well as free early diagnosis and preventive measures.

Mr Luis Stephanou, FLD projects' adviser. © FLD/Paulino Menezes

In Brazil, the epidemic has been slowing down since 1999. From 1980 to December 2003, a total of 310,310 AIDS cases were diagnosed in the country, 84 percent of which were in the south and southeast. Cases of the virus infection rose most among over 35-year-olds and heterosexual women.

Among other factors, the slowdown is due to active participation in the development of public policies, prevention and support initiatives. Many churches also have taken part in the struggle against HIV/AIDS. They have sought to overcome prejudice, develop social inclusion, and provide support and prevention methods. Spiritual support has also played a very important role for people living with HIV/AIDS.

Initiatives to combat AIDS in Brazil today set an example for the rest of the world. But representatives of civil society should not see these positive results as an excuse for complacency.

A major problem surrounding HIV infection is the countless number of individuals who are unaware of their condition. High-quality treatments are simply not enough as there are many faults in the public health system that need to be rooted out to improve the quality of life of each and every citizen.

(366 words)

Ms Carmen Lúcia Paz, BCSP executive secretary. © FLD/Paulino Menezes

By Mr Luis Stephanou, projects' adviser, Lutheran Diakonia Foundation (FLD) of the Evangelical Church of the Lutheran Confession in Brazil (IECLB), and Ms Carmen Lúcia Paz, executive secretary, Brazilian Center for the Study of Prostitution (BCSP), Porto Alegre – Rio Grande do Sul. The FLD supports HIV education and prevention initiatives of civil society groups like the BCSP.

Colombia: Friends Share Their Talents and Gifts

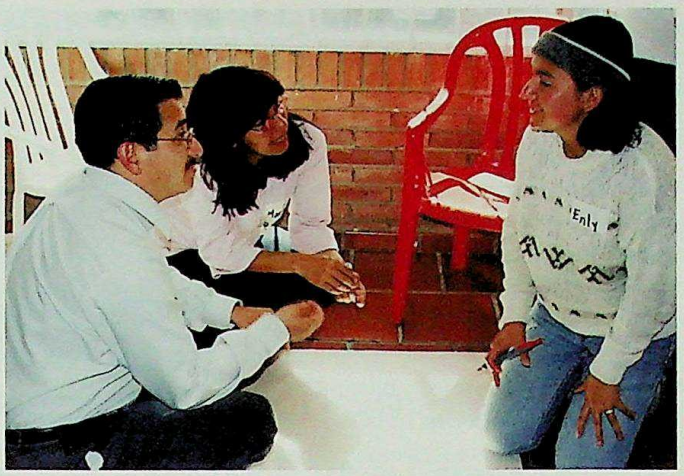
Since the launch of the Lutheran World Federation (LWF) HIV/AIDS action plan "Compassion, Conversion, Care: Responding as Churches to the HIV/AIDS Pandemic," the Evangelical Lutheran Church of Colombia (IELCO) has started several local initiatives.

In March 2003, IELCO's communication department inaugurated the *Rompiendo el Silencio* (Breaking the Silence) bulletin, to provide more information about HIV/AIDS. More recently, the so-called Friends of ASIVIDA (people living with HIV/AIDS-PLWHA) support and referral center has been started to promote information sharing, HIV prevention and accompaniment for PLWHA. This group comprising homemakers, lawyers, social communicators, teachers, pastors and psychologists, is committed to serving God and community with the different individual skills and gifts.

The Friends of ASIVIDA group recognizes the contribution and experience of civil society in HIV/AIDS work in Colombia, and works closely with non-governmental organizations especially in training programs. Its HIV-prevention approach promotes a vision that affirms love (1 Cor 13:13) and abundant life (Jn 10;

10b). Activities are tailored in a participatory and constructive manner, particularly emphasizing young people's contribution through role play, theater and drama, story telling and exercising their imagination. One of the basic principles is that the targeted person(s)/groups should reflect critically on any exercise they are involved in (awareness building); make informed decisions (conceptualization) and finally apply the results to practical situations (contextualization).

The group considers as particularly significant the January 2004 IELCO assembly response to a presentation by their pastoral team: "We have been challenged to be a living presence through ASIVIDA's pastoral work of serving persons living with HIV/AIDS and those who live with them, promoting prevention as a fundamental principle starting in the communities where the church is present."



ASIVIDA group members (from left to right) Rev. Eduardo Martínez, Ms Martha Vera and Ms Enly Puentes, during a capacity building workshop. © IELCO

As followers of Jesus Christ, the IELCO members are called to respond, thereby breaking the silence about the HIV/AIDS pandemic and its implications.

UNAIDS surveys put HIV prevalence in Colombia at around 0.7 percent, with some 180,000 PLWHA in a population of 42 million people. Sex between men is the most common mode of HIV transmission.

(337 words)

By Ms Ana Isabel Mendivelso G., IELCO psychologist; and Ms Rosa Elena Cortés T., director, communication department.

North America

HIV/AIDS Ministry in the Evangelical Lutheran Church in America

At the end of 2003, an estimated 1,039,000 to 1,185,000 people in the United States of America (USA) were living with HIV/AIDS. In 2003, there were 32,048 new cases of HIV/AIDS reported by the 33 areas (32 states and the US Virgin Islands) that have long-term, confidential name-based HIV reporting. When all 50 states are considered, the Center for Disease Control estimates that approximately 40,000 people become infected with HIV each year.

Ms Josselyn Bennett, director, Education and Program Resources, ELCA Division for Church in Society. © Private

Despite declines in new AIDS cases, the rate of new HIV infections remains high. The spread of HIV impacts people across all ages, races, sexual orientations, and socio-economic levels. The Evangelical Lutheran Church in America (ELCA) remains committed to supporting prevention education and care for those infected and affected by AIDS. The ELCA domestic hunger grants' program funds programs that support people living with HIV/AIDS (PLWHA) nationwide. Two examples are included below.

The "Open Arms of Minnesota" provides 95,000 home-delivered meals each year to PLWHA. It sustains a volunteer base of over 900 people who contribute more than 15,000 hours of assistance. Open Arms acts as a safety net for PLWHA in the Twin Cities, helping people get the nutrition needed. Eating regular, well-balanced meals is important to everyone's health, but ample and nutritious food is particularly critical for PLWHA.

The "Manchester Area Network on AIDS" (MANA) in Connecticut responds to the needs of the Greater Manchester Area community members infected/affected with HIV/AIDS through a collaboration of services, resources, and education in a caring and supportive environment. MANA provides case management for 121 individuals and their families living with HIV/AIDS. Additional services include weekly nutritional lunches, a food pantry, support groups, message therapy, acupuncture, AID-A-PET, and more.

Maintaining focus on HIV/AIDS remains a major challenge in the USA. Continuous awareness raising is imperative, particularly in view of emerging myths that a cure exists as so many people are living with the disease. Equally crucial is accessing medication for those becoming infected because they are women and people of color who do not have health coverage.

(346 words)

By Ms Josselyn Bennett, Director for Education and Program Resources in the ELCA Division for Church in Society.

Positive Church – A Youth Perspective

Over 50 percent of the 5 million people worldwide infected each year by HIV are youth, majority of them, young women. Unemployment, poverty, gender inequality, war and violence against women, lack of education, and stigma and discrimination, increase young people's vulnerability to HIV infection. But these young adults also challenge the church to utilize their great potential for peer group activism.

The editorial team of this special LWI invited youth from the regions to share their perspectives.

Colombia: Hiding Our Indifference under the Cloak of HIV Prevention

... and there was a leper who came to him and knelt before him, saying, "Lord, if you choose, you can make me clean." He stretched out his hand and touched him, saying, "I do choose. Be made clean!" Immediately his leprosy was cleansed. (Mt 8,2-3; NRSV).

A youth HIV/AIDS awareness raising workshop among displaced people living in the La Nohora settlement, Villavicencio, central Colombia. © IELCO

In our community, it is almost comfortable to talk about HIV prevention as this has become nearly the only way of dealing with the subject. But is our influence as a Lutheran church really having an impact on this major problem in Colombia? Or, is prevention the shield under which we hide our indifference?

It has been complicated for the Colombian church to tackle the issue, because this would imply not only questioning its attitudes but also formulating arguments to deal with the illness, the persons affected and their stigmatization.

HIV/AIDS is becoming more acute because of the civil strife in our country, nearly 40 years of internal conflict, which makes us a fragile and vulnerable nation when faced with the pandemic.

Ms Francia Hernández Vera, IELCO. © Private

Perhaps our church has not grasped the significance of its role in the fight against HIV/AIDS, nor the importance of working toward prevention that is based on knowledge, acceptance and love. Although we cannot stop an infection that has already happened, we can still combat low self-esteem, violence and the lack of love for oneself. The church can still teach about love and empowerment, self-respect and respect for others, acceptance rather than rejection, recognition rather than judgement, and, above all, it can stretch out its hand and affirm that "Yes, it does choose."

Prevention is unthinkable when rejection and denial prevail. The church is called to be inclusive and have a yearning to heal the world rather than preserve an institution. The road is long but we have begun to travel along it. *(312 words)*

By 24 year-old Francia Hernández Vera, a youth member of the Evangelical Lutheran Church of Colombia.

Estonia: Do We Dare Seek Them Out in the Streets?

In early 2005, Estonia had over 4,400 HIV-infected people among its 1.4 million inhabitants. About 70 percent of them were under the age of 25 years. The majority of HIV-positive people are still injecting drug users, and HIV transmission through sex is growing.

The Estonian Evangelical Lutheran Church, the largest Christian denomination in the country, does not currently have an HIV/AIDS program. Such a program is urgently needed as we live next to the HIV-positive people who feel abandoned and hopeless. These people yearn most for the message of hope and love! But they are also less likely to be found in church. They are young school drop-outs, abandoned by their families and separated from the rest society and whatever assistance it may offer. They are also people we know, but who are afraid to disclose the truth about their situation.

The only way to help them is to go where they are. Not to expect them to come to us and seek help. They are mainly youngsters, and who else could understand them better than we, young people? In Estonia, there are several safe injection sites where former injecting drug users work as volunteers. Going to the streets together

with ex-drug users would be one way to reach out to these people. The question is, 'Do we dare to do that?'

People need us everywhere. Our friends, class mates, neighbors... they may not know the consequences of casual sexual relationships, they may even think that "love = sex." They consider alcohol and drugs as effective "feel-good" tools. Or they might be infected and need someone to listen to and for comfort. We have to keep our eyes open to notice those who are closest to us.

Ms Eva-Liisa Luhamets, Estonian Evangelical Lutheran Church. © Private

We young people can also show the world how to live happier and healthier lives. We can break the perception that it is normal to have several sex partners. We can change the idea that using drugs makes one happy. We can show others how to save themselves from HIV, unwanted pregnancy, heartbreaks, broken homes and so on. *(357 words)*

By Ms Eva-Liisa Luhamets, 24, Estonian Evangelical Lutheran Church. She is currently a youth intern in the LWF Department for Mission and Development.

Youth in India Raise HIV/AIDS Awareness among Tribal Communities

"Jesus Cares: Do you ?" This HIV/AIDS slogan on the wall at the entrance to the Jeypore Evangelical Lutheran Church (JELC) bishop's office reminds us that Jesus Christ came to the world not to destroy and to kill, but to care and give fullness of life to all human beings (John 10:10). It is a thought-provoking invitation to the youth on individual responsibility concerning the spread of HIV and caring for people living with HIV/AIDS in society.

"Health Care – HIV/AIDS Concern" is one of JELC's seven mission programs. The JELC youth are involved in conducting workshops at primary and secondary schools and Sunday schools, and organizing public rallies focusing on HIV prevention.

JELC youth group member, Ms Manisha Mahanandia. © Private

JELC is in the predominantly tribal northeastern state of Orissa, considered to be one of the least developed regions in India, yet endowed with mineral resources, like coal and bauxite. There are many industries in the major cities.

A JELC youth group stages an HIV/AIDS awareness drama during the 2004 World AIDS celebrations in Koraput district. © JELC

Local government sources indicate less than 50 HIV sero-positive cases in the predominantly tribal Koraput district, but unofficial estimates cite higher figures in the small and large-scale industrial center, and hub of a highway network. Many young people especially men migrate there from rural areas seeking jobs, and readily fall prey to risks associated with commercial sex, including the spread of HIV and other sexually-transmitted infections (STIs).

In the JELC's operational areas, there are increasing reports of HIV/AIDS cases. Some of the main reasons for the spread of HIV include low literacy, migration, poverty and cultural traditions of the tribal people. Young people remain a high-risk group as they are more likely to move to the city in search of employment.

"Due to lack of adequate awareness, education, migration and cultural background there is every possibility of HIV/AIDS increase among married couples, especially the young ones. The church cannot be silent about this issue, that is why it is an important part of our vision," JELC Bishop Anam Chandra Khosla says.

Mr Livingstone Khosla, president of the JELC Central Youth Committee on HIV/AIDS, affirms the church's commitment to sustainable programs that sensitize people about the pandemic. There is an equally urgent need to specifically target child laborers and women, both low participants in any community program due to illiteracy and cultural inhibitions. *(381 words)*

By Ms Manisha Mahanandia, a JELC youth group member. Mahanandia, 20, is an activist in children's rights in Koraput district.

I Know Better, Can Offer Compassion and Care

As I grew up, AIDS was just becoming known. To me it was a dangerous disease that only affected commercial sex workers or those who were of loose morals. But as time went by, the reality that HIV/AIDS affected all people started dawning on me. Some, especially women who were role models in my neighborhood succumbed

to AIDS-related illnesses. Girls my age, with little information about HIV transmission, became sexually involved with older men, two of them died of AIDS.

As I acquired more knowledge about HIV/AIDS and saw more people die, I came to appreciate that we are all at risk of becoming infected with HIV. This strengthens me to approach those who are HIV-positive, and offer help where I can. As a youth leader in my church, I regularly join our group of people living with HIV/AIDS (PLWHA) where we listen to those infected and affected, and offer support and encouragement.

Ms Christine Mangale, Kenya Evangelical Lutheran Church. © LWF/D. – M. Grötzsch

Looking back then and now, I know my contact with PLWHA, AIDS orphans and other affected members in the community, makes me ready to offer compassion and care to the hurting. A good educational background enables me to access information, and make informed decisions and choices in life. But many girls in Africa, a continent where cultural practices inhibit women more than men, are not as lucky.

Churches have a major role in providing information about HIV/AIDS, fighting stigma and discrimination, and raising hope among the infected and affected.

Kenya, with a population of 33.8 million people, is estimated to have over 1.2 million PLWHA, and an HIV adult prevalence rate of six percent. *(276 words)*

By Ms Christine Mangale, 26, youth leader, Kenya Evangelical Lutheran Church.

Perhaps God Knew I Was Supposed to Be at This New Church

It is often said that life presents each and every one of us with inevitable challenges. Like any little girl growing up, I dreamed about my future—getting married, being successful and loved, and walking a fairly smooth path in life.

But in 1997, a series of misfortunes occurred. First I was raped, then I became pregnant, and then I was diagnosed as being HIV-infected. I had, of course, neither rehearsed for this type of life experience nor was I prepared to face it. Alone in my little world, and weighed down by the heavy burden of falling ill with HIV infection, I sometimes contemplated suicide.

Then, thanks to what I believe was divine intervention, I decided to go to my regular church, where I disclosed my sero-positive status to the bishop. "You will die in three months' time," he told me. His verdict of death was not all I got. Members of the congregation came to know about it, and I became subjected to stigma and discrimination from my own church community. It was not the right place for me; I had to move away.

I chose a congregation of another denomination. By then I was very sick, but perhaps God knew I was supposed to be at this new church. This congregation had an HIV/AIDS support group and everyone welcomed me with open arms. I began to see a change in my health. *(247 words)*

By 31-year-old Menge Matie, an unemployed single mother, assisted by the Evangelical Lutheran Church in Southern Africa.

Youth Have the Vitality to Advocate Behavioral Change

The HIV/AIDS pandemic has evoked responses across all ages challenging them to reflect on unique resources to combat this pandemic.

The youth, the most affected group, especially in Africa and Zimbabwe, can be agents of change because of their vitality. They can also intensify advocacy on gender equity and on behavioral change. But they need a moral education that is taught fearlessly and without shame. A number of young people who are sexually active do so without accurate information and the necessary skills to protect themselves from sexually transmitted infections (STIs) and HIV/AIDS.

Ms Sithozile Bokani Tshuma, LUCSA youth secretary. © Private

In confronting the HIV/AIDS challenge, the church needs to acknowledge young people as articulate and compelling advocates for programs and policies that offer visible and strong support for effective prevention methods. Such actions should be taken with sensitivity to the different customs and traditions, some of which are harmful, and thus increase the spread of HIV.

Youth believe in affirming their capabilities, which can be harnessed positively into HIV/AIDS education. With the HIV/AIDS pandemic, young adults are also challenged to be part of the struggle by advocating for behavioral change among their peers. The church should encourage the youth to join in efforts to eradicate the stigma, discrimination and denial, and silence that are still strongly associated with HIV and AIDS. *(222 words)*

By Ms Sithozile Bokani Tshuma, resource person to the Evangelical Lutheran Church in Zimbabwe HIV/AIDS program. Tshuma, 25, is also youth secretary, Lutheran Communion in Southern Africa (LUCSA).

Women's Vulnerability to HIV/AIDS – A Gender Perspective

Whether young girls or adults, women are the group most affected by HIV/AIDS. They are also the most vulnerable as victims of harmful cultural and traditional practices; as easy targets for rape during war; and as commercial sex workers. As homemakers and care providers, they also bear the heavy responsibility of sustaining communities even when they themselves have to deal with HIV/AIDS related illnesses.

The LWI editorial team invited reflections on the different challenges facing women with regard to the HIV/AIDS pandemic.

Why Are We Unable to Contain a Mammoth Pandemic Like HIV/AIDS?

Like any pandemic, HIV/AIDS is permeating in new and different ways, not only to new geographical locations but also assuming a feminine face. Fifty-seven percent of infected cases now involve females, of which 75 percent are young women and girls. How have they become vulnerable?

Ms Priscilla Singh, LWF/DMD Secretary for Women in Church and Society
© LWF/H. Putsman

Many causes can be cited, such as women's low social status in a patriarchal society, harmful cultural practices, the ignorance and myths surrounding sexuality, and cross-generational sexual relationships such as "sugar daddies" who immorally prey on vulnerable young children and girls in increasingly impoverished sections of society; the list goes on. Churches have often responded with words of consolation, through education, care giving, prayer, and development service. Despite the worthiness and necessity of such efforts, these amount only to covering a festering wound with plaster.

If feminization of HIV/AIDS is to be contained, instigation of a gender analysis of our cultures, practices, theology, economy and societal organization is needed, which could include these so-called six "Rs":

Revision of theological policies and practices that put women down, treating them as objects to be controlled, dominated and violated;

Rethinking cultural practices such as widows' inheritance, ritual cleansing after widowhood, polygamy, and so on;

Removal of ignorance and fear;

Rendering of support to women about their rights over their bodies and lives;

Reduction of ostracization; and

Reform in thinking so as not to juxtapose life with personal morality. Both life **and** morality are needed, but not at the expense of each other.

Jesus came to offer life, abundant life! Let's hear the stories of women, and respond with courage and conviction. *(274 words)*

By Ms Priscilla Singh, Secretary for Women in Church and Society, LWF Department for Mission and Development.

LWF-Supported Center in Bangladesh Welcomes Commercial Sex Workers

Twenty-four year-old Rabeya Khatun regularly visits the Saidpur drop-in center, operated by the Rangpur Dinajpur Rural Service (RDRS), the Bangladeshi associate program of the Lutheran World Federation (LWF) Department for World Service.

Married at 17 years of age, Khatun's husband started assaulting her physically after two years, because she could not bear him children. An apparently remorseful husband after a family quarrel took his wife out to the movies, and a visit to new friends in Saidpur. A long wait for her husband's return from "buying cigarettes" the same evening turned into a night of gang rape by the friends. Her husband had sold her, Rabeya learned later. She escaped after two months, and found her way to the Saidpur railway station where she met women who engage in commercial sex for a living.

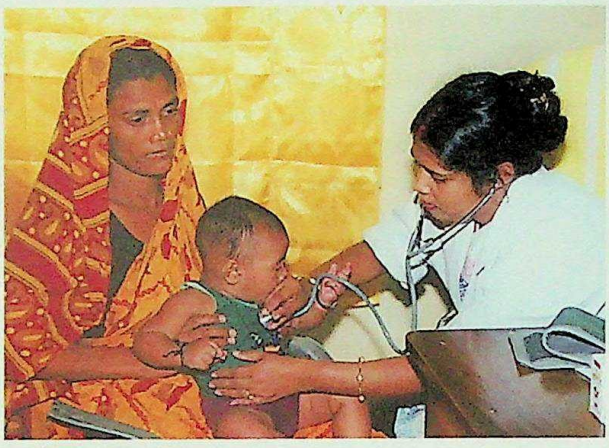
The RDRS drop-in center for so-called floating sex workers in the busy Saidpur municipality, Nilphamari District, targets commercial sex workers in the town's railway station, bus terminals and other places. These women report an average 15 to 20 clients per week,

who include night guards, day laborers, hotel traders, school boys, members of the police force and army personnel.

At the center, the women receive information on sexually transmitted infections (STIs) and HIV prevention and treatment. Interested persons may enroll in alternative income-generating skills, and non-formal education is provided for their children. The project also targets the commercial sex workers' clients through various educational campaigns.

The 386 commercial sex workers currently enrolled at the center have access to a washing facility, cooking place and rest and recreation space. There is a daily health education session, a twice-a-week visit by a lady doctor, and regular condom sale. The aim is to increase safer sex practices among commercial sex workers in the town, thereby reducing and preventing the spread of STIs and HIV.

Ms Rabeya Khatun (right) during a literacy class at the RDRS drop-in center in Saidpur. © RDRS



An RDRS doctor examines a commercial sex worker's baby at the LWF-supported center. © RDRS

Bangladesh is still considered a low HIV/AIDS prevalent country with some 13,000 HIV-positive persons in a population of over 144 million people. The adult HIV prevalence is less than 0.01 percent, but vulnerability remains high in a population with low HIV/AIDS awareness.

National HIV surveillance indicates that the rate of HIV infection among street-based commercial sex workers in central Bangladesh is significantly high compared with other parts of South Asia. HIV infection among injecting drug users, another high risk group, is already four percent. *(397 words)*

By Dr Salima Rahman, community health director, RDRS Bangladesh.

Belarus: HIV/AIDS Education Remains Crucial

My first encounter with HIV/AIDS was at the age of 18 when I experienced a range of fears about it, such as becoming infected, taking an HIV test, and so on. I was mostly afraid because I was young, and had little knowledge. My career background in social sciences and information about HIV prevention raised my own level of awareness, helping me to overcome fear and stereotypical attitudes.

By 1997, HIV-infection rate in Belarus was increasing. But at the time, AIDS was considered to be a disease of "potentially at risk" groups—homosexual men, commercial sex workers and injecting drug users. The 15 to 29 age group had the highest infection rate. There were no educational programs on HIV prevention in secondary schools. Even obligatory courses for senior pupils about a healthy lifestyle and reproductive health were somewhat scanty.

Ms Nastassia Ladzik (standing) leads an HIV/AIDS education workshop in Belarus. © World YWCA

In 2003, I started developing the project, "Counteracting the Spread of HIV/AIDS Among Young People in Belarus," with the aim to study the level of knowledge among Belarusian youth on HIV transmission and impact on their lives. Focus was on infection through injecting drug use, sexually transmitted

infections, the epidemic's status, and available HIV-prevention measures. Also considered were personal experiences of people living with HIV/AIDS and the subject's coverage in Belarusian media.

In our first operational year, we provided 20 training sessions on responsible sexual behavior for 400 pupils and students from various professional and higher educational establishments in the country, targeting the 14–29 age group. A training session was also conducted for children in an orphanage, where the average age group is 13–16 years. New ideas lately include translating and distributing the World Young Women's Christian Association (YWCA) documentary, "Women Are ..." into Russian. Networking is important in our work, and we share and exchange experiences with other like-minded non-governmental organizations.

Ms Nastassia Ladzik © World YWCA

From my personal experience as project coordinator and trainer, peer to peer education on HIV/AIDS remains crucial, especially for girls, who are the most affected and the least empowered.

(337 words)

*The World YWCA has been working to mobilize women in the fight against HIV/AIDS for several years. The global women's body collaborates with the LWF in joint ecumenical HIV/AIDS initiatives.

By Ms Nastassia Ladzik, project coordinator, "Counteracting the Spread of HIV/AIDS Among Young People in Belarus." Ladzik, 24, specializes in social work.

Reaching Out to Victims of Sexual Violence in the Democratic Republic of Congo

Therese Vay* was returning home from fetching water when a soldier raped her.

This was not an isolated case in Bakilo village near Kisangani in north eastern Democratic Republic of Congo (DRC). The civil war for the control of power and resources in the DRC, is centered mainly in the east. Soldiers frequently harass the local population and many residents have fled their homes.

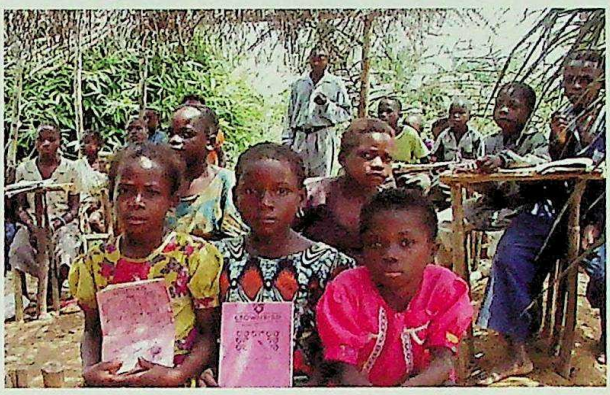
But the Vay family was determined to stay, in spite of the constant gossip and mockery that often follow rape victims here.

Today, they embrace two-year-old Denise*, the child conceived from Therese's rape. But like many others in the region, this family lives with the quiet fear that Therese and Denise could be infected with HIV, a genuine fear in a country with an adult prevalence rate of 4.2 percent, and an estimated one million people living with HIV/AIDS.

Addressing this fear constructively calls for HIV testing and counseling. The prerequisite medical procedures alone cost USD 5 and are only available in Kisangani town. For residents of a country whose annual per capita income is around USD 650, the testing and traveling costs alone are unaffordable. Counseling, however, is virtually unavailable.

Through its Department for World Service (DWS) program in Rwanda and DRC, the Lutheran World Federation (LWF) along with its partner churches, seeks to assist and support victims of sexual violence and their families.

The LWF collaborates closely with church communities and women groups to raise awareness about HIV/AIDS and violence against women, and provide trauma counseling, with the aim to encourage people to seek testing and counseling.



Activities of the LWF/DWS Rwanda-DRC program in Kisangani district include the construction or rehabilitation of classrooms. Pupils of Batende Primary School, some 72 kilometers from Kisangani town. © Thomas van Kampen/LWF/DWS Rwanda-DRC

There are positive effects. In areas where the LWF is carrying out sensitization activities, people are more informed about HIV/AIDS and how to protect themselves against HIV infection. Women rape victims now voluntarily approach the LWF-supported women groups for advice and trauma counseling.

The Vay family situation is not unique in eastern DRC where rape has been used as a weapon during almost four years of civil war.

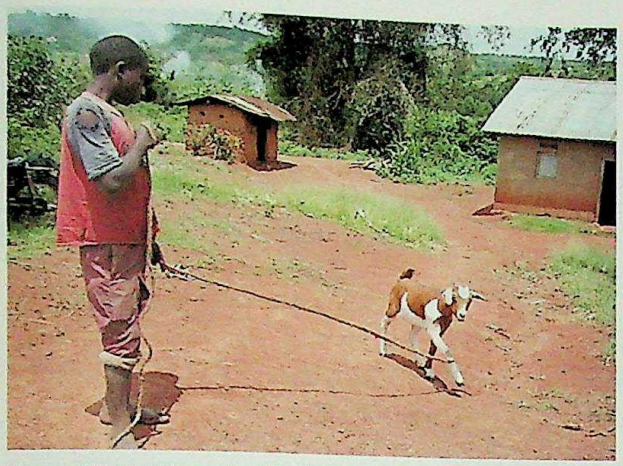
LWF/DWS Rwanda-DRC hopes to expand its work among victims of sexual violence and those infected with HIV to include food aid for the most vulnerable among people living with HIV/AIDS.

(374 words)

*Family names have been changed for confidentiality.

By Mr Emmanuel Murangira, LWF/DWS Rwanda-DRC program coordinator.

Mr Emmanuel Murangira, LWF/DWS Rwanda-DRC program coordinator. © Private



A boy and his goat donated by LWF/DWS Uganda program in Rakai
© LWF/DWS Uganda

amenities, including a goat, a roof for their house constructed with help from the women's group, a water tank, mattresses and kitchen utensils. Simon described the biggest challenge of his life as being the loneliness that this family of three deals with on a daily basis.

Their mother sometimes stops in to see them, but never stays for long. Simon's eyes brighten as he tells his visitors he has come up with his share of the money to purchase a bicycle, and would they as promised contribute theirs? This would reduce dramatically the amount of time it took him to take produce to sell at the market. Reassured, he beamed at his brother and sister knowing he could take care of them a little better, for a while longer. The LWF continues to visit Simon and his siblings, as they are but one of the many families affected in this way by HIV/AIDS.

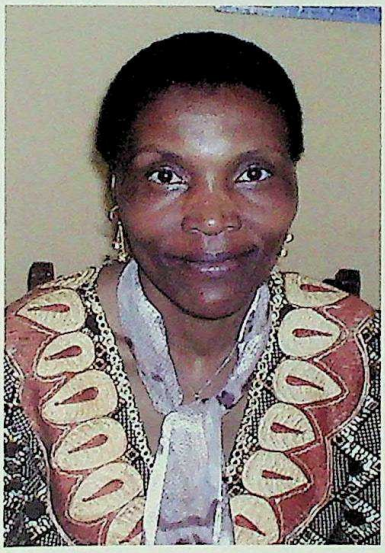
Although Uganda's HIV prevalence rate dropped from over 30 percent in the mid-1990s to approximately 6 percent over the past few years, caring for over 800,000 people living with HIV/AIDS (PLWHA) and an estimated 1.5 million AIDS orphans remains a major challenge. The LWF/DWS community-based HIV/AIDS project in Rakai provides PLWHA and their families with awareness education, counseling services and support toward basic needs. *(361 words)*

By Ms Sarah Larson, LWF/DWS Uganda.

HIV/AIDS in the Context of Levirate Marriage

In traditional societies, a form of levirate marriage used to take place in most communities. This is a practice where a widow was remarried to a brother or relative of the husband, the practice is now commonly known as wife inheritance.

The aim of levirate marriage was two fold. Firstly, it ensured the continuation of the deceased family in the case of young widows. The person who remarried the widow would bear children with her for the deceased man. Secondly, the practice gave the widow access to inherit property. Since widows were not entitled to inherit property in their own right, being re-married was a way to access land. The person who inherited the widow was expected to take care of her and her children.



Dr Esther Mombo, academic dean, St Paul's United Theological College, Limuru, Kenya
© Private

Basic survival for oneself and children compelled most widows to re-marry within the husband's family. In modern times though, levirate marriage still persists as wife inheritance. In the era of HIV/AIDS this practice is detrimental not only to women but to society in general. For example, the story of Salome.

After her husband's death, Salome, 24, was inherited by an already married relative of her deceased husband. She soon fell ill and died, the second husband got sick and died, leaving his two surviving wives infected with HIV. These families have left behind several orphans under the care of community members.

In the HIV/AIDS era, where the age group 15–49 years is the most affected in Africa, women and especially widows are particularly vulnerable. They are coerced into customary practices of levirate marriage, and/or ritual cleansing (which usually involves unprotected sex), running a clear risk of contracting and spreading HIV. AIDS deaths in such areas result in many more women becoming widows at a younger age than would otherwise be the case. The women and their children (who end up being AIDS orphans) face not only social stigma against people infected and affected by HIV/AIDS, but also economic and religious dilemma that pose a challenge to the church in society.

It is therefore important for the church to face up to living the gospel in light of old traditions that have outlived their time especially with the challenges posed by HIV/AIDS.

(374 words)

By Dr Esther Mombo, academic dean, St Paul's United Theological College, Limuru, Kenya. She introduced a course on HIV/AIDS at the World Council of Churches (WCC)-supported college, before the WCC created the HIV/AIDS curriculum that is being introduced to seminaries throughout Sub-Saharan Africa.

HIV/AIDS and Clergy – Doing What We Preach

If the war against HIV/AIDS is to be effectively won, clergy must be at the forefront in breaking the silenc whether as people living with HIV/AIDS or advocating for the rights of people living with HIV/AIDS. The storie in this section provide perspectives on how clergy deal with HIV/AIDS as care providers, as PLWHA or globa activists.

Former Norwegian Bishop Urges Churches to Take HIV/AIDS Out of 'Shame Category'

"Religion plays an important role in the struggle against HIV and AIDS," says Rev. Dr Gunnar J. Stålsett, former General Secretary of the Lutheran World Federation (LWF) and Co-chairperson of the Leadership Program Committee for the 16th International AIDS Conference to be held in Toronto, Canada in August 2006. He is convinced that not only Christians but people of all faiths are called to join in the global fight against the pandemic.

Rev. Dr Gunnar Stålsett.
© Church of Norway, Oslo Diocese

For church leaders around the world, the HIV pandemic poses many challenges. Stålsett acknowledges that churches are very good at care—"one should not underestimate that"—but he also demands that churches be more forthcoming in prevention and support the "ABC" strategy, especially the "C," the use of condoms. "This is not the sole strategy in the struggle against HIV/AIDS but an important one," the retired bishop of the Oslo Diocese, Church of Norway emphasizes.

He says religious communities are in a unique position because they are institutionally present almost everywhere. "It is their responsibility to use this presence educationally, spiritually, and for care, because they have to mobilize this potential." Stålsett sees the need for more affirmation on the local level, because the struggle against the pandemic cannot be won by governments and organizations alone. "We need a strategy of cooperation and coordination, and a common vision of overcoming the pandemic," he explains.

He also addresses the poverty dimen sion of HIV/AIDS, especially for people in the South. The 2005 G8 summit was focusing on poverty, but was not explici on HIV, he remarks. At the 16th Interna tional AIDS Conference under the theme "Time to Deliver," Stålsett hopes to see more explicit and committed action "The richer world needs to be called to share what they have with the poo Many promises were made, but the deliv ery is slow. Our approach is not to shame those bodies that have promised and no delivered. We have a rather productive approach and want to ask: 'What would it take to do what was promised?'"

Stålsett challenges church leaders to use their position in a positive way to reduce stigma and dis crimination in a very simple way: by engaging and speaking about it. "They must show in practice that people living with HIV/AIDS are normal people just like you and I. They are members of religious commu nities. The pandemic is part of everyday life in many countries where 20 to 25 percent of the population is affected. We need to take the HIV/AIDS issue out of the shame and stigma category and acknowledge 'That's life. The Church has AIDS.'" *(440 words*

** Lutheran World Information (LWI) interviewed Rev. Dr Gunnar Stålsett. He was LWF general secretary 1985–1994.*

South Africa: Responding to a Challenge That Has Grown Out of Proportion

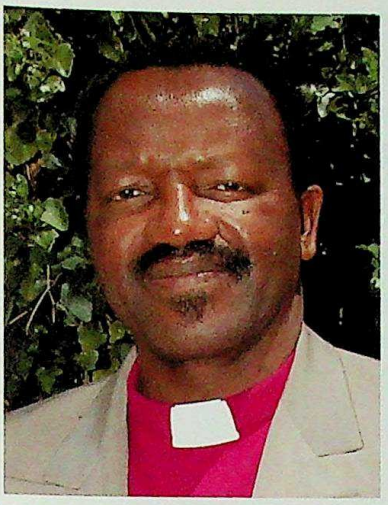
It all started in 2001 when the statistics of people living with HIV/AIDS (PLWHA) in South Africa were released. An HIV adult prevalence rate of 11 percent *(Nelson Mandela Foundation/Human Sciences Research Council)* in a population of 43 million people was alarming. The Central Diocese of the Evangelical Lutheran Church in Southern Africa (ELCSA) diocese felt challenged to respond, albeit in a small way.

The diocese's basic programs then included HIV/AIDS awareness raising through public praye services and workshops for pastors and other con gregation members. The response was overwhelmin and encouraging.

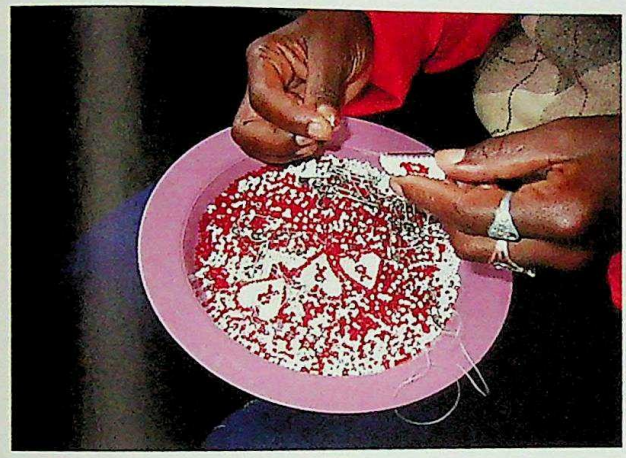
But as the challenge grew out of proportion and HIV infection assumed pandemic status, a great need was felt for a day-care center where PLWHA could

come for mutual support and counsel. The diocese could not do it alone, help was needed. On 4 December 2004, Diakonia AIDS Ministry (DAM) was inaugurated in Soweto, thanks to volunteer assistance through partnership between the Metropolitan Chicago Synod of the Evangelical Lutheran Church in America and Habitat for Humanity, and support from partners in Germany.

DAM's activities include PLWHA support groups, home-based care, orphan care and a facility for children of PLWHA. It also has educational and congregational outreach programs, and distributes food to the HIV-infected and affected, and destitute families.



Bishop Ngandaneni Phaswana, ELCSA Central Diocese. © LWF/D. - M. Grötzsch



DAM's income-generating activities for PLWHA include beadwork. © Becky A. Johnson

There is a growing positive response to the program at parish and community level. The Soweto support group has about 130 members, and there is a new group in western Johannesburg. The current 10 home-based caregivers serve about 70 people suffering from AIDS-related illnesses. DAM also assists 65 AIDS orphans and another 15 children in the child care center. In 2005, training was provided for 18 people peer educators, over 200 in basic knowledge about HIV/AIDS, and 90 in grassroots' organizing skills. Support group members are also engaged in incoming-generating activities through beadwork, sewing, gardening and shoe making.

But the program faces many challenges. These include stigma, whereby those infected and affected fear disclosing their status would lead to rejection by their loved ones, and the religious sector's judgmental attitude. Due to financial constraints the center cannot engage the much-needed health workers to administer antiretroviral therapy. A social worker is also required to respond to desperate situations encountered in orphan care and home-based care programs, including dispelling belief that witchcraft causes AIDS. *(393 words)*

By Bishop Ngandaneni Phaswana, Central Diocese, Evangelical Lutheran Church in Southern Africa (ELCSA).

A DAM support group member puts final touches on a pair of slippers. © Becky A. Johnson

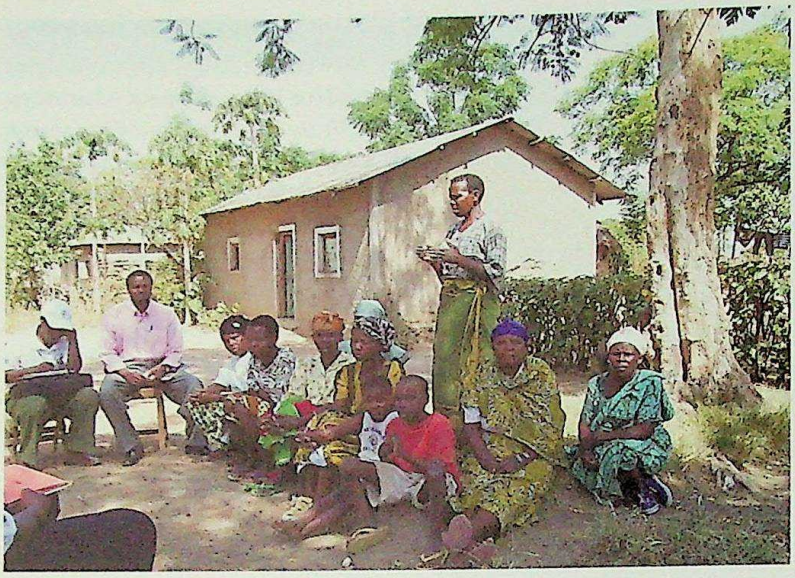
Tanzania: "You Have Been Too Open about Your Status"

Lutheran pastor Amin Sangewa had known of his seropositive status for some time. He had lost his wife and two children to AIDS between 1994 and 2003.

It was a difficult family situation. Few people said anything directly to him. Instead, suspicious looks and whispering followed him wherever he went. Painful remarks were made whenever he was around. But what shocked him most—not a single church leader comforted the family. So he decided to speak about his HIV status openly, in the hope of a change in attitude from the church.

Sangewa was wrong. His openness led to further abandonment by the community and church members. The church leadership asked him to stop any further intention of disclosing his HIV status. His contract as a Christian Council of Tanzania (CCT) chaplain at the Sokoine University of Agriculture in Morogoro, west of the capital Dar es Salaam had long been discontinued; he also wasn't assigned any duties upon returning to his Pare diocese.

But the former university chaplain was not about to give up. In March 2005, the Tanzania Network of Religious Leaders Living with HIV and AIDS (TANERELA), of which Sangewa was a co-pioneer, was formally registered. With 40 members including Muslims, TANERELA's aim is to use religious leaders as



HIV/AIDS awareness through the ELCT local community capacity building program in Musoma, northwest Tanzania. © Evangelical Lutheran Church in Tanzania

change agents in overcoming the six major obstacles in the fight against HIV/AIDS—stigma, shame, denial, discrimination, inaction or incorrect action in the communities, and to support other people living with HIV/AIDS (PLWHA).

At 47, Sangewa is now a full-time employee of TANERELA. He travels locally and abroad, teaching religious leaders how to avoid stigmatization in their regular sermons, at funerals and in other places. He urges preachers to be sensitive about their choice of words to avoid hurting and further stigmatizing PLWHA.

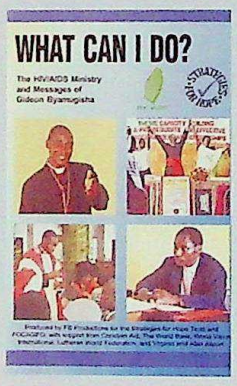
He is considering re-marrying. Asked whether he has someone in mind, he chuckled, saying he attempted once but the woman said: "You have been too open and if you marry me people will know my HIV status. Therefore, if you want us to get married stop telling people you are HIV-positive." *(355 words)*

[TANERELA is a national chapter of the African Network of Religious Leaders living with or personally affected by HIV and AIDS (ANERELA+). Established in 2002, it aims at encouraging openness about HIV/AIDS.]

Ms Elizabeth Lobulu, communication coordinator, Evangelical Lutheran Church in Tanzania, interviewed Rev. Amin Sangewa.

"What Can I Do?" – The HIV/AIDS Ministry and Messages of Gideon Byamugisha

"What Can I Do?" a 49-minute video, features Canon Gideon Byamugisha from Uganda, the first African priest to disclose his HIV-positive status. It is designed to combat HIV-related stigma, shame, discrimination and denial in churches.



In this video, whose production was supported financially by the Lutheran World Federation among other organizations, Byamugisha talks about the need for his fellow Christians to do away with judgmental attitudes toward HIV-positive people, and instead offer them love and support.

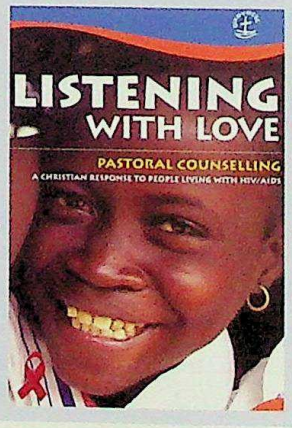
Byamugisha speaks on the video about the difficulty he has faced when buying condoms, because people usually associate condoms with immorality. He describes how he has turned these situations into impromptu AIDS education sessions.

The video, in the Strategies for Hope series, is divided into short segments on topics such as 'Coping with stigma', 'Why be tested for HIV?' and 'Challenges for the church'. It is accompanied by a 48-page Facilitator's Guide, to enable groups to explore in greater depth the issues which it raises. *(173 words)*

For further information about "What Can I Do?" please contact: **www.stratshope.org**

Listening with Love – Pastoral Counselling

Listening with Love *– Pastoral Counseling: A Christian Response to People Living with HIV/AIDS,* is designed for all Christians who are called to help people cope with HIV/AIDS. The World Council of Churches (WCC) publication provides, step by step, the basic medical facts about HIV/AIDS, guiding readers through practical, loving approaches that enable empathy and communication with people whose lives have been transformed by HIV.



The 127-page Bible-based manual uses everyday language and case studies that reveal the kinds of issues and problems that counselors typically face. *Listening with Love* is authored by Fr Robert Igo OSB, a clinical counselor and therapist prior of the Benedictine Monastery of Christ the Word in Zimbabwe. Fr Igo serves on the health desk of the Conference of Religious Superiors in Zimbabwe.

(132 words)

For further information please contact ***www.wcc-coe.org***

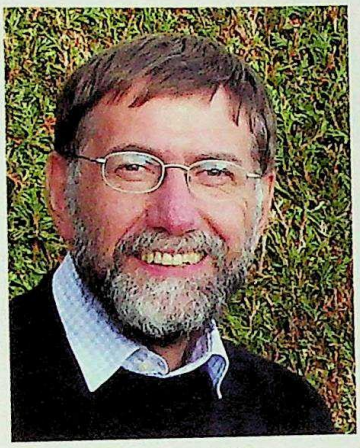
From Isolated Efforts to Ecumenical and Global Action

What started as isolated efforts in response to the HIV/AIDS pandemic has grown into a global network of civil society and governmental initiatives. Maintaining this wide network, which may sometimes seem complex, is important—the very fabric of society has been touched by HIV and AIDS. A concerted response must involve a global perspective.

The LWI editorial team invited contributions from organizations that support global HIV/AIDS initiatives.

World Council of Churches Special HIV/AIDS Initiative for Africa

Following the November 2001 "Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa" in Nairobi, during which African church leaders, international and African ecumenical organizations developed a coordinated "Plan of Action," the World Council of Churches (WCC) set up the Ecumenical HIV/AIDS Initiative in Africa (EHAIA). This special initiative is at present managed from Geneva, yet the grassroots work is done from four sub-regional offices in Nairobi for Eastern, Accra for Western, Kinshasa for Central and Harare for Southern Africa.



Dr Christoph Mann, EHAIA Project Manager. © LWF/H. Putsman

A theology consultant works from the All Africa Conference of Churches office in Lomé, Togo. The Harare office has a theology consultant since November 1. In Angola, a coordinator for the Lusophone region also began work in November.

Some of the services offered by EHAIA's regional coordinators and theology consultants include:

- Advice on how to start or intensify own implementation of the Plan of Action through denominational or local policy papers;
- Special HIV/AIDS retreats for church leaders;
- Courses to include HIV into the curricula of clergy and lay-training institutions;
- Training of trainers for church group leaders (women, youth, men);
- Exchange visits with churches for sharing of good practice.

Several member churches of the Lutheran World Federation are affiliated to the WCC. Both organizations collaborate at various levels of their HIV/AIDS work. *(228 words)*

By Dr Christoph Mann, EHAIA Project Manager.

Faith in Action: Lutherans Engage in Global Advocacy

In the global response to HIV and AIDS, lives are saved every day by programs of prevention, care, treatment and support. But it is increasingly clear that such efforts must be accompanied by advocacy to change unjust polices and practices.

Ms Linda Hartke, EAA Coordinator. © EAA

The Lutheran World Federation (LWF) constituency continues to play a leading role in the Ecumenical Advocacy Alliance (EAA), a young and ambitious global network of churches and related organizations that work together in an advocacy campaign on HIV and AIDS with the theme, "Make the Promise. Keep the Promise. Stop AIDS." Faith communities around the world have an enormous opportunity and challenge to lead in the response to the epidemic. Inspired by the biblical call to act for justice, churches must examine their own policies and practices and put pressure on government leaders.

Some examples: In July this year, the LWF stood in solidarity with people living with HIV in Queenstown, South Africa, after they were fired upon by police when marching to a local clinic demanding promised treatment. The LWF added its name to a protest letter to South African government leaders with other churches and organizations—the police have apologized and an investigation is underway. Lutherans again played a prominent role in telling governments that "the world is watching..." to see if they fulfill their promises to provide necessary funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria.

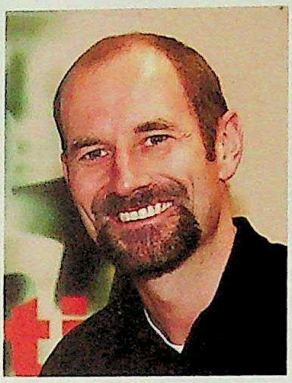
Our small staff team plays a role in encouraging action by participating churches and organizations, sharing resources, and coordinating efforts so they

have the greatest impact. The work is challenging, as the root causes that fuel the pandemic can be tough topics for frank conversation in the church—sex and sexuality, injecting drug use, and poverty. But the struggle for dialogue and action is important, no matter the discomfort, as tens of millions of lives are at stake.

The LWF is an EAA member. For more information, please see: **www.e-alliance.ch** *(330 words)*

By Ms Linda Hartke, EAA Coordinator.

Global Challenges in Mobilizing HIV/AIDS Resources



Dr Christoph Benn, Director of External Relations, Global Fund to Fight AIDS, Tuberculosis and Malaria. © epd-bild / Gerhard Bäuerle

At the start of this decade, the world briefly came together to focus on the injustice of millions of people dying from AIDS while medicines existed that could keep them alive. The world's leaders listened to activists, health workers and church leaders, who spoke about the moral imperative to provide AIDS treatment to all in need. As ideas developed, it became clear that universal access to treatment had to go hand in hand with a global effort to increase prevention of HIV/AIDS.

Yet, the world is a very different place today from what it was five years ago. The war against terror, the conflicts in the Middle East, the relative economic challenges and budget deficits in the world leading economies, and—recently—several natural disasters and a looming threat of a global bird-flu epidemic; all these factors are draining resources and attention away from the slow battle of attrition against HIV/AIDS.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that the world needs to spend USD 18 billion in 2007, and over USD 20 billion in 2008, if the tide of the growing AIDS pandemic is to be turned. Today, less than a third of that is being spent. To increase the amount, all committed to the fight must continue to use their strongest arguments against those in the world's capitals that have the difficult task of making decisions on funding. The moral imperative to prevent millions of needless deaths the warning of devastation to development, economies, and peace, if whole continents were overcome by the AIDS pandemic; and the increasingly strong, new argument of recoveries achieved—are how the tide is beginning to turn. The Global Fund to Fight AIDS, Tuberculosis and Malaria is among the organizations, which are financing this turnaround. The strongest argument for the provision of more money to fight AIDS is to show that the fight can be won. *(321 words)*

By Dr Christoph Benn, Director of External Relations at the Geneva-based Global Fund to Fight AIDS, Tuberculosis and Malaria.

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Cover image – At the July 2003 LWF Tenth Assembly in Winnipeg, Canada, youth representatives from LWF member churches demonstrated the need for open dialogue with the church on HIV/AIDS. Copyright: LWF/D. Zimmermann

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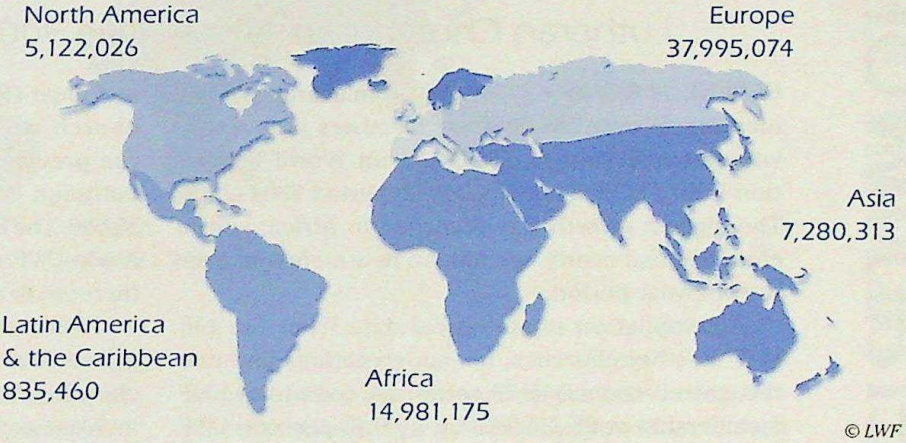
Slight Increase Pushes LWF Global Membership to 66.2 Million

An average global increase of over 286,000 new members puts worldwide membership in the Lutheran World Federation (LWF) at 66.2 million for the period 2004–2005. The highest growth was recorded in Africa, where churches had nearly one million new members over the one-year period.

A compilation of statistical data from the 140 LWF member churches, ten congregations and one recognized council in 78 countries, puts total LWF membership at 66,214,048, up by 0.43 percent. LWF churches had 65.93 million members in 2004. In 2003, LWF membership was 62.3 million.

(See page 2 ff)

LWF 2005 Membership Figures



Highlights

Lutheran World Information

Contents

Slight Increase Pushes LWF Global Membership to 66.2 Million

Lutheran Churches in Africa Have 900,000 New Members

GENEVA, 14 February 2006 (LWI) – An average global increase of over 286,000 new members puts worldwide membership in the Lutheran World Federation (LWF) at 66.2 million for the period 2004–2005. The highest growth was recorded in Africa, where churches had nearly one million new members over the one-year period.

A compilation of statistical data from the 140 LWF member churches, ten congregations and one recognized council in 78 countries, puts total LWF membership at 66,214,048, up by 0.43 percent. LWF churches had 65.93 million members in 2004. In 2003, LWF membership was 62.3 million.

In 2005 LWF member churches increased from 138 to 140, of which two have associate membership while the remaining have full membership.

The number of Lutherans worldwide rose by 229,753 to 69.76 million (69,757,570), an increase of 0.33 percent compared to 69.53 million in 2004. In 2003, there were 65.96 million Lutherans worldwide. The number of Lutherans outside the LWF membership decreased by 56,961 to 3.54 million.

Over 15 Million Lutherans in Africa

In Africa, 904,500 new members pushed the total membership in Lutheran churches there to 15,038,072, up by 6.4 percent compared to 2004. The LWF member churches on the continent registered 902,153 additional members, and a new total of 14,981,175.

Africa's highest percentage increase, 44 percent, was recorded in the Evangelical Lutheran Church of Congo (Republic of Congo), a non-LWF member church, with 1,828 members compared to 1,268 the previous year. Membership in the Evangelical Lutheran Church in Kenya rose by 36.4 percent to 75,000. The Evangelical Lutheran Church in Togo, also a non-LWF member church, recorded a 36 percent increase to reach 6,754.

With over 148,300 new members, the Ethiopian Evangelical Church Mekane Yesus, the largest LWF member church in Africa, had 4,312,407 members, a 3.5 percent increase compared to 2004. The second-largest LWF member church, the Evangelical Lutheran Church in Tanzania had half-a-million more members, an increase of 16.7 percent, pushing the current total to 3.5 million.

The Evangelical Lutheran Church in the Republic of Namibia (ELCRN) increased membership by 50,000 to 350,000 members. The Evangelical Lutheran Church in Namibia (ELCIN) had an additional 11,913 members, pushing the total to 652,195. Membership in the German-speaking Evangelical Lutheran Church in Namibia (ELCIN-GELC) dropped by 20 percent to 5,200 members, compared to 6,500 in 2004.

A 13.2 percent increase pushed membership in the fourth largest LWF member church in Africa, the Lutheran Church of Christ in Nigeria, to 1,364,420. The Evangelical Lutheran Church of Angola gained 4,000 new members and a new total of 26,000. Membership in the Evangelical Lutheran Church of Cameroon went up by 13.5 percent to 195,000 members compared to 172,000 the previous year.

A decrease of 20.2 percent in the Moravian Church in South Africa gives a new total of 80,000 members.

Asia: Small Increase Overall, Significant Growth in Taiwan

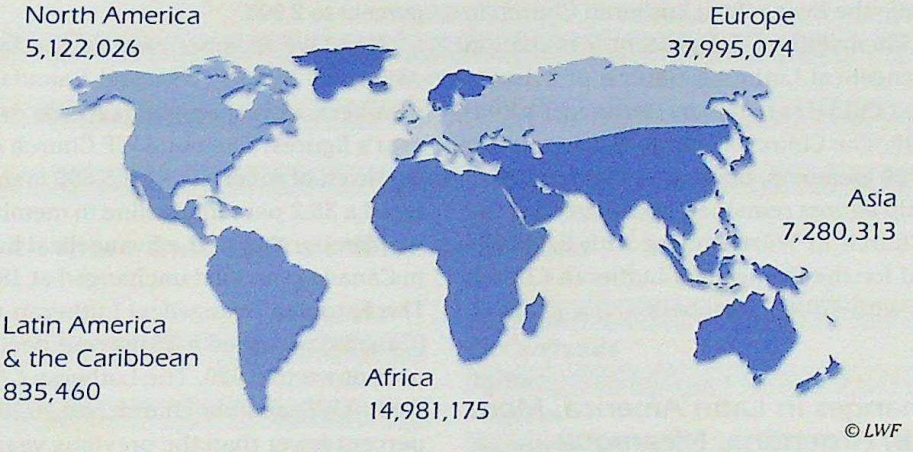
The number of Lutherans in Asia increased by 25,890 during the one-year period under review. Out of the total 7,416,992 Lutheran church members in Asia, 7,280,313 belonged to LWF churches, an increase of around 0.7 percent compared to 2004.

The Taiwan Lutheran Church recorded a 46.5 percent increase, the highest percentage in the region with a new total of 12,029 compared to 8,220 in 2004. The Bangladesh Lutheran Church gained 1,000 new members pushing the total membership to 4,000. An increase of 12.8 percent, pushed membership in the Pakpak Dairi Christian Protestant Church (Indonesia) to 34,384 members. The Lutheran Church in Malaysia and Singapore had 7,644 members, up by 10.8 percent.

In India, membership in the Evangelical Lutheran Church in Chotanagpur and Assam rose by 5.2 percent to 400,000, whereas the Northern Evangelical Lutheran Church, with 80,000 members registered a decrease of 5.9 percent.

Membership in the Protestant Christian Batak Church (Indonesia), the largest Lutheran church in Asia, remained unchanged with three million members.

LWF 2005 Membership Figures



Europe: Figures Drop by over Half-a-Million

In 2005, membership in Lutheran churches in Europe dropped by nearly 600,000 to 38,035,928. Membership in LWF member churches in the region fell by 599,479 to a total 37,995,074 members. In 2004, there was a sharp increase of 2.6 million, representing 7.3 percent, when the Protestant Church in the Netherlands (PCN) joined the LWF.

The Church of Sweden, the largest Lutheran church in the world, had 6,995,000 members in 2005, 3.1 percent less than the 7.2 million recorded in 2004. The third-largest LWF member church, the Evangelical Lutheran Church of Finland, showed a slight decrease in membership with 4, 572,611 compared to 4,586,414 in 2004. Figures in the Evangelical Lutheran Church in Denmark, the fourth largest LWF member church, remained unchanged at 4,499,501 members. The Church of Norway recorded 8,681 new members, pushing the total to 3,930,946. Membership figures in the Evangelical Lutheran Free Church of Norway fell by 997 to 21,818.

The Evangelical Church of the Augsburg Confession in Austria had 3,108 additional members and a new total of 325,429, whereas the Evangelical Lutheran Church in Romania had 32,500 members, an increase of four percent over the previous year's. A 25 percent increase in the Malagasy Protestant Church in France gave a new total of 10,000 members.

The Evangelical Lutheran Church in Russia and Other States (ELCROS) had 75,000 members, following large-scale emigration by Russian Germans. Until recently ELCROS had given its membership figures as 250,000. Last year, membership in the Evangelical Church of the Augsburg Confession in Poland fell by 3.1 percent to 77,500 members. The Silesian Evangelical Church of the Augsburg Confession in the Czech Republic recorded a 12.5 percent decrease to 35,000 members.

Germany Has Fewer Lutherans

The 12,912,101 Lutherans in Germany, the country with the highest number of Lutherans in the world, represented a decrease of 191,845 compared to the previous year. In 2004, Lutheran churches in Germany had 13.1 million members, and 13.26 million members in 2003. A 37.5 percent decline in the 25,000-member Latvian Evangelical Lutheran Church Abroad was the highest percentage decrease recorded in the country.

The Evangelical Lutheran Church of Hanover, the largest Lutheran church in Germany, had 3,072,622 members, down by 1.7 percent over the 3.13 million recorded in 2004. Membership in the Evangelical Lutheran Church in Bavaria remained unchanged at 2.7 million, while the North Elbian Evangelical Lutheran Church had 2,129,100 members, around one percent lower than in 2004.

The Evangelical Lutheran Church of Saxony recorded a 5.78 percent drop in 2005 with 843,296 members. Membership in the Evangelical Lutheran Church in Thuringia fell by 17,500 to 459,000 members, whereas that of the Evangelical Lutheran Church of Mecklenburg went down to 212,455, a decrease of 5.6 percent. With 106,587 members, the Evangelical Church of Pomerania had a 7.3 percent decline.

A 1.7 percent decline in the Evangelical Lutheran Church in Brunswick pushed the membership figures to 410,500, while the Evangelical Lutheran Church in Baden had 3,500 members, 5.5 percent less than in 2004. The Evangelical Lutheran Church of Schaumburg-Lippe had 1,615 less members, bringing its total down to 62,300. The Church of Lippe (Lutheran Section) had 32,000 members, down by 1.8 percent.

Membership figures remained unchanged for the Evangelical Church in Württemberg with 2,346,879 members, and for the Evangelical Lutheran Church in Oldenburg, with 470,471 members.

Minimal Changes in Latin America, More Lutherans in Argentina, Nicaragua

A slight decline in membership among the Latin American and Caribbean region Lutheran churches pushed the figures there down by 4,966 to a new total of 1,111,947 members. The 835,460 total recorded for LWF member churches was 6,636 lower than the previous year.

Membership in the Evangelical Church of the Lutheran Confession in Brazil, the largest Lutheran church in the region, rose by around 0.27 percent to 711,935. Some 3,000 new members in the Nicaraguan Lutheran Church of Faith and Hope, pushed the total to 7,000.

A 57 percent membership increase in the United Evangelical Lutheran Church (Argentina) gave a new total of 11,000. With 25,300 members in 2005, the Evangelical Church of the River Plate (Argentina) had 44 percent fewer members compared to 2004.

Membership in the Bolivian Evangelical Lutheran Church rose by 22.2 percent to 22,000 members. An increase of 10 percent in the Lutheran Costarican Church pushed the total membership to 1,249 members, while the Christian Lutheran Church of Honduras recorded a 20 percent increase for a new total of 1,200. Membership in the Evangelical Lutheran Church in Venezuela fell by 13 percent to 1,950.

Overall Decrease in North America

Lutheran membership in North American churches decreased by 1.16 percent down to a total of 8,154,631 compared to 8,250,658 recorded for the period ending 2004. In 2005, the region had 5,122,026 Lutherans belonging to LWF member churches compared to 5,182,002 in 2004.

The second-largest LWF member church in the world, the Evangelical Lutheran Church in America, had 4,930,429 members, a decline of 1.1 percent over the previous year. Membership in the Lithuanian Evangelical Lutheran Church in Diaspora (USA) fell by 3.3 percent to 2,900.

Non-LWF member church, the Lutheran Church – Missouri Synod (USA and Canada) had 2,463,747 members, a one percent decrease over the previous year's figures. The non-LWF Church of the Lutheran Brethren of America, with 8,860 members had registered a 38.2 percent decline in membership.

Membership in the Evangelical Lutheran Church in Canada remained unchanged at 182,077 members. The Estonian Evangelical Lutheran Church Abroad (Canada) recorded a 45 percent decline, pushing figures down to 6,620. The Lutheran Church – Canada, a non-LWF member church had 76,100 members, 6.6 percent fewer than the previous year.

The LWF membership statistics are based on information received from the LWF member churches, recognized congregations and council, as well as from other Lutheran churches, organizations, mission bodies and congregations. The figures recorded for the year ending 2004 were used for churches that did not indicate any changes by the end of January 2006. (1,637 words)

A one-page summary of the 2005 LWF Statistics is posted in PDF format on the LWF Web site under: www.lutheranworld.org/LWF_Documents/LWF-Statistics-01-2005.pdf. Full details can be found under: www.lutheranworld.org/LWF_Documents/LWF-Statistics-2005.pdf.

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The Lutheran World Federation 2005 Membership Figures

Summary

The following figures give the membership of the 140 LWF member churches (M), including two associate member churches (AM), 10 recognized congregations and one recognized council (R), as well as other Lutheran churches, bodies or congregations (C).

General Summary 2005

140 LWF member churches, 10 recognized congregations and one recognized council	66,214,048
Lutherans outside LWF constituency	3,543,522
Total	69,757,570

Continent	All Lutherans	LWF Membership	Other Churches
Africa	15,038,072	14,981,175	56,897
Asia	7,416,992	7,280,313	136,679
Europe	38,035,928	37,995,074	40,854
Latin America & the Caribbean	1,111,947	835,460	276,487
North America	8,154,631	5,122,026	3,032,605
Total	**69,757,570**	**66,214,048**	**3,543,522**

Countries with more than half a million Lutherans

Germany*	12,912,101	**Madagascar**	3,000,000
USA*	7,889,834	**Netherlands**	2,530,000
Sweden	6,995,000	**India**	1,829,183
Finland	4,572,611	**Nigeria**	1,501,445
Denmark	4,499,611	**Namibia**	1,007,395
Ethiopia	4,312,407	**Papua New Guinea**	954,188
Indonesia	4,309,317	**Brazil**	937,508
Norway	3,952,764	**South Africa**	706,023
Tanzania	3,500,000		

** These figures include the membership of the Baltic churches abroad.*

Lutheran churches with more than half a million members

Church of Sweden	6,995,000	**Evangelical Church in Württemberg**	2,346,879
Evangelical Lutheran Church in America	4,930,429	**North Elbian Evangelical Lutheran Church**	2,129,100
Evangelical Lutheran Church of Finland	4,572,611	**The Lutheran Church of Christ in Nigeria**	1,364,420
Evangelical Lutheran Church in Denmark	4,499,501	**Evangelical Lutheran Church of Saxony**	843,296
The Ethiopian Evangelical Church Mekane Yesus	4,312,407	**Evangelical Lutheran Church of Papua New Guinea**	815,000
Church of Norway	3,930,946	**Andhra Evangelical Lutheran Church**	800,000
Evangelical Lutheran Church in Tanzania	3,500,000	**Evangelical Church of the Lutheran Confession in Brazil**	711,935
Evangelical Lutheran Church of Hanover	3,072,622	**The Evangelical Lutheran Church in Namibia (ELCIN)**	652,195
Malagasy Lutheran Church	3,000,000	**Evangelical Lutheran Church in Southern Africa**	589,502
Protestant Christian Batak Church	3,000,000		
Evangelical Lutheran Church in Bavaria	2,700,000		
Protestant Church in the Netherlands	2,530,000		
Lutheran Church – Missouri Synod**	2,463,747		

*** Not an LWF member church*

The Lutheran World Federation
2005 Membership Details

(M) Member Church
(AM) Associate Member Church
(R) Recognized Congregation or Recognized Council
(C) Other Lutheran churches, bodies or congregations

Africa	Individual Churches	National Tot
Angola		26,00
Evangelical Lutheran Church of Angola (M)	26,000	
Botswana		21,11
Evangelical Lutheran Church in Botswana (M)	21,110	
Cameroon		305,35
Church of the Lutheran Brethren of Cameroon (M)	105,994	
Evangelical Lutheran Church of Cameroon (M)	195,000	
The Lutheran Church of Cameroon (C)	4,358	
Central African Republic		55,00
Lutheran Church of the Central African Republic (M)	55,000	
Chad		21,30
Church of the Lutheran Brethren of Chad (C)	21,305	
Congo, Democratic Republic		136,00
Evangelical Lutheran Church in Congo (M)	136,000	
Congo, Republic		1,82
Evangelical Lutheran Church of Congo (C)	1,828	
Eritrea		12,00
The Evangelical Church of Eritrea (M)	12,000	
Ethiopia		4,312,40
The Ethiopian Evangelical Church Mekane Yesus (M)	4,312,407	
Ghana		26,40
Evangelical Lutheran Church of Ghana (M)	26,400	
Kenya		105,00
Evangelical Lutheran Church in Kenya (M)	75,000	
Kenya Evangelical Lutheran Church (M)	30,000	
Liberia		71,19
Lutheran Church in Liberia (M)	71,196	
Madagascar		3,000,00
Malagasy Lutheran Church (M)	3,000,000	
Malawi		50,00
Evangelical Lutheran Church in Malawi (M)	50,000	

	Individual Churches	National Total
Mozambique		**5,987**
Evangelical Lutheran Church in Mozambique (M)	5,987	
Namibia		**1,007,395**
Evangelical Lutheran Church in Namibia (ELCIN-GELC) (M)	5,200	
Evangelical Lutheran Church in the Republic of Namibia (ELCRN) (M)	350,000	
The Evangelical Lutheran Church in Namibia (ELCIN) (M)	652,195	
Nigeria		**1,501,445**
The Lutheran Church of Christ in Nigeria (M)	1,364,420	
The Lutheran Church of Nigeria (M)	137,025	
Rwanda		**20,000**
Lutheran Church of Rwanda (M)	20,000	
Senegal		**3,687**
Evangelical Lutheran Church of Senegal (C)	no data	
The Lutheran Church of Senegal (M)	3,687	
Sierra Leone		**2,500**
Evangelical Lutheran Church in Sierra Leone (M)	2,500	
South Africa		**706,023**
Evangelical Lutheran Church in Southern Africa (Cape Church) (M)	4,099	
Evangelical Lutheran Church in Southern Africa (M)	589,502	
Evangelical Lutheran Church in Southern Africa (N-T) (M)	9,770	
Free Evangelical Lutheran Synod in South Africa (C)	2,652	
Lutheran Church in Southern Africa (C)	20,000	
Moravian Church in South Africa (M)	80,000	
Tanzania		**3,500,000**
Evangelical Lutheran Church in Tanzania (M)	3,500,000	
Togo		**6,754**
Evangelical Lutheran Church in Togo (C)	6,754	
Zambia		**5,683**
Evangelical Lutheran Church in Zambia (M)	5,683	
Zimbabwe		**135,000**
Evangelical Lutheran Church in Zimbabwe (M)	135,000	

Asia

Australia		**75,000**
Lutheran Church of Australia (AM)	75,000	
Bangladesh		**12,884**
Bangladesh Lutheran Church (M)	4,000	
Bangladesh Northern Evangelical Lutheran Church (M)	8,884	
Hong Kong (China)		**47,534**
Hong Kong and Macau Lutheran Church (M)	2,470	
Lutheran Church, Hong Kong Synod (C)	8,300	

	Individual Churches	National To
The Chinese Rhenish Church Hong Kong Synod (M)	14,000	
The Evangelical Lutheran Church of Hong Kong (M)	14,264	
Tsung Tsin Mission of Hong Kong (M)	8,500	
India		1,829,1
Andhra Evangelical Lutheran Church (M)	800,000	
Evangelical Lutheran Church in Madhya Pradesh (M)	15,825	
Evangelical Lutheran Church in the Himalayan States (M)	24,750	
Good Samaritan Evangelical Lutheran Church (C)	9,837	
Gossner Evangelical Lutheran Church in Chotanagpur and Assam (M)	400,000	
India Evangelical Lutheran Church (M)	56,493	
Jeypore Evangelical Lutheran Church (M)	133,000	
North Western Gossner Evangelical Lutheran Church (C)	106,778	
Northern Evangelical Lutheran Church (M)	80,000	
(see Nepal)		
South Andhra Lutheran Church (M)	45,500	
The Arcot Lutheran Church (M)	37,000	
The Tamil Evangelical Lutheran Church (M)	120,000	
Indonesia		4,309,3
Batak Christian Community Church (M)	20,000	
Christian Communion of Indonesia Church in Nias (Gereja AMIN) (M)	18,561	
Christian Protestant Angkola Church (M)	27,986	
Christian Protestant Church in Indonesia (M)	255,601	
Indonesian Christian Lutheran Church (M)	16,895	
Pakpak Dairi Christian Protestant Church (M)	34,384	
Protestant Christian Batak Church (M)	3,000,000	
Protestant Christian Church in Mentawai (M)	38,907	
Simalungun Protestant Christian Church (M)	198,479	
The Indonesian Christian Church (M)	350,000	
The Protestant Christian Church (M)	338,504	
The United Protestant Church (M)	10,000	
Israel		1
Finnish Evangelical Lutheran Mission – Shalhevetyah Christian Center and Congregation (C)	80	
Lutheran Church in Israel (Immanuel Church) (C)	50	
Japan		32,5
Japan Evangelical Lutheran Church (M)	22,027	
Japan Lutheran Brethren Church (C)	1,219	
Japan Lutheran Church (AM)	2,880	
Kinki Evangelical Lutheran Church (M)	2,742	
West Japan Evangelical Lutheran Church (C)	3,700	
Jordan		3,0
The Evangelical Lutheran Church in Jordan & the Holy Land (M)	3,000	
Korea, Republic		4,6
Lutheran Church in Korea (M)	4,698	
Malaysia		91,5
Basel Christian Church of Malaysia (M)	48,000	
Evangelical Lutheran Church in Malaysia (M)	3,000	
Lutheran Church in Malaysia and Singapore (M)	7,644	
The Protestant Church in Sabah (M)	32,872	

	Individual Churches	National Total
Myanmar		**1,860**
Evangelical Lutheran Church in Myanmar (Lutheran Bethlehem Church) (M)	1,860	
Nepal		
Northern Evangelical Lutheran Church (M) *(see India)*		
New Zealand		**1,001**
Lutheran Church of New Zealand (C)	1,001	
(a district of the Lutheran Church of Australia)		
Papua New Guinea		**954,188**
Evangelical Lutheran Church of Papua New Guinea (M)	815,000	
Gutnius Lutheran Church – Papua New Guinea (M)	139,188	
Philippines		**27,000**
Lutheran Church in the Philippines (M)	27,000	
Singapore		**4,056**
Lutheran Church in Singapore (M)	4,056	
Sri Lanka		**1,200**
Lanka Lutheran Church (M)	1,200	
Taiwan		**19,357**
China Evangelical Lutheran Church (C)	2,621	
China Lutheran Gospel Church (C)	225	
Chinese Lutheran Brethren Church (C)	1,668	
Taiwan Lutheran Church (M)	12,029	
The Lutheran Church of Taiwan (Republic of China) (M)	1,614	
The Lutheran Church of the Republic of China (C)	1,200	
Thailand		**2,500**
The Evangelical Lutheran Church in Thailand (M)	2,500	
(including the Lutheran Mission in Thailand)		

Europe

Austria		**325,429**
Evangelical Church of the Augsburg Confession in Austria (M)	325,429	
Belgium		**812**
Lutheran Church of Belgium: Arlon and Christian Mission (R)	812	
Croatia		**3,500**
Evangelical Church in the Republic of Croatia (M)	3,500	
Evangelical Church in the Republic of Croatia (M)	no data	
Czech Republic		**149,445**
Evangelical Church of Czech Brethren (M)	114,445	
Silesian Evangelical Church of the Augsburg Confession (M)	35,000	
Denmark (including Faroe Islands and Greenland)		**4,499,611**
Evangelical Lutheran Church in Denmark (M)	4,499,501	
The Evangelical Lutheran Free Church in Denmark (C)	110	

	Individual Churches	National Total
Estonia		**200,000**
Estonian Evangelical Lutheran Church (M)	200,000	
Faroe Islands		
Evangelical Lutheran Church in Denmark (M) *(see Denmark)*		
Finland		**4,572,611**
Evangelical Lutheran Church of Finland (M) *(including ELCF members abroad)*	4,572,611	
France		**260,600**
Church of the Augsburg Confession of Alsace and Lorraine (M)	210,000	
Evangelical Lutheran Church – Synod of France and Belgium (C)	600	
Evangelical Lutheran Church of France (M)	40,000	
Malagasy Protestant Church in France (M)	10,000	
Germany		**12,912,101**
Church of Lippe [Lutheran Section] (M)	32,000	
Evangelical Church in Württemberg (M)	2,346,879	
Evangelical Church of Pomerania (M)	106,587	
Evangelical Lutheran Church in Baden (M)	3,500	
Evangelical Lutheran Church in Bavaria (M)	2,700,000	
Evangelical Lutheran Church in Brunswick (M)	410,500	
Evangelical Lutheran Church in Oldenburg (M)	470,471	
Evangelical Lutheran Church in Thuringia (M)	459,000	
Evangelical Lutheran Church of Hanover (M)	3,072,622	
Evangelical Lutheran Church of Mecklenburg (M)	212,455	
Evangelical Lutheran Church of Saxony (M)	843,296	
Evangelical Lutheran Church of Schaumburg-Lippe (M)	62,300	
Evangelical Lutheran Free Church in Germany (C)	1,470	
Independent Evangelical Lutheran Church (C)	36,921	
Latvian Evangelical Lutheran Church Abroad (M)	25,000	
North Elbian Evangelical Lutheran Church (M)	2,129,100	
Greenland		
Evangelical Lutheran Church in Denmark (M) *(see Denmark)*		
Hungary		**305,000**
The Evangelical Lutheran Church in Hungary (M)	305,000	
Iceland		**250,661**
The Evangelical Lutheran Church of Iceland (M)	250,661	
Ireland		**3,500**
The Lutheran Church in Ireland (R)	3,500	
Italy		**7,000**
Evangelical Lutheran Church in Italy (M)	7,000	
Latvia		**250,000**
Evangelical Lutheran Church of Latvia (M)	250,000	
Liechtenstein		
Federation of Evangelical Lutheran Churches in Switzerland and the Principality of Liechtenstein (M) *(see Switzerland)*		

	Individual Churches	National Total
Lithuania		21,000
Evangelical Lutheran Church of Lithuania (M)	21,000	
Netherlands		2,530,000
Protestant Church in the Netherlands (M)	2,530,000	
Norway		3,952,764
Church of Norway (M)	3,930,946	
The Evangelical Lutheran Free Church of Norway (M)	21,818	
Poland		77,500
Evangelical Church of the Augsburg Confession in Poland (M)	77,500	
Romania		46,960
Evangelical Church of the Augsburg Confession in Romania (M)	14,460	
Evangelical Lutheran Church in Romania (M)	32,500	
Russian Federation		91,000
Evangelical Lutheran Church in Russia and Other States (M)	75,000	
The Evangelical Lutheran Church of Ingria in Russia (M)	16,000	
Serbia-Montenegro		49,000
Slovak Evangelical Church of the Augsburg Confession in Serbia and Montenegro (M)	49,000	
Slovak Republic		372,858
Evangelical Church of the Augsburg Confession in the Slovak Republic (M)	372,858	
Slovenia		20,000
Evangelical Church of the Augsburg Confession in Slovenia (M)	20,000	
Sweden		6,995,000
Church of Sweden (M)	6,995,000	
Switzerland (including Liechtenstein)		4,853
Federation of Evangelical Lutheran Churches in Switzerland and the Principality of Liechtenstein (M)	4,853	
United Kingdom		134,723
Lutheran Church in Great Britain (M)	2,370	
The Evangelical Lutheran Church of England (C)	1,753	
The Lutheran Council of Great Britain (R)	130,600	

Latin America & the Caribbean

Argentina		72,260
Evangelical Church of the River Plate (M)	25,300	
(see Paraguay, Uruguay)		
Evangelical Lutheran Church of Argentina (C)	30,000	
(see Chile, Uruguay)		
Protestant Congregation in Tandil (C)	160	
Protestant Society in Southern Argentina – Lutheran Church (C)	3,800	
Protestant Society of the South-East (C)	2,000	
United Evangelical Lutheran Church (M)	11,000	

	Individual Churches	National Total
Bolivia		**24,400**
Bolivian Evangelical Lutheran Church (M)	22,000	
Christian Evangelical Lutheran Church of Bolivia (C)	700	
German-Speaking Evangelical Lutheran Congregation in Bolivia (R)	1,000	
Norwegian Lutheran Mission in Bolivia (C)	700	
Brazil		**937,508**
Association of Free Lutheran Congregations (C)	1,050	
Evangelical Church of the Lutheran Confession in Brazil (M)	711,935	
Evangelical Lutheran Church of Brazil (C)	224,523	
Chile		**14,970**
Evangelical Lutheran Church in Chile (M)	3,000	
Evangelical Lutheran Church of Argentina (C) *(see Argentina)*		
Evangelical Lutheran Church of the Republic of Chile (C)	170	
Lutheran Church in Chile (M)	11,800	
Colombia		**3,596**
Evangelical Lutheran Church of Colombia (M)	3,100	
St Martin's Congregation (R)	160	
St Matthew's Congregation (R)	336	
Costa Rica		**1,849**
Evangelical Lutheran Church of Costa Rica (R)	600	
Lutheran Costarican Church (M)	1,249	
Ecuador		**2,020**
Evangelical Lutheran Church in Ecuador (R)	520	
(including the El Adviento Evangelical Lutheran Church in Quito, and The Savior Church in Guayaquil)		
Evangelical Lutheran Indigenous Church of Ecuador (C)	1,500	
El Salvador		**12,000**
Salvadoran Lutheran Synod (M)	12,000	
Guatemala		**200**
Evangelical Lutheran Congregation La Epifanía (R)	200	
Lutheran Church of Guatemala (C)	no data	
Guyana		**11,000**
Evangelical Lutheran Church in Guyana (M)	11,000	
Haiti		**no data**
The Evangelical Lutheran Church of Haiti (C)	no data	
Honduras Republic		**1,200**
Christian Lutheran Church of Honduras (M)	1,200	
Mexico		**9,179**
All Saints' Lutheran Church (C)	191	
Evangelical Lutheran Church of Mexico (C)	3,000	
German-Speaking Evangelical Congregation in Mexico (R)	3,110	
Lutheran Synod of Mexico (C)	1,211	
Mexican Lutheran Church (M)	1,500	
The Lutheran Church of the Good Shepherd (C)	167	

	Individual Churches	National Total
Nicaragua		**7,000**
The Nicaraguan Lutheran Church of Faith and Hope (M)	7,000	
Panama		**no data**
Brotherhood of Popular Pastoral Action – Lutheran Coordination (C)	no data	
Paraguay		**3,981**
Evangelical Church of the River Plate (M) *(see Argentina)*		
Evangelical Lutheran Church of Paraguay (C)	3,981	
Peru		**3,660**
Evangelical Lutheran Church in Peru (R)	400	
Evangelical Lutheran Congregation Cristo Rey (C)	100	
Norwegian Lutheran Mission (C)	2,060	
Peruvian Lutheran Evangelical Church (M)	1,100	
Suriname		**4,000**
Evangelical Lutheran Church in Suriname (M)	4,000	
Uruguay		**190**
Evangelical Church of the River Plate (M) *(see Argentina)*		
Evangelical Lutheran Church in Uruguay (C)	190	
Evangelical Lutheran Church of Argentina (C) *(see Argentina)*		
Venezuela		**2,934**
Evangelical Lutheran Church in Venezuela (M)	1,950	
Lutheran Church of Venezuela (C)	984	

North America

Canada		**264,797**
Estonian Evangelical Lutheran Church Abroad (M)	6,620	
Evangelical Lutheran Church in Canada (M)	182,077	
Lutheran Church – Canada (C)	76,100	
USA		**7,889,834**
Apostolic Lutheran Church of America (C)	7,707	
Association of Free Lutheran Congregations (C)	39,319	
Church of the Lutheran Brethren of America (C)	8,860	
Church of the Lutheran Confession (C)	8,631	
Conservative Lutheran Association (C)	994	
Evangelical Lutheran Church in America (M)	4,930,429	
Evangelical Lutheran Synod (C)	24,000	
Lithuanian Evangelical Lutheran Church in Diaspora (M)	2,900	
Lutheran Church – Missouri Synod (C)	2,463,747	
Lutheran Churches of the Reformation (C)	1,500	
The Protestant Conference [Lutheran] (C)	1,125	
Wisconsin Evangelical Lutheran Synod (C)	400,622	

These statistics are based on data received by 31 January 2006. Compiled by Janet Bond-Nash (LWF/OCS)

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LWF President Mark Hanson's Statement on Remarks by Iranian President

Emphasis on Lutherans' Commitment to Open, Honest Relationship with Jewish Community

CHICAGO, United States of America/GENEVA, 20 December 2005 (LWI) – The president of the Lutheran World Federation (LWF) Bishop Mark S. Hanson, condemned remarks by Iranian President Mahmoud Ahmadinejad, describing the Holocaust as a "myth" and calling for Israel to be "wiped off the map."

In a statement dated 19 December 2005, Hanson, presiding bishop of the Evangelical Lutheran Church in America (ELCA), affirmed the historical record of the Holocaust under legal and scholarly scrutiny. "We know and grieve the awful truth of the Shoah. No reasonable person can stand by while any nation's leader makes such outrageous and unacceptable claims," he noted.

The LWF president said Ahmadinejad's remarks, quoted widely in international media, represented a sadly different path for Iran, which in 2001 initiated the International Year of Dialogue among Civilizations at the United Nations.

Hanson stated Lutherans' commitment to an open and honest relationship with the Jewish community. He cited the presence of the former General Secretary of the World Jewish Congress, Gerhard Riegner at the 1984 LWF Seventh Assembly in Hungary, as a signal to a new start in the dialogue between Jews and Lutherans at the global level, "addressing the lamentable reality of Martin Luther's anti-Judaic writings and the tragedy of the Shoah."

In a 1994 document, Hanson added, the ELCA itself acknowledges the pain caused by Luther's anti-Judaic diatribes and his violent recommendations against the Jews.

The LWF president stressed Lutherans will continue to work with the Jewish people, Palestinian people, and all other people of good will in the Middle East in an ongoing "quest for mutual respect, hope, and peace for all people in this world."

(294 words)

The full text of the statement by Bishop Mark S. Hanson follows:

LWF President Mark Hanson's Statement on Remarks by Iranian President

In recent days, Mahmoud Ahmadinejad, the president of Iran, has been widely quoted as saying the Holocaust is a "myth," and that the State of Israel should be relocated to Europe, Canada, or Alaska. Earlier, he was quoted as saying Israel should be "wiped off the map."

I join with other religious leaders in condemning these remarks. The historical record of the Holocaust is clear and has stood up under legal and scholarly scrutiny. We have listened carefully to the eyewitnesses, many of whom have lived among us for the last half century. We know and grieve the awful truth of the Shoah. No reasonable person can stand by while any nation's leader makes such outrageous and unacceptable claims. The remarks represent a sadly different path for Iran, which in 2001 initiated the International Year of Dialogue among Civilizations at the United Nations.

The Evangelical Lutheran Church in America and the Lutheran World Federation have worked tirelessly to promote a just and lasting peace in the Middle East for all people. Our efforts have involved conversations with Israeli and Palestinian leaders as well as with Jewish, Muslim, and Christian leaders. We shall not cease our work to seek balanced and reasonable solutions that ensure peace, safety, and security for all people in that troubled land.

In the United States, I have joined with Christian, Jewish, and Muslim leaders in a 12-point plan for Middle East peace. The plan emphasizes a two-state solution, and it calls on the government of the United States to do more to promote a lasting peace in the Middle East. The ELCA Churchwide Assembly in 2005 implemented a Middle East strategy that calls for peace with justice between Israelis and Palestinians.

Moreover, we as Lutherans are committed to a relationship with the Jewish community that is open and honest. At the 1984 Assembly of the Lutheran World Federation, held in Budapest, the presence of Dr. Gerhard Riegner, then retired General Secretary of the World Jewish Congress, signaled a new start in the dialogue between Jews and Lutherans at the global level, addressing the lamentable reality of Martin Luther's anti-Judaic writings and the tragedy of the Shoah. At that time, we jointly affirmed the integrity and dignity of both faith communities and pledged to work together against all forms of racial prejudice.

In its 1994 document, "Declaration of the Evangelical Lutheran Church in America to the Jewish Community," the ELCA acknowledged the pain caused by Luther's anti-Judaic diatribes and his violent recommendations against the Jews. The ELCA expressed its "deep and abiding sorrow" over the tragic effects of these writings on subsequent generations.

In the declaration the ELCA said that "we express our urgent desire to live out our faith in Jesus Christ with

love and respect for the Jewish people. We recognize in anti-Semitism a contradiction and an affront to the Gospel, a violation of our hope and calling, and we pledge this church to oppose the deadly working of such bigotry, both within our own circles and in the society around us. Finally we pray for the continued blessing of the Blessed One upon the increasing cooperation and understanding between Lutheran Christians and the Jewish community."

Nothing can be gained by condemning or showing disrespect for any person, much less an entire people. As Lutherans, we will continue to work with the Jewish people, we will work with the Palestinian people, and we will work with all other people of good will in the Middle East. Together we will continue our quest for mutual respect, hope, and peace for all people in this world.

The Rev. Mark S. Hanson
Presiding Bishop, Evangelical Lutheran Church in America
President, The Lutheran World Federation

FEATURE: Brazilian Lutherans Enthusiastic about World Council of Churches Assembly

IECLB President Altmann: "This Will Strengthen Ecumenism in Our Church and Country"

PORTO ALEGRE, Brazil/GENEVA, 10 February 2006 (LWI) – Since March 2005, Vera Roth has been co-co-ordinator of a women's group, meeting once a month and "working non-stop like bees with order and peace," as aptly described in the group's name, *Colméia* (Portuguese word for beehive). The ten-member inter-religious voluntary team including fellow Lutheran, Elaine Neuenfeldt, is one of several working groups that have been getting ready to receive participants in the 9th Assembly of the World Council of Churches (WCC) to be held in Porto Alegre, Brazil, 14–23 February 2006.

"God in your grace, transform the world," is the theme of the assembly bringing together around 3,700 participants from churches all over the world. It is the first time since the WCC's 1948 founding that a meeting of its highest governing body is taking place in Latin America.

At the assembly, *Colméia* will be the name of a women's space to allow delegates, Brazilian and other women visitors to meet with women coming to the Assembly, discuss Brazilian and Latin American women's concerns and link these to global ones, or simply to rest and be silent. "Active participation" has been the group's motto since its formation, and during a pre-assembly meeting of Portuguese-speaking women, held 12–16 August 2005 in São Leopoldo, Rio Grande do Sul State, with around 50 participants from Angola, Brazil, Mozambique and Portugal.

The Colméia group co-coordinator, Ms Vera Roth
© Ricardo Figenbaum

Honored to Co-Host Assembly

Roth and Neuenfeldt are members of the Evangelical Church of the Lutheran Confession in Brazil (IECLB), which has been working alongside other WCC member churches in hosting the assembly under the auspices of the Brazilian National Council of Christian Churches (CONIC).

IECLB president, Rev. Dr Walter Altmann is enthusiastic about the "unprecedented anticipation for this ecumenical event, the biggest of its kind ever to take place in Latin America."

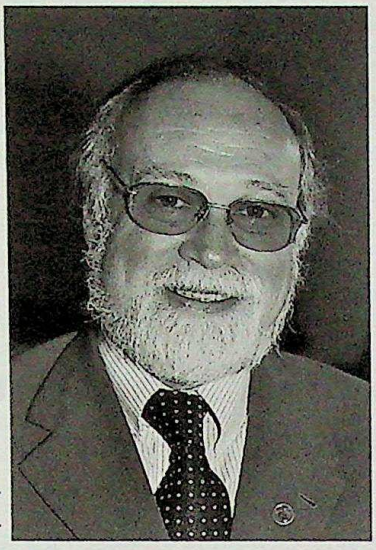
"We feel honored and happy that the assembly will be held in the city of Porto Alegre, where the IECLB has its headquarters, and in the [southern] region that is home to the largest number of Lutherans in Brazil," he stresses. The IECLB, with a membership of around 720,000 is the largest member church of both the Lutheran World Federation (LWF) and WCC in Latin America.

Ecumenical Progress, Commitment

Altmann speaks of the steady ecumenical progress and commitment which is reflected in the church's constitution. "The WCC Assembly will be an unparalleled opportunity for Lutheran congregations and members to meet with church representatives from all over the world. It will be a chance to encounter other churches, their theologies, practices and ecumenical efforts. In turn they will see how the IECLB and other churches demonstrate their faith in Brazil. This will certainly strengthen ecumenism in our church and

country," says the Lutheran leader, a member of the LWF Executive Committee.

The IECLB president is quick to point out the challenges the ecumenical movement must encounter in what he defines as an important transition period worldwide. "While growing religious pluralism proves the importance of religion in people's lives, it can, however, test the credibility of the statement of faith when it manifests itself as mutual competition, rivalry and even conflict. Given the current global circumstances, we hope this assembly will be a strong and convincing assertion of the ecumenical commitment of member churches, and that it will open new paths for ecumenical cooperation," he adds.

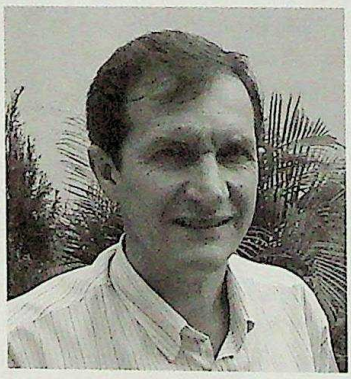


IECLB president, Rev. Dr Walter Altmann. © LWF/H. Putsman

As well as the active participation of Lutherans in 18 voluntary assembly working groups, the Lutheran School of Theology will lead an important meeting on ecumenical theology, bringing together theologians mainly from Latin America but also some from other continents. "These events will undoubtedly have long-term positive effects on the IECLB's ecumenical life," according to Altmann.

Unique Opportunity to Encounter Different Traditions

Voluntary group supervisor, Rev. Kurt Rieck, deputy pastor of Rio dos Sinos Synod, one of the 18 IECLB synods, describes the WCC event as "a unique opportunity for Lutherans and members of other churches in Brazil to encounter different cultures, ethnic groups and traditions."



Rev. Kurt Rieck, deputy pastor, IECLB Rios dos Sinos Synod. © Cláudio Kupka

Roth, who has worked over several years with IECLB women's groups echoes this sentiment. "The Assembly is an important moment in my worship life and the work of my church," she says. "Ecumenism is part of the Lutheran faith. I wouldn't consider myself Lutheran without the ecumenical side."

Other IECLB-related organizations that will be involved in the ecumenical partnership program during the event itself include the Lutheran Diakonia Foundation; Support Center for Small-Scale Farmers; Mission among Indigenous Commission—a commission focusing on issues of land, health, education and indigenous rights; Lutheran People's Ministry; Evangelical Center for Diaconal Ministry and the National Youth Ministry.

A number of congregations and parishes in Porto Alegre and nearby cities in Rio Grande do Sul are preparing to receive the WCC Assembly participants for Sunday worship, February 19. In addition to communal worship, congregation members and Assembly participants will share lunch together.

The WCC is a fellowship of over 340 Protestant, Anglican, Orthodox, and united and other churches in over 100 countries representing more than 550 million Christians. Nearly half of the 140 LWF member churches worldwide are affiliated to the WCC.

The LWF's delegated representatives to the 9th WCC Assembly are General Secretary, Rev. Dr Ishmael Noko, and Assistant General Secretary for Ecumenical Affairs, Rev. Sven Oppegaard.

(893 words)

(Contributed by Susanne Buchweitz, press advisor, Lutheran Diakonia Foundation.)

Former LWF President Krause Receives Ecumenical Award

The Focolare Movement has conferred the 2006 Klaus Hemmerle Award on Bishop emeritus Dr Christian Krause, a former president of the Lutheran World Federation (LWF), for his dedication to the ecumenical movement.

The award commemorates Roman Catholic Bishop of Aachen, Klaus Hemmerle (1929–1994), a pioneer of ecumenical life in Germany, and renowned theologian with ties to the Focolare Movement.

In his tribute to Krause during the January 20 ceremony in Aachen, Germany, Münster theologian Dr Wilfried Hagemann, particularly praised Krause's commitment to the Joint Declaration on the Doctrine of Justification. The declaration was signed in October 1999 by representatives of the LWF and the Roman Catholic Church in Augsburg, Germany.

Hagemann described Krause as a bridge builder. "Today we are honoring a Christian who devotes all his energy to the unity of the church." Krause, LWF president, 1997–2003, was bishop of the Evangelical Lutheran Church in Brunswick, Germany.

The non-remunerated award recognizes individual commitment to promoting unity and dialogue in church and public life. This was the second time the award was conferred this year. Jewish professor Ernst Ludwig Ehrlich from Basel, Switzerland, was the first recipient.

Established in 1943 in Trient, Italy, the Focolare Movement is a Roman Catholic lay movement currently represented in more than 180 countries worldwide. In addition to ecumenical engagement, the movement is particularly committed to promoting dialogue between religions. *(231 words)*

FEATURE: Norwegian Free Church Opens Way for Women's Ordination

Hospital Chaplain Katrine Bråtane Begins Her Dream Job

OSLO, Norway/GENEVA, 24 January 2006 (LWI) – Fifteen years ago Katrine Bråtane was treated at Sunnaas Rehabilitation Hospital (SRH) in Nesodden outside Norway's capital city, Oslo. Since 16 January 2006 she is back there, but this time round as the first woman in the Evangelical Lutheran Free Church of Norway (ELFCN) to work as a hospital chaplain.

Rev. Katrine Bråtane. © ELFCN/Ole Angell

"I've been dreaming of a job like this for a long time and I'm so grateful for this opportunity. In this line of work you meet people in a very fragile period of their lives, and you can show them that there is hope," 26-year-old Bråtane told *Budbæreren*, the ELFCN bi-weekly newspaper.

Her January 22 ordination in Oslo was significant in the ELFCN, which amended its constitution in July 2005 to allow the church and its congregations to call women for ordination as pastors or elders. On January 15, Bjørg Rødland, 45, was ordained as an elder of the Vågsbygd congregation, near Kristiansand in the south. Four to five women's ordinations are expected in the first half of 2006.

The ELFCN with nearly 22,000 members holds full membership in the Lutheran World Federation (LWF) since September 2005. It was an associate LWF member church since 1997.

Strengthening Diaconal Ministry

"I was surprised when the synod board contacted me with the job offer, but it's great that the Free Church also focuses on diaconal ministry now," Bråtane said of the call to serve in part-time position at the hospital, where she also spent four weeks as an intern during her theological studies.

The synod board was unanimous about hiring Bråtane, a member of Kraftverket congregation. "For a long time we have wanted to strengthen our diaconal ministry," said ELFCN Synod President, Rev. Arnfinn Løyning. "Bråtane is an amazing gift to our church. It was exciting to present her with the opportunity to work as a hospital chaplain—talk about fitting right in. We really feel that she does," added Løyning, who led the ordination service.

At the age of eleven, Bråtane was paralyzed from the shoulders down after she was hit by a truck while horse riding. In 2002, she won a historic victory in the case against her insurance company, enabling her to meet financial requirements for the help she needs on a daily basis.

The SRH chaplain feels her situation—getting around in a wheelchair, needing assistance with everything—might be an advantage in her new workplace. "I have had my share of hardships, and therefore I think I have an advantage. People can see that I haven't just cruised through life without problems. But as a pastor I have to consider each individual and see how I can help them," she added.

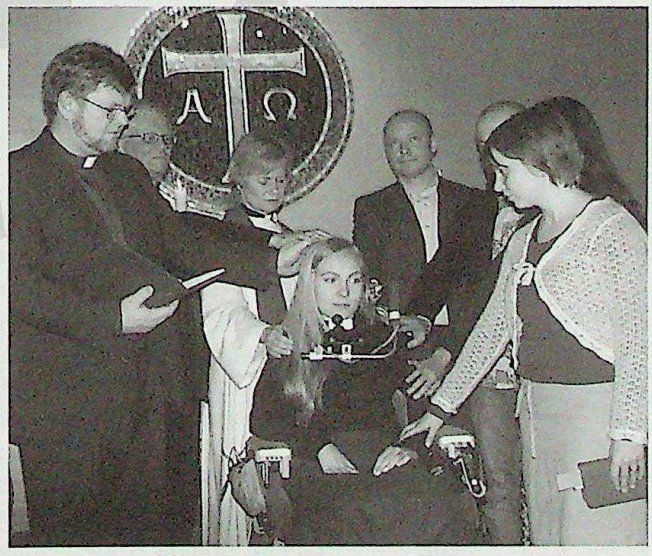
As hospital chaplain, Bråtane's responsibilities include patient counseling, and being available for patients who want to talk about their situation.

Established in 1954 as a university hospital for rehabilitation, the SRH is a 128-bed specialized health institution providing different kinds of comprehensive and multidisciplinary rehabilitation programs for patients who have suffered complex injuries following accidents, or after strokes.

(511 words)

(By Ingunn O. Mercer, ELFCN information department)

***This article is part of the ongoing *LWI Features on Healing* focusing on the LWF Tenth Assembly theme, "For the Healing of the World."**



During the ordination of Katrine Bråtane (middle), from left to right, ELCFN president, Rev. Arnfinn Løyning; vice-president Leif Gunnar Sandvand (partly hidden); Kraftverket congregation trainee pastor Eli Stokka; and other congretation members and friends. © ELFCN/Ole Angell

October

Date	Unit	Place	Title
09-10	DMD	Slovak Republic or Czech Republic (to be determined)	European Sub-regional Consultation: Analysis of Church-State Relationships in Transition
16-20	DMD	Undetermined	Regional Diakonia Network Meeting: Microcredits as a Tool for Development

November

Date	Unit	Place	Title
01-04	DMD	Undetermined	Pastoral and Leadership Seminars for Lutheran Communion in Western Africa – LUCWA
02-09	OEA	Bratislava, Slovak Republic	Lutheran-Orthodox Joint Commission
13-17	DMD	Addis Ababa, Ethiopia	Capacity Building Workshop
17-18	DMD	Tallinn, Estonia	Regional Meeting: LWF Member Churches in the Baltic States and Russia
20-24	DWS	India (to be determined)	Standing Committee for World Service
22-23 or 25-26 (to be confirmed)	DWS	Bangladesh (to be determined)	RDRS (Rangpur Dinajpur Rural Service) 10th Partners Consultation
23-25	DMD	Greifswald, Germany	Preparatory Group: 2007 European Church Leadership Consultation

December

Date	Unit	Place	Title
04-12 (to be confirmed)	OCS/DWS	San Salvador, El Salvador	DWS Latin America and Caribbean Regional Communication Training Workshop
Undetermined	OEA	Geneva, Switzerland (to be confirmed)	LWF-ILC Meeting

Undetermined

Date	Unit	Place	Title
Undetermined	OGS/OIAHR	Nairobi, Kenya	Interfaith Youth Consultation "Africa's Image Today"
Undetermined	OGS/OIAHR	Addis Ababa, Ethiopia	IFAPA (Inter-Faith Action for Peace in Africa) Commission for Africa
Undetermined	OIAHR	Karasjok, Norway	Consultation on Indigenous Issues
Undetermined	OCS/DMD	Undetermined	European Regional Meeting: LWF Youth Leadership Training in Communication Program

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PORTES OUVERTES

Life Motivations

Samedi 25 et dimanche 26 mars 2006 de 10:00 à 18:00

Venez découvrir notre centre multilingue (Français – English – Español - Deutsch), ses activités et ses thérapeutes

CONFÉRENCES

Time	Samedi	Langue	Dimanche	Langue
10:00 - 10:30	Aromatherapy - Zoë Henderson	ENG	Readings & Healing - Zoë Henderson	ENG
10:45 - 11:15	Hypnotherapy / EFT Tatjana Radovanovic	ENG	Thérapie Craniosacrale Therese Desorbay	FR
11:30 - 12:00	Coaching / Counseling / Breathing / Workshops - Isabel Contreras	ENG	Coaching / Conseil / Respiration / Ateliers - Isabel Contreras	FR
12:15 - 12:45	Kinésiologie - Leila Turner	FR	Déprogrammation généalogique / problèmes d'allergies / Ostéopathie - Pascale Saddier	FR
13:00 - 13:30	Craniosacral Therapy Therese Desorbay	ENG	Attention deficit disorder (ADD) and Hyperactivity / Coaching Sarah Keyser	ENG
13:45 - 14:15	Detox and Nutrition – Pura Vita Eva Martin	ENG	Détox et Nutrition – Pura Vita Eva Martin	FR
14:30 - 15:00	Déficit d'Attention et Hyperactivité / Coaching - Sarah Keyser	FR	Kinesiology - Leila Turner	ENG
15:15 - 15:45	Meditation and relaxation Christa Etienne Young	ENG	Hypnothérapie / EFT Tatjana Radovanovic	FR
16:00 - 16:30	Déprogrammation généalogique / problèmes d'allergies / Ostéopathie - Pascale Saddier	FR	Soins énergétiques – Méthode Barbara Brennan - Elisabeth Rinsoz	FR
16:45 - 17:15	Drainage Lymphatique / Réflexologie / Massage Pascal Vuachet / Isabel Contreras	FR	Drainage Lymphatique / Réflexologie / Massage Pascal Vuachet / Isabel Contreras	FR
17:30 - 18:00	Energy healing – Barbara Brennan method - Elisabeth Rinsoz	ENG	Méditation et relaxation	FR

YOGA / PILATES

	Samedi	Dimanche
10:00 à 10:30 et 10:30 à 11:00	Rendez-vous avec nos professeurs qui répondront à toutes vos questions et vous montreront comment les cours se déroulent.	

NOS THÉRAPEUTES

Nous sommes là pour vous accueillir et vous renseigner sur nos thérapies:

Christa Etienne Young:	Méditation et relaxation
Elisabeth Rinsoz:	Thérapie energétique (Brennan Healing Science), massages
Eva Martin:	Détox et Nutrition (Pura Vita)
Isabel Contreras:	Conseil, coaching, respiration, massage rééquilibrant énergétique, Reiki et ateliers
Leila Turner:	Kinésiologie, Facial Harmony
Pascal Vuachet:	Massages relaxants et sportifs, réflexologie, drainage lymphatique, massage anti-cellulite, soins énergétique, Reiki
Pascale Saddier:	Ostéopathie, NAET- problèmes d'allergies, NETPSY, déprogrammation généalogique
Sarah Keyser:	Déficit d'attention et hyperactivité - coaching
Tatjana Radovanovic:	Hypnothérapie, EFT (Emotional Freedom Technique), Reiki
Therese Desorbay:	Thérapie Craniosacrale, Reiki
Zoë Henderson:	Intuitive healing / readings / aromatherapy

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DECEMBER 2005

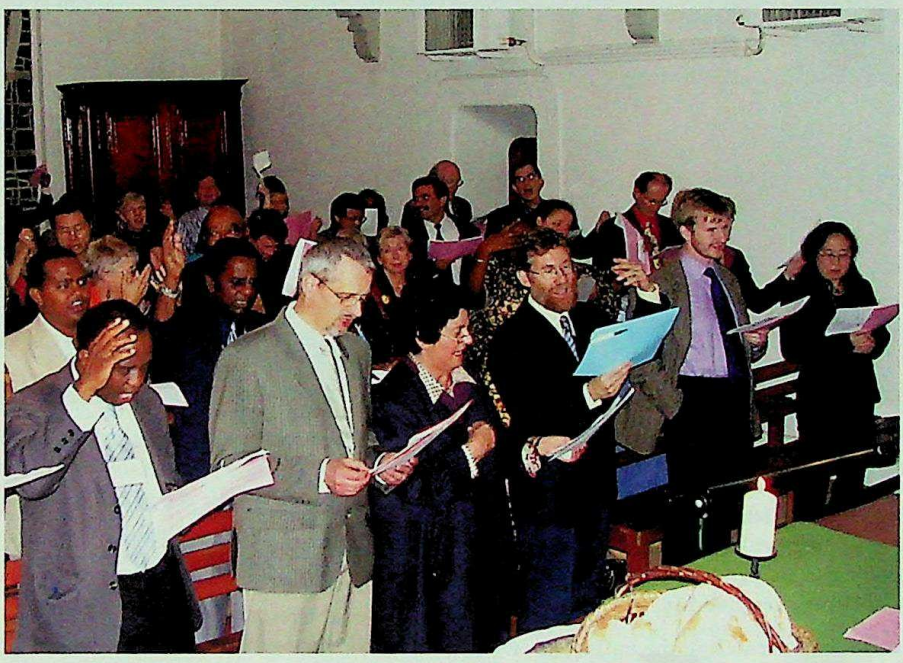
WARC UPDATE

Water and work – Executive Committee meets at Evian

When the 40 members of the Executive Committee of the World Alliance of Reformed Churches (WARC) met at the Centre International de Séjour at Evian, France, in early October, they were faced with two stark realities: the strikingly beautiful Lake Geneva visible from the hillside perch of the meeting site and the thick green folders of documents that awaited their perusal.

Both were ever present throughout the 11-day (6 to 15 October) gathering of the body that oversees the multifaceted ministries of the Alliance between meetings of its General Council.

The theme of the meeting was "Water – God's gift for life" and it was a subject that came alive daily, not just when participants took time to look out over the blue water of Lake Geneva towards Lausanne but when they worshipped, reflected and planned future programmes for WARC.



The Executive Committee members celebrate at the opening worship service. (Photo: Jet den Hollander)

Water played a key role in the twice-daily worship services, serving as the key metaphor for the bounty of God's blessings which humankind has ravaged. A special session was held early in the meeting on the theme, focusing particularly on the scarcity of clean water, particularly for the poor.

As one participant put it, "Every drop counts. Water makes the world look beautiful. Where there is water, there is also life. In fact, it is true, when you save water, you save life."

The meeting was also immersed in the reality of its two host churches, the Reformed Church of France and the Reformed Church of Alsace and Lorraine, as WARC used the time in France as an occasion to become better acquainted with the two member churches.

The opening worship was held in the small church in Evian and the following Sunday the Executive Committee was hosted by the Thonon congregation for worship and lunch. A small team of volunteers assisted with a variety of tasks throughout the meeting.

There was also a dialogue between some members of the French churches and a group of French-speaking members of the Executive Committee. In addition, during the meeting itself a larger session was held on the state of the French church.

One official told the Executive Committee that France's Reformed churches are going through dramatic changes, including losing half of their active members over the past 50 years and suffering a 30 per cent drop in the number of ministers.

The Executive Committee members, coming from nearly 30 different countries in Africa, Latin America, North America, the Caribbean, Asia, Europe, the Middle East and the Pacific, brought their own stories – particularly concerning the ill effects of neoliberal economic globalization.

"In our Latin American and Caribbean countries we are still suffering from the effects of neoliberal policies, foreign debt and the globalized market," said one Latin American member of the Executive Committee.

Not all members were able to attend. The delegate from India was refused a visa by French authorities, an action that prompted a motion calling for a strongly

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worded letter to the French government and underscored ongoing efforts by ecumenical organizations to create a policy on holding meetings in countries where all delegates would be welcome.

The meeting marked the first time the Executive Committee has gathered since the 24th General Council held at Accra, Ghana, in 2004. The papers they received in the thick green folders and those that were added during the meeting represented the Alliance's best efforts to make concrete the many statements of the Accra meeting.

"This meeting is where 'the rubber hits the road.' It is where we take the great visions of Accra and turn them into clear purposes, priorities and programmes," president Clifton Kirkpatrick said in his opening address.

"The passion we expressed and the commitments we made together in Accra have only become more urgent. On the cusp of 2006 the world like never before needs a powerful and united proclamation in word and in deed that Jesus came that 'all might have life in fullness.'"

Setri Nyomi, WARC's general secretary, reminded the Executive Committee members that they were called to leadership in the Alliance at a time when the world is facing major challenges. "We have more threats to creation, gender justice, economic justice, inclusiveness and participation, peace, health and healing and honouring diversity."

But before tackling the multitude of issues that face the world at this time, the Alliance paused to look at itself, laying out a clear vision, callings, a set of priorities and structure. Leaders said that these would bring it closer to member churches while remaining financially responsible.

"It brings us closer to the WARC constituency and closer to the issues we said we would work on at Accra," said Nyomi. Added Kirkpatrick, "What we have now is a purpose-driven Alliance, something our churches have been calling for."

Clifton Kirkpatrick addresses the Executive Committee. (Photo: Peter Kenny, ENI)

The Alliance's new vision statement says, "We are the World Alliance of Reformed Churches consisting of Reformed, Congregational, Presbyterian, Waldensian, United and Uniting churches.

"We are called to be a communion of churches joined together in Christ to promote the renewal and the unity of the church and to participate in God's transformation of the world."

Newly formed networks then met in corners of the Evian centre, pulling together a multitude of programmes that will continue to anchor the work of the Alliance in Reformed theology, justice and youth outreach over the next two years. Included in the justice work are two cooperative efforts on water, one with the World Council of Churches and another with the Lutheran World Federation.

The Executive Committee lamented the fact that there will probably not be any kind of joint assembly with the Lutheran World Federation in 2010 but celebrated the "momentous" step of agreeing to new talks with the Reformed Ecumenical Council, a move that could lead to a significantly deeper relationship, including more collaboration and the possible sharing of projects and personnel.

It wasn't all work. One day was set aside for a trip to Geneva to visit the ecumenical centre, attend regular Monday morning worship there, visit the WARC offices and hear from officials from the World Council of Churches, the Lutheran World Federation and the Conference of European Churches on the state of ecumenical relations.

After lunch there was free time and members of the Executive Committee visited the Reformation Wall and the International Museum of the Reformation and then attended worship at the Cathedral of St. Pierre in Geneva's old town. A dinner at the Calvin Auditorium was hosted by the congregations of the Church of Scotland and the Waldensian Church.

At Evian, there was an informal evening get-together as colleagues from around the world took time to learn the music and dances of their neighbours from all over the world, something that also happened throughout worship time during the meeting.

At the end of the 11 days it seemed the Executive Committee members emerged from Evian clearer in their purpose and programming, closer as a community and firm in their resolve to make the Alliance work as an ecumenical entity despite financial constraints and the broad agenda put forth to try and partner with God in the healing of the broken world.

They left Evian with their green folders bursting at the seams and perhaps with the memory of the lovely setting overlooking Lake Geneva – a reminder of God's many gifts which are to be treasured and passed on to the generations that follow. Evian, then, was about both the water and the work.

Delegates get down to work at Evian. (Photo: Margaret Owen)

Reformed church leaders challenged to be leaders for justice

Leaders of the World Alliance of Reformed Churches (WARC) meeting in Evian, France, in October were challenged to take on the major concerns of a world crying out for justice in the opening addresses by president Clifton Kirkpatrick and general secretary Setri Nyomi.

"The world is crying out. Christ is crying out for our Reformed churches to be the vanguard of a movement for justice in the economy and the earth, to live out the missiologies of life, to be centres of spiritual renewal for a world hungry for the gospel and to be living demonstrations of the unity and fullness of life that God intends for all of humanity.

"Friends, we have our marching orders set before us," Kirkpatrick said. The very fabric of the world is being torn apart by the global economic system that makes a mockery of God's promise that there will be enough for all, he said.

Germán Zijlstra and Elizabeth Delgado Ciézar: globalization continues to hurt Latin America. (Photo: Jet den Hollander)

"It is our core calling to enable Reformed churches everywhere to confess our faith in terms of the fullness of life that God intends for humanity and to call our world to repent of the injustice that is creating massive poverty and environmental degradation and to find a new way where we can all live together in dignity and justice," Kirkpatrick said.

His call was echoed by Nyomi who reminded the Executive Committee members that they are meeting at a time when the world is facing major challenges. "We have an exciting opportunity to make a difference," he said.

Since WARC's General Council met in August 2004, Nyomi said, there are increased threats to the creation, gender justice, inclusiveness and participation, health, healing and the honouring of diversity.

In addition, the ongoing war in Iraq and devastation of HIV/AIDS, the London bombings and natural disasters such as hurricane Katrina and the tsunami of December 2004 "remind us that we live in a world in which the sense of life in fullness is alien to a larger number of communities than was the case before Accra."

Meanwhile reports from WARC's area councils presented at the Executive Committee meeting stated that neoliberal economic globalization is continuing to take its toll on Reformed church members from around the world.

Representatives from churches in Latin America, Northeast Asia and Africa in particular talked about the suffering of church members and the attempts by churches to work for peace and justice in the midst of these problems.

"In our Latin American and Caribbean countries we are still suffering from the effects of neoliberal policies, foreign debt and the globalized market," said Germán Zijlstra of Argentina.

"So these are not easy times for our peoples. Generally, many of them are continuing to experience a situation of social, economic and political crisis, Bolivia being perhaps most recently one of the clearest examples of political instability.

"Violence, lack of respect for human rights and devaluation of the meaning of life are continuing in Colombia. Throughout the continent, marginalization and poverty are situations that are not diminishing."

Despite the troubles in Latin America, Reformed churches in the area reacted immediately to assist churches in Southeast Asia whose members had been hit by the tsunami of December 2004, providing prayers, solidarity and aid.

Churches in WARC's Northeast Asia area also talked about their efforts to support victims of the current economic system, including their fight for human rights for foreign residents.

"The more active churches have initiated several projects to respond to the needs of jobless people, opening shelters and crisis counselling centres and developing job training for the jobless people," said Junko Kikuchi of Japan.

African churches have been busy setting up programmes that will focus on HIV/AIDS, poverty alleviation, economic justice and development.

An opportunity to deepen relationship with Reformed Ecumenical Council

The World Alliance of Reformed Churches (WARC) took a "momentous" step to deepen its relationship with the Reformed Ecumenical Council (REC) at the meeting of WARC's Executive Committee in Evian, France, in October.

WARC has 75 million members in 218 churches in 107 countries. REC has 12 million members in 40 churches in 25 countries. The two bodies, which have 27 common member churches, have been in bilateral talks since 1998.

The Alliance's 40-member Executive Committee agreed to begin a new set of talks with REC aimed at bringing greater cooperation and collaboration, including the possible sharing of projects and personnel.

Talks including four members of each body will begin in early 2006.

The agreement to begin the new process towards a closer partnership was greeted with a standing ovation and spontaneous singing of "Alleluia."

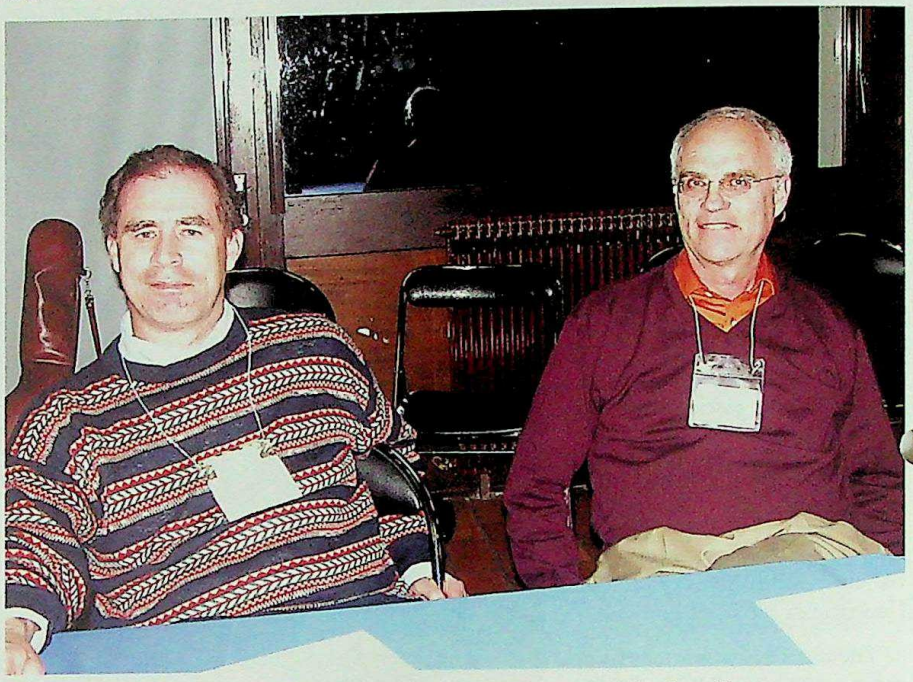
"This is a historic development which will send a strong message from these two organizations that serve the Reformed family," said Setri Nyomi, WARC's general secretary.

"This is a very exciting proposal, one that will be of tremendous benefit to WARC and I hope, REC," noted Alexander Horsburgh of Scotland. Added Susan Davies of the United States, "We have just done something momentous."

A report placed before the Executive Committee stated that the move by the Alliance to accept the invitation from REC to a new set of talks would be "an expression of the Alliance's belief in the reconfiguration of the ecumenical architecture."

When the invitation was made by REC in July at its General Assembly in Utrecht, Netherlands, it was suggested that one possible outcome of the talks could be REC maintaining its identity as an entity within WARC.

However, while recommending the new talks to the Executive Committee, WARC's membership, constitution and by-laws sub-committee expressed concern over the practical operation of the Alliance if REC retains its independence within WARC.



REC was represented by president Douwe Visser (left) and general secretary Richard van Houten. (Photo: Margaret Owen)

Speaking to the WARC Executive Committee, Richard van Houten, general secretary of REC, said, "It's a complex proposal and in the United States we have a saying, 'The devil is in the details.'"

Still, added WARC president Clifton Kirkpatrick, "There is a new energy between us and the Reformed Ecumenical Council that has been growing for years."

Speaking at the REC General Assembly in July, Nyomi referred to the growing closeness between the two worldwide Reformed church communions as a witness to the world in a time when religious differences can result in violence.

The WARC general secretary welcomed the process agreed to by the REC assembly, saying, "When the two organizations dare to journey together in God's mission, our member churches will be served better and, in fact, our witness as Reformed churches will be stronger."

"It is an important contribution that our Reformed family can make to the reconfiguration within the ecumenical movement in the 21st century.

"We live in a broken world in which religion and religious differences are being used by people with vested interest to perpetrate terror, violence and insecurity. This is one reason why Christian communities need to be intentional about reconfiguring the instruments that serve our churches so that we can be better witnesses to our Lord Jesus Christ.

"WARC and REC, which serve the Reformed family, can dare to lead the way," Nyomi said.

Following the meeting in Utrecht, WARC president Clifton Kirkpatrick wrote that he was thrilled by the steps taken by REC and said that he felt that "common witness of the Reformed churches is more critical than ever."

In 2004 REC's van Houten led a delegation that attended the WARC General Council in Accra, Ghana. The two organizations have exchanged stewards for their meetings and WARC was represented at the REC meeting by Nyomi and former vice-president Pieter Holtrop of the Netherlands.

"I hope we will continue to search together for other concrete ways in which we can work together and to be open to the Spirit's leading on how we can serve our churches best. We do have much in common, not the least of which is the common Reformed family we serve," Nyomi said.

WARC and LWF will not meet in 2010

Hopes of a joint assembly of the World Alliance of Reformed Churches (WARC) and the Lutheran World Federation (LWF) in 2010 appear to have been dashed.

WARC president Clifton Kirkpatrick and general secretary Setri Nyomi wrote to the LWF in August asking the Lutherans to hold their next assembly with WARC. The LWF has said that this will not be possible.

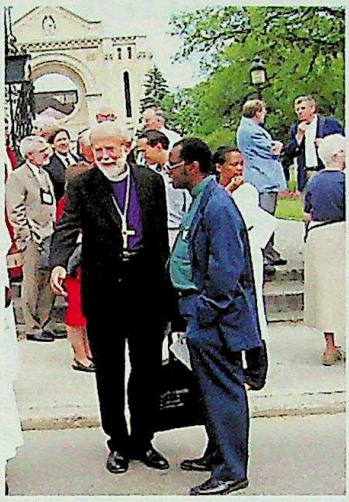
At the WARC Executive Committee meeting in Evian, France, in October, Kirkpatrick was instructed to write formally to LWF president Bishop Mark S. Hanson expressing WARC's disappointment.

"We learned with a deep sense of disappointment that the Lutheran World Federation, while affirming their willingness to consider ecumenical gatherings in the future, decided to proceed on their own with an assembly in Stuttgart in 2010," Kirkpatrick told the WARC Executive Committee.

He added later, "We would have liked to see these two bodies give an example. If it were still possible to do this around 2010, we would still welcome it. It is our understanding that it is not."

In an address to the WARC Executive Committee meeting during a visit to the ecumenical centre in Geneva, LWF general secretary Ishmael Noko said that the Lutherans remain committed to ecumenical cooperation and that there was a need to change the way its assemblies are organized.

However he cautioned against a joint meeting that did not include the World Council of Churches (WCC). "The danger is that we can be misunderstood if we gather only as WARC and LWF," he said.



Bishop Mark S. Hanson and Setri Nyomi: No joint meeting in 2010. (Photo: Peter Kenny, ENI)

In their August letter to the LWF, Kirkpatrick and Nyomi reminded the Lutherans that it has long been a dream of both groups to hold a common assembly, possibly also involving the WCC and other communions.

"Meanwhile, we in WARC believe that we have a unique opportunity for WARC and LWF to set the example – not as the end desired but as an expression of our commitment," the WARC leaders wrote.

In the light of the decision by the Lutherans not to meet with WARC in 2010, WARC's Executive Committee decided to put off making any decisions regarding its next General Council until 2007 and to make any decision in light of the ongoing process of reconfiguration underway in the ecumenical movement and the role of world communions in that process.

WARC will also hold discussions on what being a communion would mean for the Reformed family of churches and have those conversations guide its decision about the next General Council.

WARC and the LWF have been in dialogue on theological issues since the 1960s. In July in 2006 a joint working group will meet in Utrecht to talk about the ecumenical implications for the Joint Declaration on the Doctrine of Justification, the history of Lutheran-Reformed relations and visible structures of church fellowship.

The two groups also cooperate on a variety of projects and have regular joint meetings of their executive staff teams.

South African church enters two-year process of readmission to WARC

The World Alliance of Reformed Churches (WARC) has agreed to a two-year process that could bring the South African church, the Nederduitsch Hervormde Kerk (NHK), back into its membership after a 23-year absence.

The NHK was expelled from WARC in 1982 at the Ottawa General Council over its support of the apartheid system in South Africa.

Meeting in Evian, France, in October, the Alliance's Executive Committee said that the NHK needs to make clear to the churches of South Africa and around the world that it rejects apartheid as sinful and heretical and that there can be no theological or biblical justification for it.

"This will include a full public recognition of the sinfulness of apartheid and its biblical and theological justification that were used to support it as heretical," the Executive Committee decided after hearing a report from the membership, constitution and by-laws sub-committee of WARC.

In addition the NHK has been told to strengthen its ecumenical ties among churches in South Africa and begin a process of conciliation at the local and national levels in South Africa. "The NHK needs to demonstrate steps in becoming a key player in contributing to the transformation of South African churches by bringing racial integration and harmony."

WARC's Executive Committee also authorized a visit to the NHK and its key partners prior to taking a decision on the NHK's future involvement in WARC in 2007.

Vision and priorities bring WARC closer to member churches

The Executive Committee of the World Alliance of Reformed Churches (WARC) has agreed to a new vision, callings, a set of priorities and structure. Leaders stressed that these will bring WARC closer to the member churches while remaining financially responsible.

The Executive Committee, made up of 40 representatives from around the world, took the final steps in approving the vision document after several days of deliberations during its October meeting at Evian, France.

"It brings us closer to the WARC constituency and closer to the issues we said we would work on at Accra," said Setri Nyomi, general secretary of WARC. "People in the regions will now be more of a part of the team."

> *"We are the World Alliance of Reformed Churches consisting of Reformed, Congregational, Presbyterian, Waldensian, United and Uniting churches. We are called to be a communion of churches joined together in Christ to promote the renewal and unity of the church and to participate in God's transformation of the world."*

Added Clifton Kirkpatrick, president of the Alliance, "What we have now is a purpose-driven Alliance, something our churches have been calling for. The networks we have agreed to set up have a huge potential to connect creative people to do the Alliance work in a whole new way."

WARC's new vision statement says, "We are the World Alliance of Reformed Churches consisting of Reformed, Congregational, Presbyterian, Waldensian, United and Uniting churches.

"We are called to be a communion of churches joined together in Christ to promote the renewal and the unity of the church and to participate in God's transformation of the world."

Its new core callings, rooted in the statements of the 24th General Council, are:

- to covenant for justice in the economy and the earth;
- to search for spiritual renewal and renewal of Reformed worship;
- to foster communion within the Reformed family and the unity of the church ecumenical;
- to interpret and re-interpret the Reformed tradition and theology for contemporary witness;
- to foster mission in unity, mission renewal and mission empowerment;
- to promote inclusivity and partnership in church and society;
- to enable Reformed churches to witness for justice and peace.

The smaller Alliance staff, organized in a more flexible structure, and eight networks made up of executive committee members and other volunteers from around the world, will work on numerous programmes organized around the priorities and under a new set of values.

Those values include:

- the renewal of the church by the word of God discerned in partnership and with full partnership with one another;
- conciliarity which is togetherness, mutual accountability, strengthening and learning;
- the commitment to justice, diversity, reconciliation and sufficiency that responds to the cries of suffering people and the groans of creation.

Setri Nyomi: "It brings us closer to the WARC constituency." (Photo: Margaret Owen)

The networks will implement WARC actions and contribute to policy development. A core group within each network includes members of the Executive Committee. The networks will meet regularly by email or by telephone conference call.

The networks include:

- covenanting for justice in the economy and the earth and enabling Reformed churches to witness for justice and peace;
- communion within the Reformed family and unity within the church ecumenical;
- interpreting and reinterpreting the Reformed tradition and theology for contemporary witness and for spiritual and worship renewal;
- fostering mission in unity, mission renewal and mission empowerment;
- gender justice;
- youth;
- fundraising and finance;
- communications.

Alliance networks launch ambitious agenda of programmes

New studies on theology, worship and spiritual renewal.

More gender justice programmes.

Increased youth involvement.

Continued mobilization against economic and ecological injustice.

Just days after being formed at the meeting of the Executive Committee new networks of the World Alliance of Reformed Churches (WARC) began to lay out an ambitious agenda for the next two years.

Core groups of the networks made up of Executive Committee members worked throughout one full day at the meeting making plans which were brought to the full Executive Committee for action.

The networks will be expanded in the coming weeks with resource persons from the member churches.

The network on Reformed tradition and theology, spiritual renewal and worship outlined a number of programmes that keep Reformed theology at the centre of the work of the Alliance. They include:

- a theological study on the Reformed understanding of communion which will reflect on the relationship between covenanting and the question of church communion;
- WARC's participation in a study on the contemporary significance of the 16th century Reformation and in upcoming celebrations of John Calvin's 500th birthday and other significant events;
- an area council-led reflection on how Reformed worship is changing in its various contexts;
- WARC joining Hartford Theological Seminary in the United States in a consultation on Reformed perspectives on religious pluralism;
- A Global Institute of Theology to be held in Geneva in 2008 on the theme of Reformed identity and contemporary witness.

In introducing the broad scope of its programmes which were endorsed by the Executive Committee, the gender justice network made it clear that it will continue to work closely with both women and men.

"In the process of full realization of gender justice in the Alliance and beyond, there is a need for active involvement of men and women at all levels starting with WARC. We recognize that the issues relating to gender justice can be developed only in a genuine partnership of men and women," said Leila Al-Saleeby of Lebanon, moderator of the network.

With that in mind the network agreed to bring more men into its gender awareness programmes and work on the development of male identities which empower both women and men.

The network also agreed to:

- develop a historical study on women's participation in the life and work of the church in a variety of cultural contexts;
- accompany ordained women who are in need of support;
- carry on the work on gender and HIV/AIDS;
- continue the Theological Education Scholarship Fund for Women in the South and make it better known, particularly to those churches who do not yet ordain women;
- maintain involvement with the World Council of Churches on programmes concerning the Decade to Overcome Violence;
- and provide resources that will help WARC member churches develop healthy discussions on human sexuality.

A broad range of programmes planned by WARC's youth network took into consideration "the fact that church leadership in many member churches excludes young people from full participation in many aspects of church life, especially in decision-making areas."

"We implore the Executive Committee to take urgent steps in addressing this disparity," added Marcelle Orange-Mafi of New Zealand in introducing the report of the network.

The Executive Committee then supported the network's plans to encourage WARC member churches to include young people in church structures and decision-making mechanisms. It also agreed to develop a WARC internship and youth exchange programmes within member churches and offer young people opportunities to understand what it means to be part of Reformed churches.

"We feel that the voices of young people are not heard within churches regarding urgent issues which concern them such as HIV/AIDS, human sexuality and globalization," the youth network stated.

The youth network's plans for workshops and consultations, sharing of resources and cooperative efforts with ecumenical partners on these issues were endorsed by the Executive Committee.

WARC will continue to work with its member churches in helping them to understand and implement the statements of the Accra Confession on the church and neoliberal economic globalization as recommended by the covenanting for justice network.

It will also endeavour to share with the wider ecumenical movement the Reformed theological perspectives on justice, an action praised by Susan Davies of the United States who said it was very important for the Reformed world to offer theological input on justice issues.

As an example, she said the Accra Confession is something WARC can share more broadly. "What we have here is a bit of a treasure to offer to our civil societies," Davies said.

The covenanting for justice network will also:

- work to mobilize churches to address economic and ecological injustice;
- monitor and analyse geopolitical issues from a global perspective;
- continue to campaign for the abolition of the death penalty;
- join the World Council of Churches' ecumenical network on water and participate in a series of regional workshops titled "Stirring Waters" with the Lutheran World Federation.

The youth network lays out plans for the next two years. (Photo: Margaret Owen)

"Water – God's gift for life" was theme for Alliance Executive Committee

Every drop counts.

In Evian, France, a community known worldwide for its healing waters, leaders of the World Alliance of Reformed Churches (WARC) took time during daily worship and in a special presentation to consider the theme: "Water – God's gift for life."

WARC also plans to produce a booklet of reflections on water with contributions from Executive Committee members.

During one morning session on the theme the Executive Committee focused on the scarcity of clean water, its privatization and distribution in Africa, Latin America and the United States.

"We live in a world which is blessed with oceans, seas, rivers, streams full of water and yet to some this is a nightmare because millions of people lack good drinking water," said Mulambya Peggy Kabonde of Zambia.

"In this situation water has become an essential commodity which many of our people have to queue for every day."

God provided water so that all could be sustained, therefore this gift from God should be respected, she added.

"Water should not be wasted but be preserved wisely at all costs because it sustains all living creatures. Every drop counts. Water makes the world look beautiful. Where there is water, there is also life.

"In fact, it is true, when you save water, you save life."

Kabonde said that people from the developing world face a scarcity of clean water and therefore it must be preserved. "It is my hope that a lasting solution will be found to uphold the dignity of man and woman that God created in his image for all to have safe and clean water."

Argentinian Astrid Hardtke said that privatization of water in Latin America has taken away the rights of many people. People who cannot pay lose access to water.

Delegates bless each other with water during worship at the Evian meeting. (Photo: Jet den Hollander)

"We have to find a way to protect water and ensure that everybody can have access to it in an equitable way, not forgetting all the other creatures on earth. Using only the necessary amount of water at home and teaching our children is a first step but we must go further than this," Hardtke said.

"Protesting against polluting factories and the wrong use of water and asking for protective laws will help to keep God's gift for life safe."

American Oliver Patterson said he was conflicted as he prepared his presentation in the aftermath of hurricane Katrina which devastated New Orleans, but he added, "I do believe that a powerful stream for disciples of Jesus the Christ is the social justice stream.

"Perhaps, during the last week of August 2005, God let the rest of the world see the underbelly of the United States: the oppressed, the poor, the former slaves. God made it clear that racism is alive and well in the U.S. and that institutional structures are designed to reinforce it."

Seong-Won Park, executive secretary of WARC's department of cooperation and witness, said WARC should make an apology for the role of Christian theology in promoting the notion that the earth is to be dominated, abused and exploited by humankind.

WARC's task should now be to reintroduce the idea that water is more than a mere commodity and is, in fact, God's gift for life, Park said.

Frank talk on WARC's finances

The October meeting of the Executive Committee of the World Alliance of Reformed Churches (WARC) began with frank talk about the state of WARC's finances.

Both president Clifton Kirkpatrick and general secretary Setri Nyomi mentioned the topic in their opening addresses, expressing both concern and guarded optimism.

"We must face up to the financial crisis facing the Alliance," Kirkpatrick said. "Unless we take dramatic steps to find new financial resources and to build a new sense of ownership and responsibility for the Alliance in our member churches, we will have no future."

The Alliance over the past year was operating on a reduced staff. However Nyomi expressed optimism concerning WARC's future and its opportunities to make a difference in the world.

"The challenges facing the world are indeed tremendous. Our institutional challenges, especially with regards to finance, are also many. However we are convinced that with a vision, purpose and clear priorities, we will be able to overcome these challenges."

A report to the Executive Committee from the former finance coordinator stated that WARC's income was reduced in 2004 because of the financial difficulties of many member churches in the North and South as well as the strength of the Swiss franc against other currencies which reduced the value of real income.

The finance and fundraising network told the Executive Committee that the Alliance "cannot function indefinitely in a deficit position."

Executive Committee members heard that WARC's investments were performing well but the network and current finance coordinator Maureen O'Brien made it clear that more income must be generated from member churches and other sources.

With that in mind, member churches were encouraged to set aside one Sunday a year when an offering will be dedicated to the work of the Alliance. And, after some discussion, the minimum annual contribution for member churches was kept at U.S. dollars 500.

During the Executive Committee meeting members took part in a workshop to generate new ideas for fundraising and there was a separate session on how to be ambassadors for the Alliance. In addition both a staff fundraising task group and the finance and fundraising network are working on ways to generate more revenue.

After much discussion the Executive Committee approved a 2006 budget of 2.4 million Swiss francs.

In the midst of the numerous open discussions on the state of WARC's finances, the moderator of the Alliance's finance committee from 2004-2005, Gottfried Locher, concluded: "I think we have a common sense of urgency now."

French church faces new challenges 100 years after church-state law

One hundred years after the official separation of church and state in France, the country's secular stance faces new challenges due to shifts in the religious landscape, says a top Reformed church leader.

The French church faces new challenges, said Marcel Manoël, president of the Reformed Church of France (centre). He is accompanied by Jean-Paul Humbert, president of the Reformed Church of Alsace and Lorraine. (Photo: Margaret Owen)

Protestants – a tiny minority in traditionally Roman Catholic France who were historically persecuted – welcomed the separation of church and state in 1905 because it allowed them to exist "on equal terms with Catholicism," the head of the Reformed Church of France, Marcel Manoël, told the Executive Committee of the World Alliance of Reformed Churches (WARC) at Evian.

But the change in France's religious make-up is fuelling mistrust, conflict and a sort of "secularist rigidity," Manoël noted in his October address.

Among changes highlighted by Manoël have been the growth of Islam and the mushrooming of new religious groups. Though no official statistics on religious affiliation exist, Muslims are reckoned to account for between five and 10 per cent of France's 60 million population.

Still, suggested Manoël, "The Muslim presence has become more visible but there is no certainty that the way they practise their religion will not change profoundly in a secular culture."

In recent years there has been fierce debate about whether female Muslim students may wear the Islamic headscarf to school and the adoption by parliament of a law against sects in 2001, generated strong criticism from Protestant and Catholic leaders.

Protestantism remains largely supportive of the secular stance because it prevents "any religious take-over of power in politics," noted Manoël, the president of the Reformed church's national council. But, he cautioned, there was a need for vigilance because the religious freedom of some groups was not always guaranteed.

"Evangelical groups are suspected of being dangerous sects, immigrant churches, particularly African churches, suspected of political scheming, or church movements and agencies discriminated against because they clearly affirm their Protestant identity," he said.

This means the more established churches have to react. "We have to show our solidarity," he said.

The growth of immigrant churches in big cities is also affecting traditional denominations, the Protestant leader said. "In the beginning they were ethnic churches and then they opened up to the French public," Manoël explained. "The question is how to demonstrate that in our diversity we are the one church of Jesus Christ."

In other ways, too, the Reformed church, which, with about 300,000 adherents is France's biggest Protestant denomination, is experiencing dramatic changes.

The number of active members has halved over 50 years and congregations in traditionally Protestant areas – especially the countryside – have shrunk and there has been a 30 per cent drop in ministers. Still, parishes in big cities like Paris are now growing and more people, especially women, want to become pastors.

In the past, Protestant church participation was passed down through the family, noted the church leader. Now interest is shown from people with no traditional links to the Reformed church, like "Catholics disappointed with their church as well as evangelicals and non-believers," Manoël added.

"Without doubt there are fewer people but they are more active," he asserted. "We are beginning to see a new way of being the church which is less about organizing members and more about helping them to witness in contemporary society."

Ecumenical News International

New WARC Mission Project to start in 2006

A new Mission Project was authorized by the Executive Committee of the World Alliance of Reformed Churches (WARC) at its Executive Committee in October.

The new project arises out of the work of the Mission in Unity Project which has been jointly sponsored by WARC and the John Knox International Centre but will conclude at the end of 2005. The new project will be based at WARC.

It results from a mission consultation in February 2005 and the deliberation of WARC's Officers and Executive Committee as well as analysis both of recommendations on mission that came out of the 24th General Council and of the current priorities of mission partners.

The network core group on mission, including Roberto Jordan and Elizabeth Delgado Ciézar, deliberated on the six new priorities of the new WARC mission project. (Photo: Margaret Owen)

The outcome is a small project, initially for five years, with a limited number of programmatic foci. Like the Mission in Unity Project, the new project has its starting point in the Reformed family but keeps as its horizon the whole church and its ultimate reconciliation.

"The challenge for the church of Jesus Christ is to rethink its nature and calling, to recognize unity as God's gift and then be changed by interacting with others. For the world church but also for our own Reformed family, this is a major challenge," said Jet den Hollander, executive secretary for both the new Mission Project and its predecessor.

The new project has six priorities, including:

- mission study, reinterpretation and empowerment;
- international mission relations;
- new expressions of Reformed unity;
- relations and cooperation of historic and immigrant churches of the North;
- theological education for mission in unity;
- documentation and networking.

WARC member churches, sister organizations, mission communities and other strategic partners have been invited to co-finance the venture and some have already made commitments.

In speaking about the project prior to the Executive Committee meeting, den Hollander said she was enthusiastic about the new project which is to be launched at an interesting time in the life of WARC and its member churches.

"Mission means different things in different contexts. That is why the life and witness of WARC member churches around the globe show such a fascinating variety. Common to all our churches, however, is the need for ongoing reflection on what it is that God is calling us to be and do, here and now.

"What kind of faith response does our context today demand? What kind of mission legacies shape our witness? Do the motives, priorities, methodologies, relationships and structures for mission which we inherited enhance or hinder our faithful witness? Who are God's partners in our context? How does such partnership find concrete expression?"

Den Hollander said the Mission in Unity Project has been working with churches to ask these questions for some time. Now there is the input from the WARC General Council at Accra and its focus on the intolerable levels of economic injustice and ecological degradation which have further highlighted the need for a mission praxis that takes seriously the structural dimensions of sin.

With that in mind, the General Council called for new approaches to mission empowerment, mutual learning and pilot schemes to help transform unequal mission relations into new models of sharing and relating.

Immediately following the Executive Committee meeting in October a transfer meeting was held in Geneva involving WARC and the John Knox Centre to allow the essentials of the Mission in Unity Project to continue in the new, broader Mission Project.

Den Hollander is inviting churches who wish to participate in pilot schemes on mission, those with stories about their mission or those looking at re-examining how their theological and mission formation fosters mission praxis, to be in touch with her.

"The Reformed family needs your insights and experiences. WARC looks forward to walk, talk and move forward with you in mission," she said.

The Lombard Prize: one thousand U.S. dollars for best theological essay

The theme for the 2005-2006 Lombard Prize was set by the Executive Committee of the World Alliance of Reformed Churches (WARC) at its October meeting at Evian, France.

It is: "Water, source of life: socio-economic, theological and interreligious perspectives."

The prize is named after the late Georges Lombard, the general treasurer of the Alliance from 1948 to 1970, whose family, along with the Lombard Odier Darier Hentsch Bank, established the award for essays written by young theological students and young pastors from WARC member churches.

Confidance Worlanyo Kwasi Bansah received the Lombard prize presented by Salome Twum, WARC Executive Committee member.

The U.S. dollar 1,000 prize goes to the best essay of between 5,000 and 6,000 words, written in English. Submissions for the 2005-2006 prize must be sent electronically to WARC (warc@warc.ch) by 30 April 2006. An independent jury will judge the submissions.

The prize, which has been awarded every two years, has two past winners.

Odair Pedroso Mateus, WARC's executive secretary for theology and ecumenical engagement, explained the significance of the prize. "The Lombard Prize is meaningful from the perspective of theological students. It stimulates and rewards theological imagination. It offers an attractive financial compensation. It is a door that might open many other doors to theological students willing to pursue further theological research.

"It's a prize that is designed for young people," he added. "We wanted young people to be involved in Reformed theology. We are encouraging the new leaders of the Reformed churches."

He said that those submitting essays will be encouraged not just to show that they can learn theology but relate it to the emerging issues of our time. That is why the theme will be water, Mateus said.

"If the human relationship to water does not change in the coming years, two-thirds of the world will soon not have free access to clean water. That is the importance of this topic for church life and witness."

The 2003-2004 Lombard Prize was presented to Confidance Worlanyo Kwasi Bansah, a young pastor of the Evangelical Presbyterian Church, Ghana, at the church's 64th synod. The presentation, which included a cash prize, was made by WARC general secretary Setri Nyomi and Executive Committee member Salome Twum.

Bansah was awarded the prize for his essay on "The Good Samaritan Today: Salvation, Solidarity and Mission." The presentation was delayed until Nyomi's August visit to Ghana.

In 2001 Sifiso Mpofu of the United Congregational Church of Southern Africa and S. Muthu Raj of the Church of South India were presented with first and second prizes. Their topic was "How Reformed worship and theology can learn from and influence financial institutions at the present time."

United Church of Christ in U.S. endorses same-sex marriage

The United Church of Christ has become the first major denomination in the United States to endorse same-sex marriage.

In a move heralded as historic by gay rights proponents and criticized by opponents of same-sex relationships, the church's General Synod, meeting in Atlanta in July, voted overwhelmingly in favour of a resolution that "affirms equal marriage rights for couples regardless of gender."

The resolution does not establish a policy for the 1.3-million-member denomination because the church has an autonomous governing structure and the denomination's churches are under no obligation to follow the synod's recommendations.

John H. Thomas, the denomination's president, noted the symbolism of adopting the resolution on the U.S. Independence Day holiday.

"On this July fourth the General Synod of the United Church of Christ has acted courageously to declare freedom, affirming marriage equality, affirming the civil rights of same gender couples to have their relationships recognized as marriages by the state and encouraging our local churches to celebrate and bless those marriages," he said.

Before the vote, opponents of the measure expressed their displeasure with the resolution and several said that some United Church of Christ congregations might leave if it were approved.

Ecumenical News International

Women's gathering links economic justice and gender equality

An international gathering of Reformed church women has stated that there is an "inseparable link between ecology, economic justice and gender equality" and participants committed themselves to developing a feminist critique of neoliberal economics.

"This link shows its deathly face when elements of life such as water are privatized and thus become inaccessible for many. Women carry the main weight of the commodification of God's creation.

"The feminization of poverty can be seen in the fact that 60 to 70 per cent of the world's poor are women," the statement said.

The meeting also underscored the impact of ecological, economic and gender injustices on women and the role played by unjust trade rules as well as the International Monetary Fund and the World Bank.

The 24 women gathered in St. Mary, Jamaica, in August to respond to the Accra Confession, a statement of the 24th General Council of the World Alliance of Reformed Churches (WARC), and make visible the economic justice issues raised by it.

The meeting was organized by WARC's former department of partnership of women and men and included pastors, theologians, university professors, economists, homemakers, business executives, journalists and social workers.

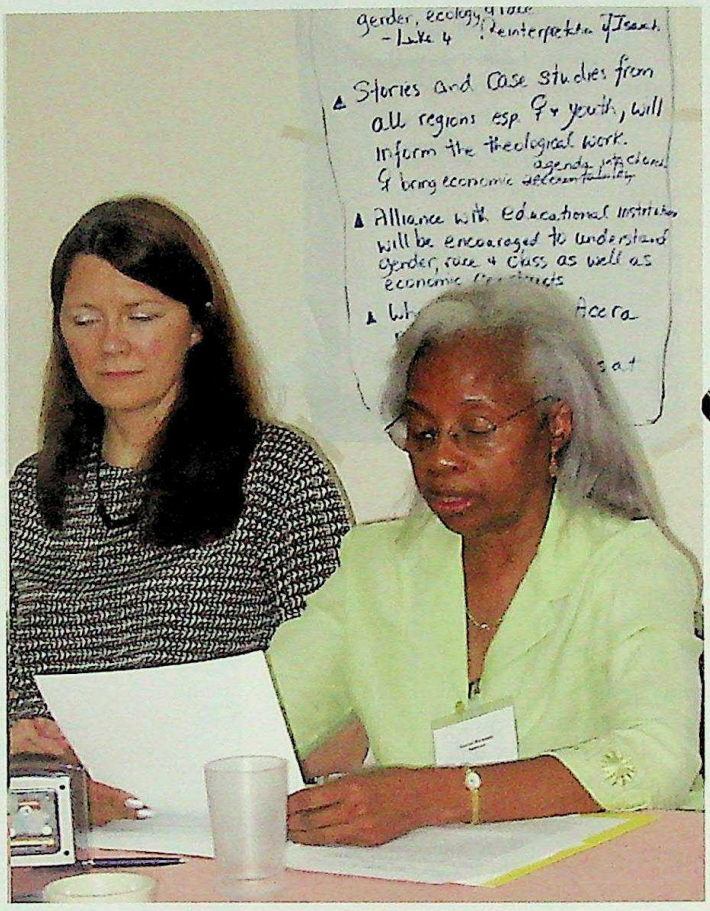
It was hosted by the United Church of Jamaica and the Cayman Islands and participants were given the opportunity of worshipping and interacting with local congregations.

The WARC gathering of women from six countries stated that the language of the Accra Confession is so general that "women are rendered invisible" but called for women in the 218 member churches around the world to analyse the document.

The Accra Confession critiques neoliberal economic globalization and states that working to create a more just economy is essential to the integrity of the Christian faith.

It is a clear indication that despite many gains by women around the world, women still bare the brunt of unjust systems, poverty and violence, as was pointed out by the Women's Pre-Council meeting where 400 women from around the world gathered at Accra prior to the WARC General Council.

"We have taken time to listen to cries of injustice from particular locations in Ghana, Jamaica, the Philippines, Sweden, Canada and Germany, expressing women's experiences of poverty, the impact of racial injustice, HIV/AIDS on women and youth, trafficking in women and children and the effects of neoliberal globalization on women and youth in urban settings," the message from the Jamaica gathering stated.



Judith Van Osdol and Ouida Ridgard spent time grappling with the Accra Confession at the Jamaica women's gathering.

The women agreed to:

- ensure that the Accra Confession is more widely distributed;
- develop a feminist economic perspective on the Accra Confession;
- share the Accra Confession with political leaders and other organizations;
- develop liturgical materials that reflect a critical gender perspective;
- work in partnership with other church groups and social movements on economic justice issues.

The meeting affirmed that the Accra Confession places economic and ecological justice at the centre of Reformed churches' theological reflection and faith practices and that "the struggle against the chains of oppression, the yokes of injustice and the captivity of people who are oppressed are valid and central in the ministry of the church."

Despite these affirmations, the women's gathering reflected critically on the Accra Confession, stating that:

- the power imbalance between the genders and the patriarchal and racist structures that justify, support and worsen the crisis for women are not mentioned in the document;
- a number of issues crucial to women (including migration and underemployment) are omitted;

- the reproductive work of women is not recognized.

In assessing the event, Patricia Sheerattan-Bisnauth, the executive secretary of the former department of partnership of women and men, stated that it was an opportunity to hear again that those on the periphery of society must be brought into the movement of centring on globalization.

"The Accra Confession is an invitation to women and men to covenant together in naming and denouncing economic violence which is based on power and oppression and is a major threat to the lives of more than two-thirds of the world's population.

"Voices from the margins – such as women, young people, indigenous people and ethnic minorities must be integrally woven to strengthen the fabric of resistance and hope," she said.

The Jamaica meeting – A view from Latin America

From 20 to 25 August in St. Mary, Jamaica, a meeting was held concerning the Accra Confession which was issued at the 24th General Council of the World Alliance of Reformed Churches (WARC).

The purpose of the meeting was to provide a space for women to analyse the Accra Confession from their own perspective and offer a gender interpretation of that document.

Despite the many advances by women in many parts of the world, we are still experiencing violence, poverty and oppression. Because of these terrible and destructive consequences, women firmly support the covenanting for economic justice in the economy and the earth as articulated by the Accra Confession.

However, we need to provide our own reading and interpretation of this statement. There are particular aspects and elements that we want to underline, critique, highlight and bring about concerning the Accra Confession.

The presentations approached the theme from three different vantages: Bible studies on the Accra Confession and gender justice; actions carried out by WARC along with partners; and case studies on economic and gender injustice.

We listened to the story of a divorced German woman who suffers the consequences of the decline of the welfare state in Europe, the story of a black immigrant woman who suffers discrimination in Canada, the stories of many women illegally trafficked from the Philippines and forced into prostitution.

We talked about the slaughtering of women by HIV in Ghana, the negative effect on youth of the neoliberal economic model, the destruction of nature in Jamaica. We also talked about important actions carried out by organizations like Kairos in Canada that are seeking and proposing alternatives to this model.

Women from different parts of the world analysed the Accra Confession from a critical gender perspective, writes Verónica Millenaar (first row, far right).

It was very interesting to work by analysing the real stories of women around the world and build solidarity concerning the pain and urgency of their plights.

We also analysed the elements that were missing in the Accra Confession. Our intention was not to criticize with the aim of rewriting it but to do our own interpretation, pointing out those elements we believed were missing.

The Accra Confession should be used throughout the Alliance churches. In each of our areas we can interpret and analyse its contents. It was very interesting to start a closer dialogue between North and South on the theme of economic injustice. Although economic injustice is much more cruel in the South, the effects on women of the patriarchal system are the same in North and South and an approach that recognizes this fact is necessary to strengthen the work we do together.

One of the challenges presented and proposed was to develop pedagogical structures for education in the local communities about the inseparable link that exists between economic and gender injustice.

The results of this meeting were very positive, offering the possibility to Latin American churches to continue the dialogue with the world on these justice issues that affect so many of our communities.

Verónica Millenaar of Argentina wrote this article for La Voz.

WARC leaders: end global poverty

Leaders of the World Alliance of Reformed Churches (WARC) in recent weeks have made several strong statements both in the United States and the United Kingdom calling for an end to global poverty.

In September Setri Nyomi, general secretary of WARC, joined a long list of international religious leaders at the United Nations in New York City in condemning systemic poverty and calling for the implementation of the United Nation's Millennium Development Goals.

"I am glad this consultation has taken place so that church leaders from different traditions can speak with one voice at the urgency of global poverty. I am glad we are not only speaking to ourselves. But also to the United Nations and national leaders," he said.

"It is indeed an outrage that so many people seem condemned to poverty. Churches have reaffirmed our commitment to strengthen our resolve to be critical partners with governments, ensuring the voices of the poor are heard and that global poverty is addressed from its roots – including the challenging of systems of injustice that continue to impoverish.

"As we congratulate the United Nations in this 60th year, we hope all – governments, religious communities and civil society as a whole – engage fully in comprehensively addressing global poverty."

The Consultation of Religious Leaders on Global Poverty called on all governments to create a just society, build partnerships, promote accountability and transparency, cancel debts, increase development assistance, promote trade justice and end conflicts that exacerbate poverty.

"We recognize that poverty cannot be uncoupled from structures of injustice in the world. We call upon governments to protect human life, defend human rights, foster just economies and create conditions in which all people can fulfill their human potential," the religious leaders stated.

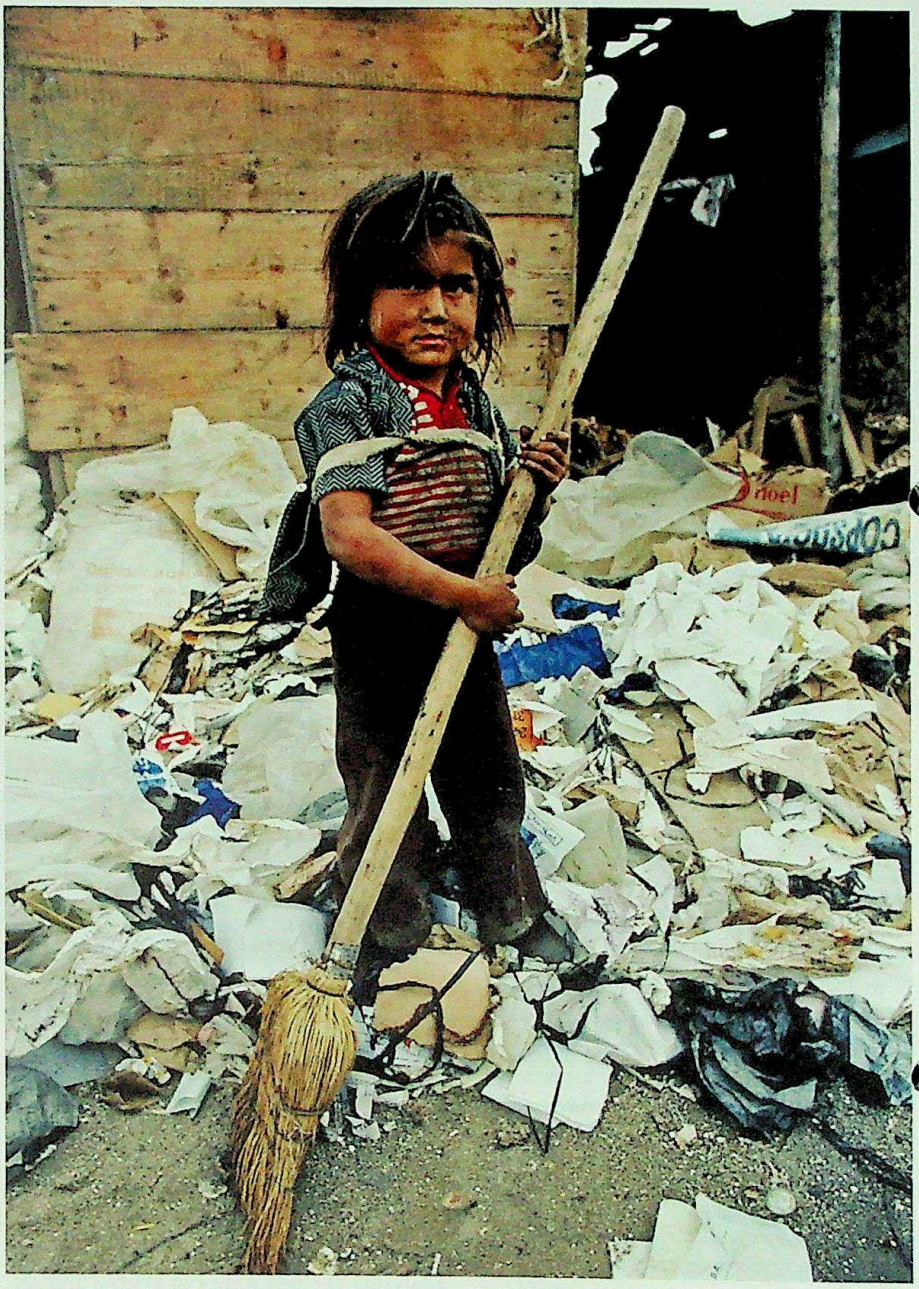
While affirming the development work of churches around the world, the religious leaders also called on those same churches to continue to be active partners in building a just world economy. "As Christian leaders we challenge our own churches to pursue partnerships with governments, international organizations, civil society and across confessional lines.

"Without new strategic partnerships, the world will fail to fulfil the aspirations of the Millennium Declaration," the religious leaders said in a statement.

In another September address WARC president Clifton Kirkpatrick told the World Association of Taiwanese Christian Churches meeting in Houston, Texas, that churches must act on poverty.

"In a world where 24,000 people die each day from hunger and poverty, where countless millions are afflicted with AIDS, where terrorism and state sanctioned violence are rampant and where we are driving our environment to the potential for extinction, we have our task cut out for us.

"We are indeed called to be God's agents of blessing, God's agents for



This young girl is one of millions condemned to poverty. (Photo: UN/DPI)

the fullness of life that this world so desperately needs," Kirkpatrick said.

The WARC president said that Reformed churches around the world must be at the forefront of the movement to end global poverty.

In a July sermon Nyomi said churches must keep the attention of the world on the victims of poverty after meetings of the G8 leaders and the Live8 concerts.

Nyomi was speaking at a special service on the Make Poverty History campaign during the Assembly of the United Reformed Church at Warwick University, Coventry, in the United Kingdom.

He said that many people of faith have long brought issues of poverty and injustice into the public arena with good analysis of the issues and significant action. He praised the Make Poverty History campaign for its added impact.

"This week the world's attention will be focused on the very public gestures that are being made in connection with the G8 leaders' meeting with initiatives attributed to the British government. The media will make us believe what a wonderful bunch they are. We will focus on how good the producers and artists in the Live8 concerts are.

"But let us not forget that very conscientious people of faith have been working tirelessly through churches, Christian Aid and others for a long time and that if the world had been listening we could have made poverty history decades ago," Nyomi said.

While thankful that the debts of 18 countries have been eased by recent gestures by the richer nations, the Alliance leader reminded his listeners that many more people continue to suffer under heavy burdens.

"The Live8 and G8 will come and go but it is the inspiring work of the churches and ecumenical organizations that will need to remain vigilant in our standing with victims of injustice before we can see the back of poverty."

Nyomi said many in the South do not have access to clean water, decent education or good health care because of the burdens of debt and related structural adjustment programmes imposed on them by the richer nations of the North.

"We have millions consigned to prisons of poverty, joblessness, lack of access to health and education. They will remain in these jails because of the world we live in unless the analysis goes deeper."

The WARC general secretary said churches must use every possible tool to help make poverty history.

"Let us commit ourselves to exposing the distortions inherent in the unjust world in which we live and act out of faith together...and expose those who consign fellow human beings to prisons of poverty and injustice.

"Poverty will not be history unless you and I take our analysis deeper. Poverty will indeed be history if you and I dare by faith to remove the distortions in our world and help bring fullness of life to all."

Filipino bishop calls for probe of pastor's killing

Bishop Elizier Pascua of the United Church of Christ in the Philippines has urged President Gloria Macapagal-Arroyo's government to investigate the August shooting of a pastor who campaigned against the entry of mining corporations on the Philippines island of Palawan.

Bishop Elizier Pascua (Photo: Crosslight)

Raul Domingo, who also chaired the Bagong Alyansang Makabayan, an organization calling for government reform in Palawan, south of Manila, died in hospital a few days later.

The bishop's plea has been adopted by 30 church and development groups from around the world, including the World Alliance of Reformed Churches (WARC), through the Ecumenical Advocacy Alliance. They said they were "deeply concerned" about the killing of 34 activists in 2005.

"We condemn the shooting of Pastor Raul Domingo as part of a pattern of persecuting our church workers," Pascua said.

The bishop urged the government authorities to investigate the shooting and "bring to court those who brazenly and arrogantly attack and violate the human rights of church workers like Pastor Raul."

Pascua said he was concerned that there seemed to be "a pattern of shooting church workers who advocate human rights and who are vigilant against big mining companies."

He cited the cases of two other activist church lay leaders in Palawan who were killed by gunmen on motorcycles. One was shot and killed in 2004 and the other in February this year.

Domingo, aged 43, had just alighted from a passenger jeep near his family home in San Jose in Palawan on 20 August when two men on a motorcycle shot the pastor from behind. Residents brought the injured pastor to an Adventist hospital in nearby Puerto Princesa.

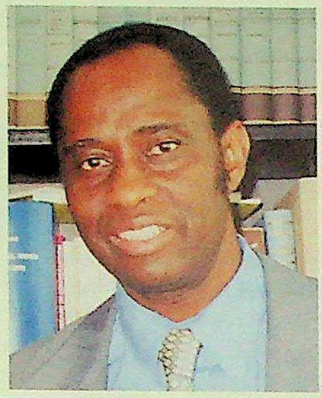
His killing came little more than a month after a fact-finding team from the World Council of Churches (WCC) went to the Philippines to probe the killings of church workers and urged the Filipino president to put an end to the violent deaths.

Representatives of the WCC were invited by the National Council of Churches in the Philippines (NCCP) to take part in the fact-finding mission to probe the killing of church people in July. In a statement following visits to various parts of the country the WCC and the NCCP urged the Arroyo government to take action to stop the pattern of killings.

They said it was "reminiscent of the Ferdinand Marcos' dictatorship" when he ruled the country under martial law from 1972 to 1986.

One of the killings the fact-finding team probed was that of Edison Lapuz, conference minister of the United Church of Christ in Central Philippines, who organized a conference on the ill-effects of big mining before he was killed in May.

FROM THE DESK OF THE GENERAL SECRETARY



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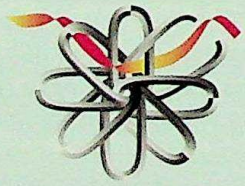

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"Where there is no vision, the people perish." (Proverbs 29.18)

One of the joys of working in the World Alliance of Reformed Churches (WARC) is that we can point to a long history of vision and leadership that has made it possible for us to express our faith in ways that contribute to the transformation of our communities.

The recently concluded meeting of WARC's Executive Committee, which was elected at the 24th General Council, continued that tradition. In its meeting in Evian, France, in October the new Executive Committee demonstrated that the WARC family could indeed be grateful to God for the leadership of the Alliance in this era.

The most important task they set for themselves was to clarify the vision and core callings of the Alliance. This is an expression of their conviction that WARC and its member churches can be effective only if we have a clear vision. Indeed, they agree with the writer of Proverbs who says that where there is no vision, the people perish.

The vision affirmed in Evian is one which is consistent with our self-understanding over many decades. It is one built on values which were articulated in the WARC uniting General Council in Nairobi, Kenya, in 1970.

It states: "We are the World Alliance of Reformed Churches consisting of Reformed, Congregational, Presbyterian, Waldensian, United and Uniting churches. We are called to be a communion of churches joined together in Christ, to promote the renewal and the unity of the church and to participate in God's transformation of the world."

This vision led the Alliance to seven core callings which emerged from the mandates of the 24th General Council:

- to covenant for justice in the economy and the earth;
- to search for spiritual renewal and renewal of Reformed worship;
- to foster communion within the Reformed family and the unity of the church ecumenical;
- to interpret and re-interpret the Reformed tradition and theology for contemporary witness;
- to foster mission in unity, mission renewal and mission empowerment;
- to promote inclusivity and partnership in church and society;
- to enable Reformed churches to witness for justice and peace.

It is one thing for the Alliance in its global expression to articulate this vision clearly and to assert itself as an instrument for life. It is another for its member churches to be equally committed to this or a similar vision. Indeed, if any of WARC's member churches, congregations or individuals operate without a clear vision, they will be ineffective and in some cases a burden on their congregations.

This, therefore, leads me to three questions: Do you have a clear vision? Does your church have a clear vision of what it is and what it is called to be? If you belong to or are a leader in a WARC member church, does your church's vision include expressing itself as part of a communion of Reformed churches committed to transforming the world?

With all the challenges facing the world today, the church, more than ever before, must have a clear vision. We need a vision that enables us to respond to the cries of the hungry, the helpless, the weak and poor in this world in which the gods of economic globalization seem so insensitive to victims of the economies.

We need a vision that enables our churches and individual Christians to be renewed spiritually – where young people feel the relevance of the church in their lives and are therefore found active in our churches on every continent. We need a vision that values working towards greater communion within the Reformed family, a vision which commits us to working for Christian unity.

We need a vision where women and men, young and old, feel they belong and where no one feels excluded, a vision where the church is at the forefront of working towards peace and justice in this broken world.

The Alliance, under the leadership of our president, Clifton Kirkpatrick, and the entire Executive Committee, have led WARC in articulating this clear vision. This vision also undergirds the new structure WARC has put in place. In this era, WARC is making a real effort to include the gifts of professionals and dedicated persons in our member churches as resource persons organized in networks. You may even volunteer to be in our databank of resource persons.

With this vision, we can begin to renew our commitment to work towards transforming the Alliance, transforming the churches and transforming the world.

Setri Nyomi

CEC KEK

monitor

52

OCTOBER 2005

NEWS FROM THE CONFERENCE OF EUROPEAN CHURCHES • **NOUVELLES** DE LA CONFÉRENCE DES EGLISES EUROPÉENNES • **NACHRICHTEN** DER KONFERENZ EUROPÄISCHER KIRCHEN

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Keith Clements: challenges for ecumenism in Europe today

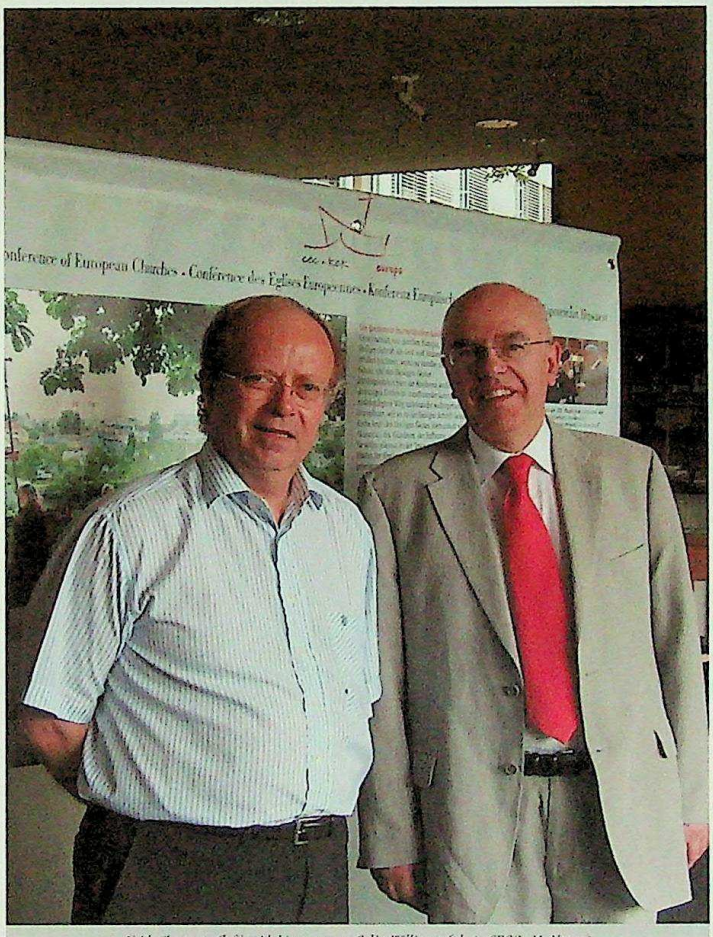
The Rev. Dr Keith Clements will retire at the end of November 2005, after eight years of service as General Secretary of the Conference of European Churches (CEC). The CEC *Monitor* has taken this opportunity to interview him.

You have been the General Secretary of CEC since 1997, just after the Graz Assembly, and you leave after having put into motion the process for the third European Ecumenical Assembly (EEA3). How do you evaluate the evolution of the ecumenical situation in Europe during this span of time?

In some ways ecumenism has become more difficult. The official leadership of all the main church traditions are a great deal more cautious than they were a decade or so ago, and more anxious about maintaining their identity. This leads to each church tending to envision "unity" more and more on its own terms and according to its own ecclesiology. We lack a vision transcending our divisions and inviting us to a common future. At the same time, there is a great deal of impatience with these problems not least on the part of lay-people, clergy at parish level and young people. We must as ecumenical bodies discern where there is this lively interest and commitment, and seek to encourage it rather than give in to defeatist pessimism. This is what makes events like the EEA3 being planned for Sibiu in 2007 so important.

What are, in your opinion, the main challenges for ecumenism in Europe today?

The main challenge is for the European churches to be able to exhibit in their own common life an example of peace, solidarity and sharing that will witness to hope for Europe itself. The "European project" of integration is in crisis because there is no real agreement in the European political leadership at the moment about what that project is for or on which values it should be based. This is at the same time a (literally) heaven-sent opportunity and challenge for the churches. CEC, combining as it does the work of



Keith Clements (left) with his successor Colin Williams (photo CEC/L. M. Negro)

L'œcuménisme selon Keith Clements

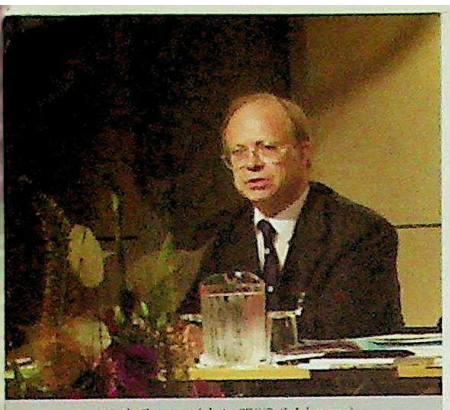
Dans cette interview, le Secrétaire général sortant de la KEK, Dr Keith Clements, évalue la situation œcuménique actuelle. "L'œcuménisme est devenu plus difficile", déclare-t-il. "La direction officielle des principales traditions ecclésiastiques fait preuve d'une plus grande prudence qu'il y a une décennie environ, motivée par le souci de préserver son identité ... Il nous manque une vision transcendant nos divisions et nous invitant à envisager un avenir commun. Nous assistons parallèlement à une grande impatience par rapport à ces problèmes de la part notamment des laïques, du clergé des paroisses locales et des jeunes. En tant qu'instances œcumé-

suite à la page 2

Die Ökumene nach Keith Clements

In diesem Interview beurteilt der scheidende Generalsekretär der KEK, Pfr. Dr. Keith Clements, die gegenwärtige ökumenische Situation. "Ökumenismus ist schwierigier geworden", sagt er. "Führende Persönlichkeiten aller wichtigen Kirchentraditionen sind sehr viel vorsichtiger als noch vor einem Jahrzehnt und weitaus besorgter, ihre Identität zu bewahren... Es fehlt uns an einer Vision, die unsere Trennungen überwinden und uns zu einer gemeinsamen Zukunft aufrufen kann. Gleichzeitig gibt es viel Unwillen über diese Probleme und Fragen, nicht zuletzt auf seiten der Laien, der Geistlichen auf der Gemeindeebene und der jungen Leute. Als

Fortsetzung auf Seite 2



Keith Clements (photo CEC/O.G. Johansen)

suite de la page 1

L'œcuménisme selon Keith Clements

niques, nous devons pouvoir discerner où règne un vif intérêt accompagné d'un engagement et nous efforcer de l'encourager plutôt que de céder à un pessimisme défaitiste. C'est ce qui confère à des manifestations comme le Troisième Rassemblement Œcuménique Européen (ROE3) programmé pour 2007 à Sibiu toute leur importance."

Le principal défi auxquelles les Eglises européennes se trouvent confrontées est le suivant: "Etre en mesure de donner dans leur propre vie commune un exemple de paix, de solidarité et de partage témoignant de l'espérance de l'Europe vis-à-vis d'elle-même. Le projet européen d'intégration est en crise car il n'existe pour l'instant aucun accord réel chez les dirigeants politiques européens quant à la teneur d'un tel projet ou aux valeurs sur lesquelles il devrait se fonder. Cet état de fait représente à la fois une opportunité et un défi pour les Eglises. La KEK qui associe travail de dialogue théologique inter-Eglises et engagement en matière de questions sociétaires, est l'instrument le plus vital dont disposent les Eglises européennes."

Keith Clements poursuit en évoquant les expériences les plus passionnantes qui ont jalonné son mandat, comme par exemple "une veillée nocturne avec le Patriarche de l'Eglise orthodoxe serbe à Belgrade durant les bombardements de l'OTAN en mai 1999" ou encore le lancement de la *Charta Oecumenica* en 2001.

inter-church theological dialogue and engagement with societal issues, is the most vital instrument that the European churches have at their disposal. So it's a challenge for the European churches to make the best use of CEC in the next few years.

What has been the most exciting experience you have had during your tenure? And what was the most difficult one?

Well, various experiences have been "exciting" in different ways. Sitting at night with the Patriarch of the Serbian Orthodox Church in Belgrade during the NATO bombing in May 1999, as the lights went out and we had to continue by candlelight, was definitely exciting. April 2001, the Ecumenical Encounter in Strasbourg that brought together church leaders and young people in equal strength and saw the launching of the *Charta Oecumenica* was a great, positive highlight.

At a slightly different level, not a single event but a process, it has been very satisfying to watch the steadily widening involvement of CEC member churches, from both eastern and western Europe, in the Church and Society Commission since the CEC-EECCS integration of 1999.

The most difficult experience? Undoubtedly very hard was the process of downsizing the CEC staffing level in 1998-99 consequent upon the financial crisis facing us then. Perhaps the most difficult continuing frustration is realizing again and again, despite the excellent work of our communications staff, that so little is known about CEC in some of our church circles.

What are your plans for the future? Do you hope to you continue to be active in the life of the churches?

It really will be retirement, back in the UK. This has been a very demanding job, physically and at every other level and while I'm deeply thankful that the health problem I had in 2000 seems to have been resolved, I need to take a rest.

That doesn't mean being wholly inactive. I shall be at the WCC Assembly in Porto Alegre as a writer, and have some more writing plans. I hope to do some more work on the ecumenical pioneer J.H. Oldham whose biography I had published in 1999, and in the longer-term to write something on what we mean by "Christian Europe." Then there are some invitations to be a visiting lecturer in various parts of the world. Apart from that I hope I can make myself useful as and when required to promoting the ecumenical cause and when my experience can be drawn upon.

What will you miss most in leaving Geneva?

The many friends I've made here and in the CEC constituency as a whole. Worship in the English-speaking Lutheran Church in Geneva. And the view of Mt Blanc and the Alps from my apartment balcony.

What do you most look forward to in returning to Britain?

As well as resuming a m[illegible] normal family life (including becoming a grandfather this December!): English beer, pork pies and slightly better manners on the roads than in some continental countries.

What would you wish for your successor?

As rich an experience as I have had!

Fortsetzung von Seite 1

Die Ökumene nach Keith Clements

ökumenische Gremien müssen wir erkennen, wo es dieses lebendige Interesse und diese lebendige Verpflichtung gibt, und versuchen, diese zu ermutigen anstatt einem vernichtenden Pessimismus nachzugeben. Das ist es, was Ereignisse wie die Dritte Europäische Versammlung, die 2007 in Sibiu stattfinden soll, so wichtig macht."

Die grösste Herausforderung für die Kirchen in Europa ist es, "fähig zu sein, in ihrem eigenen gemeinsamen Leben ein Beispiel des Friedens, der Solidarität und des Miteinanderteilens zu setzen, das von der Hoffnung für Europa selbst Zeugnis ablegt.

Das europäische Projekt der Integration befindet sich in einer Krise, weil es im Augenblick keine wirkliche Übereinstimmung unter der politischen Führerschaft in Europa darüber gibt, welches Projekt dafür ist oder auf welche Werte es aufgebaut sein sollte. Gleichzeitig ist das eine Gelegenheit und eine Herausforderung für die Kirchen. Die Konferenz Europäischer Kirchen, die die Arbeit des zwischenkirchlichen Dialogs und das Verpflichtetsein zu gesellschaftlichen Fragen miteinander verbindet, ist das wichtigste Instrument, das den europäischen Kirc[illegible] zur Verfügung steht."

Keith Clements zitiert weiter die wichtigsten Erlebnisse und Erfahrungen seiner Amtszeit, z.B. "abends während des NATO-Bombenangriffs im Mai 1999 mit dem Patriarchen der Serbisch-orthodoxen Kirche in Belgrad zusammen zu sein" oder im Jahr 2001 die Charta Oecumenica zu lancieren.

Monitor

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Tomas Gärtner aus Dresden ist Templeton "European Religion Writer" 2004

Tomas Gärtner aus Dresden (Deutschland), freier Journalist, hauptsächlich für die Tageszeitung "Dresdner Neueste Nachrichten" (DNN) schreibend, ist mit dem John Templeton Preis "European Religion Writer of the Year 2004" ausgezeichnet worden.

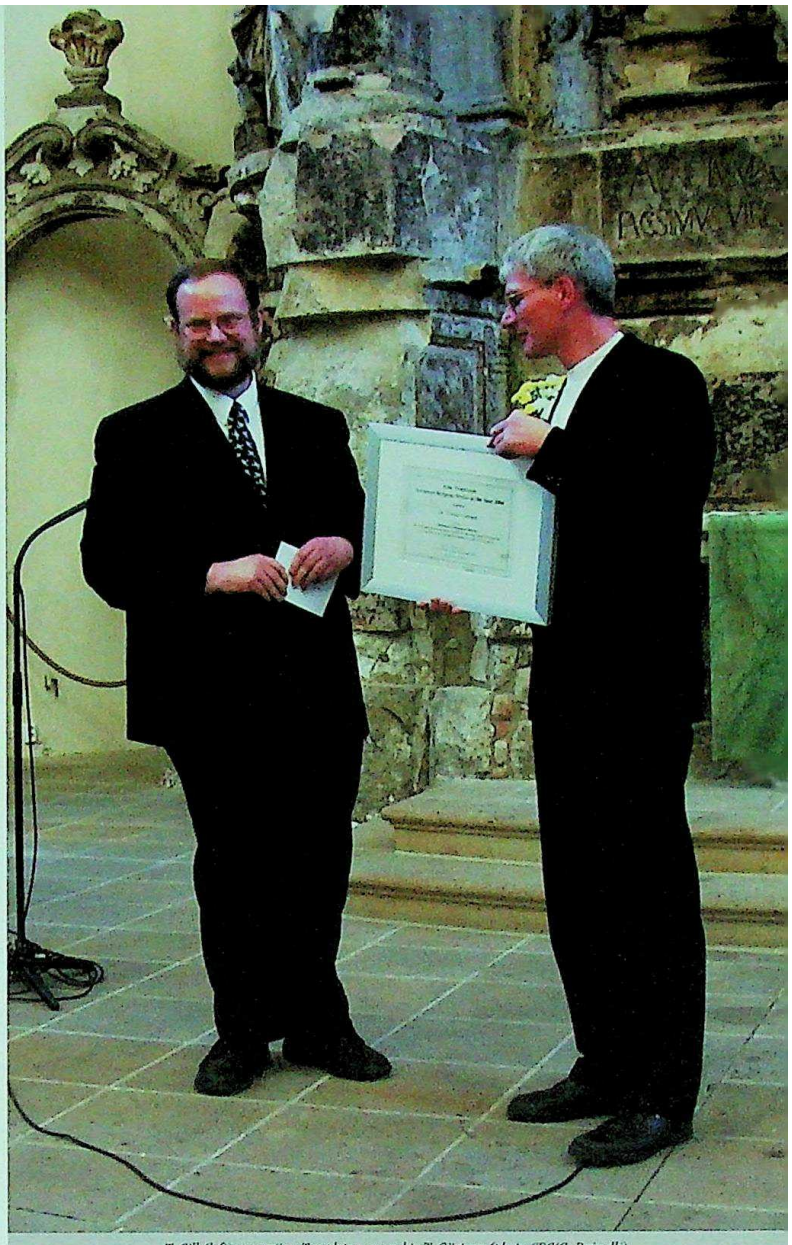
Der Preis, mit CHF 5.000 dotiert, ist im Namen der John Templeton-Stiftung von dem Kommunikationsbüro der KEK verwaltet. Die Preisverleihung fand am 21. September 2005 in der Dreikönigskirche (Haus der Kirche) in Dresden statt, in Zusammenarbeit mit der Evangelisch-Lutherischen Kirche Saxens (siehe unten).

Ziel dieses Preises ist es, Journalisten oder Journalistinnen zu ehren, die in der nicht-religiösen Presse genau, unparteiisch und in einem ökumenischen Geist über religiöse Themen schreiben.

Tomas Gärtner wurde 1962 in Riesa (Sachsen/Ostdeutschland) geboren, studierte Germanistik und Literatur an der Universität Leipzig und hat einen Dr. phil. in deutscher Literatur. Seit 1993 arbeitet er als freier Journalist. Grösstenteils schreibt er für die Tageszeitung "Dresdner Neueste Nachrichten", aber auch für Wochenschriften der protestantischen und römisch-katholischen Kirchen in Sachsen, für christliche Zeitungen (z.B. "Publik Forum"), für die Nachrichtenagentur "Evangelischer Pressedienst" (epd) und für den Radiosender "Mitteldeutscher Rundfunk" (MDR).

Gärtners Beiträge für den Templeton-Preis umfassten drei Artikel, die in DNN erschienen waren. "Obwohl die von ihm eingereichten Artikel", so die Jury, "sich auf lokale Themen bezogen, haben sie doch allgemeine Fragen der Stelle, die die Religion in einem höchst säkularisierten Teil Europas, Ostdeutschland, einnimmt, angesprochen. Tomas Gärtner erzählt seine Geschichten objektiv und gestattet so den Lesern, ihre eigenen Schlussfolgerungen zu ziehen statt ihnen Ansichten aufzudrängen."

Die "Dresdner Neueste Nachrichten" ist eine der zwei Tageszeitungen in Dresden. Die Auflage beträgt etwa 34.000 Exemplare. Eine Besonderheit der DNN ist eine wöchentliche Sonderseite für kirchliche und religiöse Themen.



T. Gill (left) presenting Templeton award to T. Gärtner (photo CEC/G. Rainelli)

European Religion Writer of the Year 2004

The John Templeton prize for the "European Religion Writer of the Year 2004" has been awarded to Dr Tomas Gärtner, a freelance journalist from Dresden, Germany. With the support of the Evangelical Lutheran Church of Saxony, the award ceremony took place in the historical Dreikönigskirchen (Church of the Three Kings) of Dresden, 21 September. The aim of the award is to honour journalists who write about religion in the secular press with accuracy, impartiality and with an ecumenical spirit. It is administered by the Conference of European Churches (CEC) on behalf of the prestigious "John Templeton Foundation".

Dr Gärtner's entry for the Templeton prize included three articles published by the daily newspaper "Dresdner Neueste Nachrichten" (DNN). "The articles he has submitted", said the judges, "although local in focus, address broad issues of the place of religion in a highly secularised part of Europe, Eastern Germany". Tomas Gärtner, the judges added, "tells his stories with objectivity, permitting readers to draw their own conclusions rather than imposing judgements upon them."

The prize, which includes a certificate and a check for 5,000 Swiss Francs, was given on behalf of the Templeton Foundation by the Rev. Theodore Gill, Senior Editor of the World Council of Churches. Rev. Gill recalled Sir John Templeton's passion for "research into the interaction of religion, modern science, technology and the cultures of our time".

OKR Christof Vetter, spokesperson of the Evangelical Church in Germany, underlined the value of Dr Gärtner's reporting on the life of the local church: "Church is where you can see the belltower, where people meet to worship and to help each other. The Templeton Prize has been awarded to someone who does not write about grand assemblies and conferences, but about the grass-roots".

"It is a high art to write about religion in a secular world", said Jochen Bohl, Bishop of the Evangelical Lutheran Church of Saxony. Both as a reader and as a bishop, he said he appreciates Dr Gärtners "solid knowledge of the church and of theological issues".

Thanking the Templeton Foundation and CEC, Dr Gärtner stated he tries "to tell people about the church, not only Christians, but especially those who are strangers to the church". There are many interesting things to report about the church, he said, "besides the three topics we are always beating to death: broken-down churches, not enough money, departing members. Not only is there a wealth of art in the churches, of unique examples of cultural history, of architectural beauty; there is also a wealth of people who don't make pious speeches, but whose faith opens their eyes to the suffering of this world, and they are doing something about it in very practical ways".

European church representatives address the G8 leaders

Representatives of different churches from all over Europe adopted an "Open letter from CEC to the G8 Summit", welcoming "the initiative of the British Government in prioritising the Millennium Development Goals (MDGs), as a focus for the G8". The summit of the world's eight leading industrialised countries was held in Scotland, from 6-8 July 2005.

"A part of the world-wide church, hearing the voice of those in need, we believe in God's commandment to safeguard the world and to guarantee protection of human dignity, social justice and care for God's creation" the document states. "We find it imperative that the G8 delivers in the key areas of multilateral debt, development aid, trade justice and climate change".

The open letter was adopted by the Church and Society Commission of the Conference of European Churches (CEC), gathered in Dunblane, Scotland, from 15 to 19 June 2005.

The plenary meeting of the 24-member Church and Society Commission of CEC has also set priorities and approved a work programme for 2005/2006, focussing on themes such as European Integration, social issues, peace, security and reconciliation, human rights and religious freedom.

The Commission thoroughly discussed several issues such as the "Lisbon Strategy", the European Constitutional Treaty and the issue of peace, security and reconciliation.

Churches have stressed the importance of the overall coherence of EU policies and of the need to keep the spirit of the "Lisbon strategy" for a sustainable development truly integrating economic, social and environmental dimensions alive. Strong concerns have been expressed on the developments of the European Constitutional Treaty following the referenda results in France and the Netherlands and the decisions taken by the European Council at their last Summit.

"The programme adopted by the Commission reflects the interests and strong concerns of European churches for the political developments taking place in Europe", said Rev. Rüdiger Noll, Director of the Church and Society Commission and Associate General Secretary of CEC. "We will keep working in close co-operation with partner organisations and agencies, as well as with other Commissions' desks of CEC, which is the best way for us to keep responding to the challenges coming from the European institutions."

The plenary also held intense discussions on the issue of globalisation, as the Church and Society Commission of CEC embarks in the co-ordination of the European contribution to the General Assembly of the World Council of Churches in Porto Alegre in February 2006.

The full text of the "Open letter from CEC to the G8 Summit" can be found on our website at: http://www.cec-kek.org/pdf/G8 summit.pdf

Church & Society upcoming events

The plenary meetings of the Church and Society Commission of CEC are always and especially the opportunity to plan the future work of the Commission. Other meetings, consultations and conferences also represent vital moments in the life of the commission where relevant subjects are discussed and policy is developed.

Sharing information and developing joint strategies vis-à-vis the European Institutions will be at the base of the *annual meeting of the Church and Society Secretaries* of European churches. The meeting in 2005, which will take place in Brussels on 19-21 October, is the third of its kind in a row. These meetings have proved to be a very important arena to strengthen the network among the church and society secretaries in European churches, to provide a forum of contact between civil servants and decision-makers from the European Institutions and European Churches, and to introduce and discuss relevant issues on the agenda of the European Institutions. This year the focus will be on the implementation of the Lisbon Strategy. The churches' main concern is how to maintain the balance between competitiveness, social cohesion and environmental protection and these will be discussed in the presence of representatives of the European Commission and European parliament. The meeting will also be the right forum to continue the discussion on the future of the European integration process following the referenda on the Constitutional Treaty in France and The Netherlands.

Another opportunity to discuss the Lisbon Strategy and the European Social Policy and to compare different positions on the theme of the shared social responsible society will be the conference organized jointly with Eurodiaconia on *"Towards cultures of quality life for all"*. This conference will take place in Brussels on 22-23 November. The discussion will focus on the future of the European Social Model and will try to address the question "do we have a common vision on how we want to live together as a social responsible society in the European union of the year 2030?". Issues will include: the Lisbon Strategy; the coherence between the European Social Model and the models in the member states; the imbalance of income and wealth in Europe; the compatibility of national social systems; and gender perspectives.

The Church & Society Commission has embarked in the project of coordinating the European Churches' contribution to the WCC Assembly which will be held in Porto Alegre, Brasil in February 2006. A *coordinating meeting on globalization* will provide the possibility for a large number of European delegates to the WCC Assembly to share views on the issue of globalization, on its consequences and on the impact it has on the life of European churches and Christians. The meeting will not only be an opportunity to network before the Porto Alegre Assembly but also to discuss the Church & Society position paper on globalization proposed by the Task-Force on globalization, which was established by the Commission's Executive Committee. On 8-9 December, in Brussels, European delegates will have the opportunity to also form a platform for European churches for the discussion on globalization and to develop a common strategy also beyond the WCC Assembly.

Donatella Rostagno

Participants at the Church & Society Plenary in Dunblane (photo CEC/S. Lamotte)

Des représentants des Eglises européennes s'adressent aux dirigeants du G8

Des représentants de différentes Eglises de toute l'Europe ont adopté une "Lettre ouverte de la KEK au Sommet du G8", se félicitant de "l'initiative du gouvernement britannique de considérer les Objectifs de développement pour le nouveau millénaire comme un point fort retenant l'attention du G8". Ce sommet, réunissant les huit plus grands pays industrialisés, s'est tenu en Ecosse, du 6 au 8 juillet 2005.

"Nous considérons qu'il est impératif pour le G8 de prendre position dans des domaines clés comme la dette multilatérale, l'aide au développement, le commerce juste et les changements climatiques", a précisé cette lettre, adoptée par la Commission Eglise & Société de la Conférence des Eglises européennes (KEK) réunie à Dunblane, en Ecosse, du 15 au 19 juin 2005.

La plénière des 24 membres de la Commission Eglise & Société de la KEK a par ailleurs défini des priorités et approuvé un programme de travail pour la période 2005/2006, mettant l'accent sur des thèmes tels que l'intégration européenne, les questions sociales, la paix, la sécurité et la réconciliation, les droits de la personne et la liberté religieuse.

La Commission a discuté en détail divers points; entre autres la "Stratégie de Lisbonne", le Traité constitutionnel européen, la question de la paix, de la sécurité et de la réconciliation, et le défi que représente la mondialisation.

Vertreter europäischer Kirchen wenden sich an G8 Führer

Vertreter verschiedener Kirchen aus ganz Europa haben einen "Offenen Brief von der KEK an das G8 Gipfeltreffen" angenommen, in dem sie "die Initiative der britischen Regierung" gutheissen, "die Millenniumsentwicklungsziele als eine Priorität für G8 anzusehen". Der Gipfel der acht führenden Industrieländer der Welt fand vom 6.-8. Juli 2005 in Schottland statt. "Wir finden es äusserst wichtig, dass G8 zu Schlüsselbereichen wie der multilateralen Schuldenlast, der Entwicklungshilfe, der Gerechtigkeit im Handel und dem Klimawechsel Stellung nimmt", heisst es in dem Brief.

Der offene Brief wurde von der Kommission Kirche und Gesellschaft der Konferenz Euopäischer Kirchen (KEK) auf ihrer Sitzung in Dunblane, Schottland (15.-19. Juni 2005) angenommen. Die Plenarsitzung der 24-köpfigen Kommission Kirche und Gesellschaft der KEK hat auch Prioritäten gesetzt, ein Arbeitsprogramm für 2005/2006 angenommen und sich auf Themen wie europäische Integration, soziale Fragen, Frieden, Sicherheit und Versöhnung, Menschenrechte und Religionsfreiheit konzentriert.

Die Kommission hat sich auch eingehend mit Fragen wie der "Lissabon-Strategie", dem Vertrag der Europäischen Verfassung, der Frage des Friedens, der Sicherheit und Versöhnung ebenso wie der Herausforderung durch die Globalisierung befasst.

Migration in the Mediterranean region: the "Amman Process"

Many of you will remember the pictures of boats arriving on Italian, Greek or Spanish shores. For several weeks last year the journey of the German ship Cap Anamur was covered by the media. Refugees and migrants who were rescued from drowning had to stay on the boat because the governments of Italy and Malta, as well as Germany, denied responsibility for receiving the persons in need, and assessing if there was a need for refugee protection. The situation of boat people in the Mediterranean Sea is of great concern in the whole region: thousands of refugees and migrants try to cross the sea under unbelievable conditions. Migrants pay an enormous amount for such a trip. As many migrants waiting for their passage in Morocco or Algeria, Tunisia, or Libya, do not have the possibility of an "orderly" travel with visa and regular means of transport, they turn to the smugglers knowing that this entails risks. Traffickers exploit this situation, creating dependence by offering the trip under the condition that the person "works" for them.

The boats are not secure, because the smugglers fear they will loose them, and many smugglers could care less about safety standards. Over the past 10 years, more persons have died trying to cross the Mediterranean Sea to reach Europe than at all other borders in Europe in the previous 50 years. The Italian, Greek and Spanish churches have been bringing this to our attention since the 1990s.

European policies respond to this challenge with more controls and employing military techniques of surveillance. The Mediterranean region is, for economic and strategic reasons, a highly militarised region. In the absence of comprehensive migration management, it is left to military and border guards to control the sea and to detect boats. While in the past years people rescued were often taken to Europe now, many are taken back to the Southern Mediterranean countries immediately.

While a large number of refugees arrive at the Southern European shores, comparably few apply for asylum in these countries. Per 100,000 inhabitants, Portugal had one asylum seeker in 2003, Spain 14, Italy 24, Greece 74, France 87, Malta 115 and Cyprus 547. Cyprus has experience a considerable increase of asylum applications over the past two years, as has Malta. On Malta, a lot needs to be said with regard to the treatment of asylum seekers and refugees which cannot be regarded to be in compliance with standards of the EU asylum directives.

Last year, after the long journey of the Cap Anamour, the Italian government negotiated a bilateral agreement with Libya to return migrants arriving by boat on the Italian island of Lampedusa. Italy pays for the facilities of what are called "reception centers", situated in the desert, this makes contact impossible and affords little hope in finding protection. Libya has not ratified the UN Refugee Convention of 1951 /1968. Libya has returned refugees to Ethiopia and Eritrea.

At the same time, this bilateral agreement was accompanied by a political decision of the EU Council of Foreign Ministers to lift economic sanctions against Libya in autumn 2004. In the recent months, a delegation of the European Parliament visited the centers in Libya and reported that the standards of these centers are inhuman.

The Southern European EU member states Greece, Italy, Spain and Portugal have turned from emigration countries to immigration countries in the past two decades. For Greece, Spain and Portugal, we should remember that until the mid-1970s, they were under military dictatorships, forcing many people to seek asylum and live in exile. Also, the economic situation drove people to seek a better future elsewhere.

The economic situation for the Southern European countries has changed in the last decades in fact, all of them depend, to a large extent, on migrants for the functioning of their economies. This is true particularly for Italy and Spain, but Greece and Portugal also receive a considerable number of migrants compared to other European countries.

The Amman Process is a network of church related organisations which work in the area of migration and asylum within the Mediterranean area. In its actual composition, it has existed since 1996. The members in the Middle East belong to the Middle East Council of Churches (MECC), the Southern European members belong to the Churches' Commission for Migrants (CCME).

In the Amman Process churches co-operate in: Egypt, Palestinian Territories, Jordan, Syria, Lebanon, Iraq, Turkey, Greece, Italy, France, Spain and Portugal.

Its aims are to share information on current and potential developments in the region and the best practices, to develop common analyses about the causes and consequences of migration in the Mediterranean region, to formulate advocacy strategies to insure humane and just treatment for refugees and migrants who do arrive in other countries and to monitor the root causes of forced migration.

The activities of the Amman Process include regular meetings of the network, reciprocal participation at regional meetings, exchange of information on urgent issues, special missions (e.g. into conflict areas), and mutual support for particular situations of need (e.g. in case of violation of human rights in one or the other country).

Issues of discussion in the meetings over the last years have included: inter-religious and intercultural dialogue, the ratification of the UN Convention on the Rights of all Migrants and the members of their families, the effects of the war on Iraq, durable solutions for refugees and refugee resettlement, combating trafficking in human beings, effects of EU policies with regard to the Mediterranean, the Barcelona Process, MEDA Programme and Anna-Lindh-Foundation, and now the European Neighbourhood Policy with specific country action plans. The domination of security policy, particularly with the stigma of terrorism linked to Arab and Islamic countries, has been of great concern to the churches. In this situation, confidence building, maintaining dialogue and identifying areas where change may be possible is of crucial importance.

Doris Peschke (photo CEC)

For the Middle Eastern Churches an important issue, in a situation of violence and unresolved conflicts, is how stability and economic development can be achieved so that people, and very particularly members of the Christian minority churches, do not leave their countries in order to maintain the Christian presence in the region. At the same time, the churches and the services of the Middle East Council of Churches have been carrying out remarkable services for refugees, e.g. Iraqi refugees, but also Pales-

tinian refugees in the region. For the European churches, access to asylum for refugees from the region has been a major focus. With work being envisaged on refugee resettlement, more practical co-operation might be foreseen in the coming years.

Sharing of the work done on both sides of the Mediterranean is an important part of the Amman Process. As an example, the Guidelines for Action against Trafficking in Women, which were elaborated in the project Christian Action and Networking against Trafficking in Women with support from the EU Commission, were translated into Arabic by MECC for use in the region as well.

The issues of migrants' rights in both the Middle Eastern countries as well as in European countries and the protection of refugees remain on the agenda. We hope that the churches will increase their co-operation so that "strangers are welcomed".

Doris Peschke
General Secretary of CCME

This article is an excerpt from Doris Peschke's presentation at the CEC Central Committee meeting in Aghios Nikolaos, Crete, June 2005.

Migration et Méditerranée: le processus d'Amman

Le processus d'Amman est un réseau d'Eglises et d'organisations reliées aux Eglises, actives dans le domaine de la migration et de l'asile dans la région méditerranéenne: Egypte, Territoires palestiniens, Jordanie, Syrie, Liban, Irak, Turquie, Grèce, Italie, France, Espagne et Portugal.

Il poursuit les objectifs suivants: partager des informations sur les développements en cours ou potentiels dans la région et les pratiques universelles; développer des analyses communes des causes et conséquences de la migration dans la région méditerranéenne; définir des stratégies de soutien en faveur d'un traitement humain et juste des réfugiés et des migrants arrivant dans un pays étranger; s'intéresser de près aux causes racines de la migration forcée.

Les activités du processus Amman incluent des rencontres régulières des membres du réseau, une participation réciproque aux réunions régionales, un partage d'informations sur les questions urgentes, des missions spéciales (par ex. dans les zones en conflit) et un soutien mutuel dans des situations particulières, comme dans le cas de violation des droits de la personne dans l'un ou l'autre des pays.

Citons parmi les thèmes de discussion abordés lors des réunions au cours des dernières années: le dialogue interreligieux et interculturel, la ratification de la Convention de l'ONU sur les Droits de tous les Migrants et des membres de leur famille, les effets de la guerre en Irak, des solutions durables pour les réfugiés et leur réinstallation, la lutte contre la traite d'êtres humains, les effets en région méditerranéenne des politiques engagées par l'UE. La prépondérance d'une politique sécuritaire, avec notamment les stigmates du terrorisme en relation avec les pays arabes et islamiques, préoccupe beaucoup les Eglises. Dans ce contexte, l'instauration d'un climat de confiance, le maintien du dialogue et l'identification de domaines susceptibles d'évoluer, revêtent une importance capitale.

Les Eglises du Moyen-Orient sont d'avis qu'il est important de déterminer comment parvenir à la stabilité et au développement économique afin que les personnes, entres autres les chrétiens, n'aient pas à quitter leur pays. Parallèlement, les Eglises et le Conseil des Eglises au Moyen-Orient (MECC) ont rendu de remarquables services aux réfugiés. Aux yeux des Eglises européennes l'accès à l'asile pour les réfugiés originaires de cette région est une question majeure. Une coopération plus pratique pourrait être envisagée au cours des années à venir en relation avec le travail prévu en matière de réinstallation des réfugiés. *(Doris Peschke)*

Annual meeting of the Amman Process Network

The annual meeting of the Amman Process Network was held in Amman, Jordan from 16-18 September 2005. Participants included representatives of the member churches of the Middle East Council of Churches (MECC) and of the Churches' Commission for Migrants in Europe (CCME) as well as experts from the UN High Commission for Refugees and Jordan government officials. At the center of the debate was the issue of the restrictive European policies on immigration, laws proposed concerning the forced return and detention of asylum seekers and irregular migrants, and the risks of bi-lateral return agreements with countries such as Libya. Also discussed was the situation of refugees and migrants in the Middle East, with particular regard to the dramatic situation of refugees from Iraq in the desert at the Jordanian border, of Palestinian refugee camps in Lebanon and of migrants in countries such as the Arab Emirates.

"An efficient cooperation among churches of the Mediterranean defending the human rights of migrants is vital," said Annemarie Dupré, moderator of CCME. Among the priorities for the next year are the monitoring of the European Union's programmes on migration and refugees (including the "Barcelona Process" and the EU Neighbourhood Policy) and work on the issue of "new slavery" in its different forms.

Agenda

OCTOBER

19-21 October, Brussels, Belgium: annual meeting of the Church & Society Secretaries of the European Churches. Info: csc@cec-kek.be

21 October, Paris, France: Celebrations for the 100th birthday of the Federation of Protestant Churches in France. Info: fpf@portestants.org

24-30 October, Turku, Finland: EYCE 35th General Meeting. Info: general.secretary@eyce.org

27-31 October, London, England: CCME Assembly. On 28 October there will be a conference at London City Hall on "Global governance of migration – a response to global migration". Info: info@ccme.be

NOVEMBER

6-10 November, Berlin, Germany: Synod of the Evangelical Church in Germany (EKD). Info: europa@ekd.de

9-12 November, Brussels, Belgium: Conference on refugee resettlement. Info: info@ccme.be

22-23 November, Brussels, Belgium: CEC and Eurodiaconia consultation on "Towards cultures of quality life for all". Info: csc@cec-kek.be

DECEMBER

8-9 December, Brussels, Belgium: European consultation on globalisation. Info: csc@cec-kek.be

Kirche und Film im Dialog: 50 Jahre Interfilm

Gegründet am 22. Oktober 1955 in Paris durch Pioniere evangelischer Filmarbeit ist Interfilm ein internationales Netzwerk kirchlicher Film- und Medieneinrichtungen sowie engagierter Einzelpersonen zur Koordinierung des Dialogs zwischen Kirche und Film. Geleitet von der Basis und den Zielen des Ökumenischen Rates der Kirchen (ÖRK) umfasst es Mitglieder aus den Kirchen der Reformation und der Orthodoxie, aber auch einige jüdische Personen und solche aus der katholischen Tradition, sofern sie nicht im Rahmen der Internationalen Katholischen Organisation für Kommunikation (SIGNIS) tätig sind.

Dass es Interfilm gibt, ist dem beharrlichen Engagement weitsichtiger Persönlichkeiten zu verdanken, die nach den Erfahrungen des zweiten Weltkrieges im Rahmen der ökumenischen Bewegung auf die gesellschaftliche Bedeutung des mittlerweile fünfzig Jahre alt gewordenen Massenmediums Film aufmerksam gemacht und gefragt haben, wie auf die Tatsache zu reagieren ist, dass der Kinobesuch teilweise grösseren Zuspruch hat als der Kirchenbesuch. Es wurde gefragt, was Kirche angesichts dieser Entwicklung tun kann und tun soll und die Antwort darauf war durchaus vielfältig. In Frankreich setzten die Filmenthusiasten vor allem auf das Filmgespräch in Kino, Gemeindehäusern und Kirchen zur Vertiefung und zum besseren Verständnis des ausgewählten kommerziellen Films. In Deutschland und in der Schweiz legte man das Gewicht auf eine von der Werbung unabhängige evangelische Filmpublizistik als Hilfe zur kritischen Beschäftigung mit dem Kinoangebot und auf den Verleih und die Vorführung ausgewählter Filme. Die Angelsachsen dagegen förderten eindeutig eigene religiöse Produktionen, wobei man schnell an die Grenzen der finanziellen Möglichkeiten kam.

Bereits 1960 entschloss sich Interfilm angesichts der begrenzten Mittel und Wirkungsmöglichkeiten die Idee, eigene Filme zu produzieren oder Filmpolitik zu betreiben, aufzugeben. Dies sollten, soweit möglich, die einzelnen Mitglieder in ihren Ländern tun. Dagegen konzentrierte sich Interfilm bewusst auf die Frage von Beurteilungskriterien für die Bewertung von Filmen und auf die Würdigung und Förderung herausragender aktueller Filme, wie sie sich mittlerweile an zahlreichen internationalen Filmfestivals präsentierte. Der Dialog mit der Welt des Films war mittlerweile so weit gediehen, dass Interfilm bereits 1963 an den Internationalen Filmfestspielen Berlin und an der Internationalen Filmwoche Mannheim parallel zu den Preisen der offiziellen Festivaljury einen eigenen Jurypreis an einen Wettbewerbsfilm vergeben konnte. Ein Jahr später war Interfilm mit einer eigenen Jury auch an den Internationalen Kurzfilmtagen Oberhausen präsent und 1969 konnte sogar auch in Cannes, dem renommiertesten Internationalen Filmfestival, eine Interfilm-Jury akkreditiert werden. Zusammen mit der Internationalen Katholischen Filmorganisation OCIC wurde 1973 in Locarno und ein Jahr darauf auch in Cannes eine ökumenische Jury eingerichtet. Die Perestroika machte für kurze Zeit ökumenische Jurys in Moskau und St. Petersburg möglich. Auf Dauer wurden solche nach dem Fall der Berliner Mauer an den Festivals von Leipzig (1990), Karlovy Vary (1994), Cottbus (1999), Bratislava (2001 und Zlin 2002) möglich. Und die Liste der Festivaljurys ist damit nicht vollständig.

Die Jurys verleihen einen Preis (und eventuell Lobende Erwähnungen) an Filme, die sich durch künstlerische Qualität auszeichnen, die eine dem Evangelium entsprechende menschliche Haltung und Aussage zum Ausdruck bringen oder zur Auseinandersetzung damit anregen und den Zuschauer für spirituelle, gesellschaftliche und soziale Fragen und Werte sensibilisieren. Die Mitglieder der Jurys (und damit insgesamt die Mitglieder von Interfilm) lernen dabei, wie wichtig ist, sensibel mit dem Kunstwerk Film umzugehen und eigene kirchliche Traditionen in einer allgemein verständlichen Sprache zu reflektieren. Sie entwickeln ein Gespür für Filmtendenzen, die am Rande stehen, und entdecken das Filmschaffen aus anderen Kontinenten. Sie machen sich stark für Sozial- und Gesellschaftskritik und erkennen, dass Filminhalte nicht nur eine Nähe zur biblischen Botschaft aufweisen kön-

Interfilm Director Karsten Visarius (right) presenting ecumenical award to Wim Wenders, Locarno, 6 August 2005 (photo CEC/L.M. Negro)

nen, sondern auch eine wichtige Anfrage an Kirche und Theologie selbst darstellen. An den besten europäischen Preisträger kann Interfilm seit 1997 jährlich auf der Berlinale zusammen mit der KEK jährlich den neuerdings mit 10'000 dotierten Europäischen John Templeton-Filmpreis vergeben und damit dem Film zu einer grösseren Beachtung verhelfen. Seit 2004 läuft am Festival "Visions du Réel" in Nyon zudem das Projekt für einen John Templeton-Dokumentarfilmpreis.

In Ergänzung zu den Studientagungen und Seminarangeboten zahlreicher Mitglieder (Akademien, Medienzentralen, Pfarrerweiterbildungsinstitutionen) führt Interfilm selbst (in Zusammenarbeit mit WACC, der World Association for Christian Communication) regelmässig internationale Filmseminare durch, zuletzt zum Thema "Europa eine Seele geben" in Bad Segeberg/Deutschland (1997), in Nîmes/Frankreich (1998), Riga/Lettland (1999), Örebro/Schweden (2000), mit Fortsetzungen in Sofia/Bulgarien (2001), Mannheim/Deutschland (2002), Iasi/Rumänien (2003) zum Thema "Zeichen und Geschichten der Hoffnung im Kino" und auf Kreta (2004) zum Thema "Orthodoxe Ikonographie und zeitgenössische Filmkultur". Mit der Aufzählung dieser Seminarreihe wird deutlich, dass sich die Beschäftigung von Kirche und Film zwar stark auf gesellschaftsdiakonische Aspekte eingelassen hat, aber auch, dass Film ein spannendes Thema für die Theologie ist.

Das kommt in hervorragender Weise in der soeben erschienen Dissertation "*Kirche, Film und Festivals*" zum Ausdruck, in welcher Julia Helmke Geschichte sowie Bewertungskriterien evangelischer und ökumenischer Juryarbeit in den Jahren 1948 bis 1988 darstellt. Erschienen im Verlag Christliche Publizistik, Erlangen 2005, als Band XI in der Reihe "Studien zur Christlichen Publizistik" (ISBN 3-933992-11-7).

Ferner zur Geschichte von Interfilm: Julia Helmke/Hans Hodel/Karsten Visarius (Hrsg), *Kirche und Film im Dialog/Church and Film in Dialogue. Fünfzig Jahre INTERFILM/Fifty Years INTERFILM*. Geschäftsstelle Interfilm c/o GEP, Emil-von Behring-Str.3, D-60394 Frankfurt a/M; Internet: www.inter-film.org

Hans Hodel
Präsident von Interfilm

L'Eglise et le film en dialogue: 50 ans d'Interfilm

Interfilm est un réseau œcuménique européen international du cinéma regroupant des organisations du monde des médias et des personnes assurant la promotion du dialogue entre l'Eglise et le cinéma. Inspiré par les principes de base du Conseil œcuménique des Eglises il réunit des chrétiens de tradition protestante et orthodoxe ainsi que quelques catholiques et quelques juifs. Il a été créé en 1955 par des membres du mouvement œcuménique qui se demandaient pourquoi le cinéma attire souvent plus de personnes que ne le fait l'Eglise. Les projets proposés incluaient des groupes de discussion sur les films dans les Eglises locales, une critique cinématographique indépendante, la diffusion de films sélectionnés ou encore la création de films religieux par les Eglises. Mais des ressources limitées ont conduit Interfilm à se concentrer sur le développement de critères destinés à l'évaluation des films et à la promotion des meilleurs œuvres cinématographiques, notamment à l'occasion de festivals internationaux.

Dès 1963, des jurys Interfilm aux festivals de Berlin et Mannheim en Allemagne, ont décerné leurs propres Prix à des films commerciaux en marge des Prix officiels des festivals.

En 1969 un jury Interfilm a été accrédité à Cannes, et depuis 1973 des jurys œcuméniques sont opérationnels sur des festivals, en association avec l'organisation catholique du film, l'OCIC, partout en Europe, y compris dans les pays d'Europe de l'Est depuis 1989.

Depuis 1997 Interfilm et la KEK présentent conjointement le Prix John Templeton, doté de € 10,000, récompensant le meilleur film européen de l'année sélectionné au festival de Berlin et depuis 2004 décernent à Nyon en Suisse le Prix Templeton au meilleur film documentaire européen.

Mission in Unity

Common witness and multi-cultural exchange in Europe

This summer, my wife and I walked the West Highland Way, a long-distance footpath that threads its way through the beautiful scenery of Scotland. En route I noted how many times the hotel staff had problems understanding the strange accents of their Scottish visitors. I met staff from Russia, Poland, Croatia, Slovakia, and several other Central and Eastern European countries. In the May 2005 edition of *Sourozh*, the quarterly journal of the Russian Orthodox Diocese of Sourozh, Bishop Basil refers to the increase in the numbers of citizens of the former Soviet Union living in the UK, and the corresponding increase in attendance at Liturgy at the Cathedral in London.

The arrival of active Christians from Africa, Asia and Latin America adds further nuances to the challenge to Europe's Churches, already struggling to respond to the criss-crossing of the continent by European migrant workers and refugees. At a time of maturing ecumenical experience and encounter, our churches are faced with the complex, often painful, issues of national, ethnic, and religious identity and their competing claims.

The arrival of active Christians from Africa, Asia and Latin America adds further nuances to the challenge to Europe's Churches, already struggling to respond to the criss-crossing of the continent by European migrant workers and refugees. At a time of maturing ecumenical experience and encounter, our churches are faced with the complex, often painful, issues of national, ethnic, and religious identity and their competing claims. It remains to be seen whether our search for a common witness will deepen or shrink as a result of the inevitable multi-cultural exchange, including its religious dimension.

In this exchange and movement, despite the obvious fact that the greater majority of active Christians have opted to retain their traditional affiliation, there *are* British protestants who have become Orthodox, African Pentecostals who have become Baptist, Iranian Muslims who have become Anglicans, and Syrian Orthodox who are now Reformed. It would take a bold theologian indeed to categorically locate all of this activity beyond the realm of the Spirit's gracious inspiration. However, in predicting an increase in denominational transfers and in recognising that some of this is likely to be as a result of methods that lack Christian authenticity, it should cease to be surprising that mission and proselytism adopt new patterns in new locations. From Oslo to Tbilisi, from Moscow to Madrid, I have heard Lutheran, Roman Catholic, and Orthodox Bishops recount disturbing stories of manipulative proselytic activity.

Earlier this year, a lively discussion at CEC's Central Committee underlined the opportune nature of our research focus on mission and proselytism. Its importance is further underlined by a relative lack of empirical data informing ecumenical discussion on proselytism. This Autumn, the Mission Research office will initiate an inquiry into the phenomenon. A part of this data-gathering exercise will be to gather and present case-studies for CEC member churches and others to separately and jointly reflect upon. You are invited to submit material for consideration as case study material.

Please use my e-mail address jackson@pmti.edu.hu to submit scripts in electronic format.

Darrell Jackson

in brief

General Secretariat

The London bomb attacks: Message from CEC General Secretary. The General Secretary of CEC, the Rev. Dr Keith Clements, sent the following message to CEC Member Churches in Britain and Ireland on the occasion of the bombings in London last July: "Christians and churches throughout Europe are united in shock, revulsion and grief at the bomb outrages in London. As yet another European city suffers attacks of indiscriminate violence we in the Conference of European Churches are united in prayer for all victims, the bereaved and injured and those who are caring for them. We especially bear in mind our member churches in Great Britain and particularly those congregations and their pastors in London, who have suffered and yet will be sharing in Christ's ministry of comfort and healing. It is hard to speculate on the mentality of those who would seek to murder and wreak havoc in this way. We can only pray that they may be brought to justice and, by God's mercy, to repentance. Presumably they wish to spread fear and division among the people of London and Britain. For that reason, we hope and pray that Christians, Muslims, Jews and all people of faith will be bound ever more closely together in their renunciation of violence, their affirmation of the sacredness of every life in the sight of God, and God's command to live at peace with one another".

Shock and sadness at the death of Brother Roger of Taizé. The General Secretaries of the Conference of European Churches (CEC) and the Council of European Bishops' Conferences (CCEE), Rev. Dr Keith Clements and Mgr. Aldo Giordano, in a joint statement, expressed their shock and sadness at the news of the death of Brother Roger Schutz, the founder of the Community of Taizé in Burgundy, France, on 16 August 2005.

"Brother Roger", they stated, "founded the Taizé community in 1949, at a time when people throughout the world were trying to discover ways of ensuring that there would be no more wars. His community was dedicated to building bridges of prayer and dialogue between Christians, in an similar effort to ensure that there would be no more conflict between them.

It is a unique tribute to the power of the style of life and prayer at Taizé that in so many parishes, universities and other institutions where Christians in Europe and much further afield gather to pray, people opt for what they describe as 'Taizé prayer'. Brother Roger and his community have touched many of those hearts that are known to besearching for God or for new and meaningful spiritual experiences. This is a service for which all Europe's Christians will be for ever be grateful.

CEC and CCEE have particular reason to express their gratitude to Brother Roger for his outstanding contribution to the Second European Ecumenical Assembly held in Graz in 1997.

Brother Roger was undoubtedly a man very close to God in this life. We pray that the Lord may welcome him into his eternal home. Brother Roger was a man of reconciliation and peace – may the poor woman who took his life know God's forgiveness and come to peace in her heart and soul. May God bless the members of the community of Taizé and the many thousands of friends they have, in this moment of loss. In his first letter to the Thessalonians, Saint Paul encouraged that the Christian community not to be overwhelmed by their grief but to remember always that, 'through Jesus, God will bring with him those who have fallen asleep' and he asked the community to 'comfort one another with these words'. We hope Saint Paul's message will be heard by all grieving for Brother Roger at this time".

European and USA Churches to work closely together. The ecumenical situation in Europe and the United States, security, religion and conflict, and the European and USA churches' role in the process of globalisation were the themes of a consultation on "Europe and the USA today: common challenges, common ecumenical responsibilities". It was held in the Ecumenical Centre of Geneva on 14 September 2005. Thirty church representatives from America and from ten European countries took part in the consultation, jointly convened by the National Council of Churches USA (NCC USA) and CEC.

"Inter-regional dialogue is going to be more and more important in the coming years, and this was a good example", stated Dr Keith Clements, CEC General Secretary. "The churches of the USA and Europe face many common challenges and responsibilities", he added, "including the basic one above all on how to be ecumenical in a fundamentalist age. We look forward to developing specific plans for cooperation."

"For the well being of the global community it is imperative that churches respond to the present challenges together", said Rev. Bob Edgar, General Secretary of NCC USA. "This consultation was an opportunity to tackle important issues. We know that some of them deserve deeper consideration and action, and we celebrate the fact that we were called to deeper action".

During the consultation Rev. Edgar noted that the fallout from Hurricane Katrina may change the political and religious landscape of the United States: "Hurricane Katrina exposed racism and poverty in the United States", and the leadership of President George W. Bush is now in question. The member churches of NCC USA (Protestant, Anglican and Orthodox), he said are strongly committed to "ending poverty, respect the environment and work for peace and justice". At the same time, they are working to build a "larger ecumenical table" which would include the Roman Catholic Church and those Evangelical churches which are not in membership with the NCC.

This was echoed by CEC President Rev. Jean-Arnold de Clermont, who mentioned among the ecumenical challenges in Europe the development of closer ties with Catholics and Evangelicals, the relations between majority and minority churches, and the development of a common understanding of mission in a secularised Europe.

Church & Society

European Churches confronting poverty. The Church and Society Commission of the CEC and Eurodiaconia presented the book "European Churches confronting Poverty – Social Action against social exclusion" in a conference hosted on 21 June 2005 in the European Parliament (Brussels) by its Vice-President, Dr. Ingo Friedrich, MEP. In a Europe where many countries are confronted to varying degrees with the problem of poverty and social exclusion, the book takes a look at the commitment of the church in the context of an economy, which is under pressure from globalisation and competition.

"In times of globalisation and individualisation, we need a social anchor, an island of stability, a light-house for human rights, peace, freedom and social state", said Vice-President Friedrich. "We need a commitment to social justice and the fight against poverty and all forms of exclusion as a priority", he added.

Rev. Rüdiger Noll, Director of the Church and Society Commission of CEC, stressed the vital role of churches in combating poverty and their engagement in raising awareness on the fact that "there are many victims of globalisation also in Europe". Rev. Noll addressed, in particular, the European Parliament by saying: "The European Parliament and we, the churches, are on a common journey to tackle poverty in Europe". Rev. Dr Peter Pavlovic, one of the book authors and a CEC executive, added: "Churches can be good partners for politicians in their action to overcome poverty".

Albert Brandstätter, Secretary General of Eurodiaconia, spoke of "diaconia" as the churches' social work "oriented towards those who are in need and who are excluded. Social inclusion has to be a core of the Lisbon strategy. The social inclusion pillar of the strategy is at stake. To invest there is not idle

but highly necessary, in terms of European soul, in terms of public investment, in terms of well being of all".

The co-editor of the book, Rainer Volz, Director of Men's Services Department of the Protestant Church of Rhineland explained the broad variety of anti-poverty-action of churches in the European countries. "There is a large variety of conceiving the action for or with the Poor. This book gives important information about one important group of 'civil' actors like faith based institutions, groups and movements, diaconal organisations and churches."

Book details: *European Churches Confronting Poverty. Social Action Against Social Exclusion*. Edited by Hermann Noordegraaf and Rainer Volz and published by SWI Verlag, Bochum, Germany (2004, 297 pages, ISBN 3925895906, 22,50 €).

Church & Society Plenary in Dunblane (photo CEC/S. Lamotte)

European Commission and religious leaders committed to continuing dialogue. Following his invitation, sixteen religious leaders from the Christian, Jewish and Muslim traditions met on 12 July with the President of the European Commission, Manuel Barroso. President Barroso and the religious leaders "reaffirmed that they are dedicated to building a free, united, prosperous and peaceful Europe, characterised by solidarity, where all citizens and nations, regardless of their religion, convictions, language, culture, tradition and ethnic origin, may live together and feel at home united in diversity" – as stated in the final communiqué of the meeting.

"The European Commission and the religious leaders are dedicated to continuing their dialogue to make this common vision of a united Europe a reality", the final statement continues. Whether the Constitutional Treaty and with it article I-47 and Article I-52 (on the open, transparent and regular dialogue between the European Institutions and the communities of faith and conviction) will come into force or not, the dialogue between the European Commission has been taking place successfully for many years and it will continue. The formal adoption of the Constitutional Treaty is not a pre-condition for dialogue to continue – these were some of the sentiments expressed by President Barroso in addressing the religious leaders.

In his contribution to the discussion, Rev Thomas Wipf, President of the Swiss Protestant Federation, emphasized that not only should the concerns of the people, as expressed in the French and Dutch referenda, be taken seriously but that the process of building a value-based Europe, which is more than just an economic space, must also be continued. "The big issue of our times seems to be to think European and to overcome selfish and narrow national thinking. We need a new vision of Europe, a new narrative. Maybe the notion of solidarity, inside and outside of Europe, as well as Europe's responsibility in a global context can provide such narratives for the future," he added.

Rev. Rüdiger Noll, Director of the Church & Society Commission of CEC, highlighted the need for closer co-operation between the churches and the European Commission in the field of education. "Churches are involved in people's formation at all ages. They support people in the development of their own identity, which is a pre-condition for opening up for a European identity."

President Barroso and all religious leaders agreed that such a meeting could not have been more timely. The Bishop of London, Richard Chartres, emphasized the important co-operation and mutual support of the religious communities in London after the atrocities. After the tragic events in London, the leaders of the various religious communities along with the President of the European Commission issued a strong statement which concluded: "All participants strongly condemn the terrorist attacks against innocent people in London. No reason, in particular not a religious one, can justify such acts against humanity."

New Issues in Stem cells and Regenerative Medicine. Human stem cells are a subject of continuing scientific, medical, ethical and political discussion and controversy within Europe and the wider international arena. The working group on Bioethics and Biotechnology of the Church and Society Commission of CEC has produced several papers on this subject. They have now published an update on stem cell ethics in the light of developments in research during the past five years to April 2005. These developments include obtaining stem cells from surplus embryos from pre-implantation genetic diagnosis (PGD); creating cloned embryos to provide a source of cells to study particular diseases; deriving stem cells by parthenogenesis (stimulating a human egg to be fertilised chemically without sperm) or from animal-human hybrid embryos as alternatives to human embryos; and the prospects for reprogrammable adult stem cells. "We aim to foster discussion within our churches and to contribute to the wider debates of stem cell and cloning and related issues both in Europe and further afield", the document states.

"We begin", the introduction explains, "by summarising the main arguments about embryonic stem cells. The prospect of using stem cells to provide replacement cells to treat a wide range of otherwise incurable degenerative diseases is a compassionate aim with which most agree. The primary ethical controversy is whether the human embryo can be used as a source for these cells. There is also a major scientific debate on the potential and efficacy of embryonic versus adult stem cells. Among our member churches there are many for whom all research on embryos which causes their destruction is completely unacceptable, as a matter of fundamental principle. Human life is seen as a continuum from conception to death. To destroy an embryo by using it for research is tantamount to the willful destruction of a human life. For those holding to this view, the ethical case is clear and straightforward. The position is 'under no circumstances.' Only adult or cord blood stem cell research is permissible. Many of our churches do not, however, share this view and consider that the status of the human embryo increases with development, and would allow embryo research under particular circumstances. Some would argue that to use embryos to create stem cells for potentially lifesaving therapies is more justified than for treating infertility, providing that no other means are possible and that embryos are not used beyond 14 days. Others argue, on the contrary, that to use embryos merely as a source of cells is too instru-

mental, negating any sense that the human embryo has a special status. To the extent that embryo research is allowed for limited purposes, a measure of instrumentality is accepted, but this does not mean all uses are thereby permitted.

Many would therefore object to the creation of embryos for stem cell research, but might reluctantly agree to use of surplus embryos from IVF treatment, given that these would normally be destroyed".

The full text of the document "New Issues in Stem cells and Regenerative Medicine" can be found on our website at www.cec-kek.org

CCME

NGO coalition expresses deep concern on proposed EU return standards. A coalition of 13 NGOs assisting migrants and refugees expressed on 1 September 2005 their serious concerns regarding current EU policies on the detention and removal of irregular migrants and rejected asylum seekers. In the context of the draft of a directive on common standards on return, adopted by the EU Commission, the NGO coalition suggests a set of nine principles to ensure respect for human rights.

The coalition of church-related and human right organisations urged the European Parliament and the Member States to take into account some common principles necessary to ensure that return procedures fully respect the needs and the dignity of individuals. In any case both detention and removal should only be the last resort in dealing with irregular migrants and rejected asylum seekers.

The nine common principles underline that those facing removal and detention must enjoy the right of an effective remedy and legal review of the decisions affecting them. Particular importance is also attached to the protection of vulnerable persons such as children, the seriously ill or trafficked persons against removal. The text suggests the establishment of independent institutions to monitor detention and removal and deal with complaints of ill-treatment in detention or removal operations.

Representatives of the NGO coalition expressed concern that the proposed directive on return mainly follows a repressive logic rather than elaborating principles focussed around the human rights of those facing detention or removal. Caroline Intrand, who represented the Churches' Commission for Migrants in Europe and the French CIMADE on the NGO Coalition explained, "Detention and removal pose serious challenges to the human rights of those affected. After important work on the human rights aspects of this had already been done by the Council of Europe, we had hoped that the EU Commission would further elaborate a human-rights centred approach. However it appears that the new proposal gives priority to a supposed 'efficiency' regarding the technical aspects of removal. This might have a seriously negative effect on the rights of those facing removal".

EEA3

On the way to Sibiu: CEC President visits Romanian Churches. The Third European Ecumenical Assembly (EEA3), to be held in Sibiu, Romania, 4-8 September 2007, is fully supported by the Romanian churches. This is what emerged from the first visit of the President of the Conference of European Churches (CEC), Rev. Jean-Arnold de Clermont, to the CEC member churches in Romania. The visit took place from 28 August through 2 September 2005. Rev. de Clermont was accompanied by CEC Study Secretary, Prof. Viorel Ionita, a Romanian citizen and Orthodox priest.

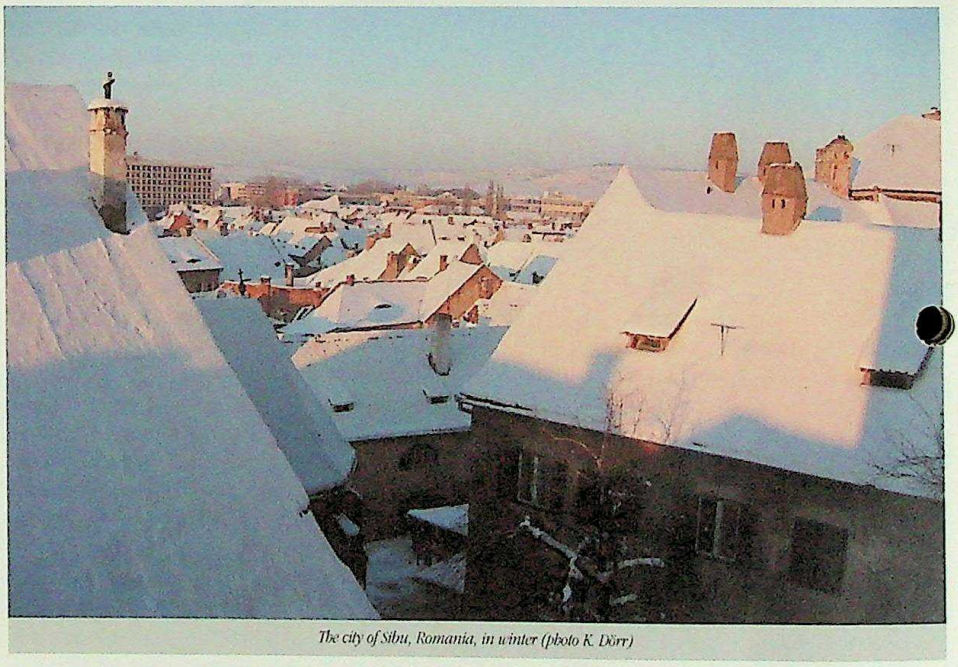
On the occasion of the Feast Day of the Beheading of St. John the Baptist, Rev. de Clermont and Prof. Ionita took part in the Orthodox Liturgy in the Cathedral of Bucharest. They attended a luncheon with His Beatitude Teoctist, Patriarch of the Romanian Orthodox Church. A press conference followed, during which de Clermont stated the importance of the role played by Romanian Orthodox representatives within CEC and in the preparations for the forthcoming European Ecumenical Assembly. "CEC rejoices that the EEA3, as His Beatitude Teoctist assured me, enjoys the full support of the Romanian Orthodox Church."

The same support was expressed by the Lutheran and Reformed Churches during meetings held in Cluj and Oradea with Bishop Géza Pap of the Reformed Church in Transylvania, Bishop Laszlo Tökes of the Reformed Church in Oradea, and Bishop's Counselor Feher Attila of the Evangelical Lutheran Church. These meetings, as well as the meeting with Orthodox Archbishop Bartholomew of Cluj, provided an opportunity for exchange and dialogue on the life of the churches, ecumenical relations, and preparations for the Sibiu Assembly.

The visit ended in Sibiu, where Rev. de Clermont and Prof. Ionita represented CEC and delivered a message of condolence during the funeral for Metropolitan Antonie of Sibiu who passed away during their visit to Romania.

The stay in Sibiu was also an opportunity to meet Prof. Hans Klein, Assistant Bishop of the Evangelical Church of the Augsburg Confession in Romania and other local church representatives to discuss plans for the EEA3.

"At the same time", Rev. de Clermont stated, "it was good to see all the building and renovations going on in preparation for Sibiu being the Cultural Capital of Europe in 2007."



The city of Sibiu, Romania, in winter (photo K. Dörr)

For the full text of the declaration, please go to:

English: http://www.cec-kek.org/English/CommonprinciplesonremovalE.pdf

Deutsch: http://www.cec-kek.org/English/CommonprinciplesonremovalD.pdf