



– AIDSLink #61 – Ethics and HIV&AIDS

Be especially careful when you are trying to do good so that you don't make a performance out of it. It might be good theatre but the God who made you won't be applauding.
Matt 6:1 (The Message)

June 2007

HIV and AIDS has generated a host of ethical questions that are unique, poignant, and often emotional. This month we encourage you to think about ethics at the global, project and individual level and the practical implications of this in your setting. Your insights and feedback to AIDSLink are greatly welcome. If you are unable to access any web resources, I am happy to mail you the information on a CD on request.

Diane

international.aids-consultant@sim.org

SIM AIDS related ministries and HOPE for AIDS

CONTENT

1. Ethics in the context of HIV&AIDS
2. Fighting stigma and discrimination
3. Routine testing in health care facilities – new guidelines
4. Should voluntary counselling and testing counsellors address alcohol use?
5. Ethics: seeking justice for all
6. Making it known – Micah Network consultation + prevention resource
7. Tip of the Month – Story-based monitoring and evaluation – The most significant change

1. Ethics in the context of HIV&AIDS

As the ripples of yet another meeting of G8 leaders wash over the international community, many prominent social activists including Bono and Geldof, are highlighting the moral and ethical dilemmas which still remain largely unaddressed. We see complex “big picture” issues involving questions of justice, poverty, and common good. How much responsibility do wealthy countries have to respond to the global HIV&AIDS crisis? What constitutes ‘fair’ profit making from AIDS drugs? What are the ethical implications of balancing limited resources in prevention, care and treatment? And what are reasonable measures to protect human rights in vaccine development?

Whilst bio-ethical issues are daunting, so too is the contentious debate over how religious convictions and local cultural beliefs and practices should influence HIV prevention and treatment. Suffering, pain, human rights, and confidentiality present pastoral challenges, as do ethical questions related to life stage issues clustering around birth infancy and childhood, around youth and adults living with HIV, and around the end of life.

These require us to make choices. But what directs these choices? Why reflect on the meaning of ethics? Overberg (2006) in *Ethics and AIDS*, suggests that these choices are important on a personal level because they (1) shape the person we are becoming, (2) have a real effect on other people, and (3) embody and express our relationship with God. The Christian tradition of moral decision making acknowledges the value of all persons and the relationship of God, human beings and the rest of creation.

For discussion:

1. What ethical questions are currently under discussion in your setting?
2. To what extent is our decision making at a personal and program level influenced by gender, race, class, culture, history, and local and world politics as well as our commitment to the gospel?

Now read Matthew 6.

3. What ethical issues does Jesus address in this chapter?
4. Which of these are relevant to your setting? Are they in the list you made for Qu.1? Why or why not?
5. How could you and your community best consider these issues?

2. Fighting stigma and discrimination

HIV related stigma consists of negative attitudes towards those infected or suspected of being infected with HIV and those affected by association, such as orphans or the children and families of people living with HIV. Stigma and discrimination are found in all parts of the world, but their manifestation varies from place to place. They are pervasive.

Susan Bertrand, RN flowerz63@hotmail.com who works at the Spring of Life, HIV&AIDS Counselling Center Jos, Nigeria writes:

The issue of stigma and discrimination continues to be a big challenge in HIV&AIDS care and prevention here in Nigeria. At the Spring of Life HIV&AIDS Counselling Center we care for people living positively through free HIV testing, counselling and home-based care. We are encouraged to see many people with a general increase in awareness of HIV and a desire to know their status. This helps in prevention, but can also cause stigma and discrimination for many people who disclose their status to loved ones. It is still widely believed that one can get HIV from sharing utensils, using the same toilet seat or being close to someone with HIV. Lack of education causes fear which contributes to stigma. People are afraid of that which they don't know, and would prefer to no longer associate with a person who is positive. Instead of embracing them, many people run away and ostracize that person.

We have a two year old orphan girl who has been coming to our center for one year now. Both her parents died of HIV. At the mother's burial the family wanted to bury the girl alive with her mother. She was showing obvious signs of the virus with severe rashes, malnutrition and swelling in her face. She was considered an outcast and disgrace to her family. She will forever wear the shame of her parents' illness. Her grandparents refused to care for her, so the grandparent's relatives agreed to take her in. The sad reality is that this is not an uncommon issue. We see situations like this one on a daily basis.

Stigma is a big obstacle in reaching people with the news about HIV&AIDS. The biggest way we can eliminate the problem of stigma for those living with HIV&AIDS is to show Christ's love to them. We must be imitators of Jesus, and lead godly lives so others may see and follow in our footsteps. At Spring of Life we have come one step closer to fighting this pandemic one life at a time, and will continue to love those who are living with HIV&AIDS through the power of the gospel.

3. Routine testing in health care facilities – new guidelines

Until recently, the primary model for providing HIV testing and counselling has been client-initiated voluntary counselling and testing (VCT), rather than provider-initiated. But less than 12% of men and 10% of women in sub-Saharan Africa have been tested for HIV and received their test results, despite high levels of knowledge about the existence of HIV and the increasing provision of life-prolonging drugs through the public health sector. Health facilities represent a key point of contact with people with HIV who are in need of HIV prevention, treatment, care and support. WHO is calling for health care providers to now begin routinely recommending an HIV test to patients attending their facilities to increase the numbers who know their status. We "strongly support the continued scale up of client-initiated HIV testing and counselling, but recognise the need for additional, innovative and varied approaches," WHO and UNAIDS said in new testing guidelines just released.

"*Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities*" can be downloaded (2.2MB) from: www.who.int/hiv/who_pitc_guidelines.pdf

Key Recommendations include:

- Generalized HIV epidemics: "HIV testing and counselling should be recommended to all patients attending all health facilities, whether or not the patient has symptoms of HIV disease and regardless of the patient's reason for attending the health facility."
- Concentrated and low-level HIV epidemics: "Depending on the epidemiological and social context, countries should consider recommending HIV testing and counselling to all patients in selected health facilities (e.g. antenatal, tuberculosis, sexual health, and health services for most-at-risk populations).

Other recommendations include:

- All HIV testing must be voluntary, confidential, and undertaken with the patient's consent.

- Patients have the right to decline the test. They should not be tested for HIV against their will, without their knowledge, without adequate information or without receiving their test results.
- Pre-test information and post-test counselling remain integral components of the HIV testing process.
- Patients should receive support to avoid potential negative consequences of knowing and disclosing their HIV status, such as discrimination or violence.
- Testing must be linked to appropriate HIV prevention, treatment, care and support services.
- Decisions about HIV testing in health facilities should always be guided by what is in the best interests of the individual patient.
- Provider-initiated HIV testing and counselling is not, and should not be construed as, an endorsement of coercive or mandatory HIV testing.
- Implementation of provider-initiated HIV testing and counselling should be undertaken in consultation with key stakeholders, including civil society groups, acknowledging that what works and is ethical will inevitably differ across countries.
- When implementing provider-initiated HIV testing and counselling, equal efforts must be made to ensure that a supportive social, policy and legal framework is in place to maximize positive outcomes and minimize potential harms to patients.
- A system that monitors and evaluates the implementation and scale-up of provider-initiated testing and counselling should be developed and implemented concurrently.

4. Should voluntary counselling and testing counsellors address alcohol use?

“Should voluntary counseling and testing counselors address alcohol use with clients? Findings from an operations research study in Kenya”, was motivated by the fact that little is known about alcohol use among VCT clients and their need for alcohol counseling. Data from this study indicate that many clients are affected by alcohol as a result of their own or their partners’ drinking, and therefore VCT providers have an important role to play in discussing alcohol use with clients and in making referrals as appropriate.

Alcohol increases people's vulnerability to HIV by blunting self-monitoring behaviour, thus increasing the likelihood of having multiple partners and unprotected sex. The paper noted that "evidence suggests a direct biomedical link between alcohol consumption and HIV infection and disease". "Heavy and sustained alcohol use depress the immune system and cause alcohol-induced malnutrition, which can cause vulnerability to HIV infection." "Emerging laboratory evidence suggests that alcohol may morphologically alter cellular structure to increase both HIV infectivity and vulnerability of cells." As it is known that alcohol interferes with the body's ability to metabolize antiretroviral drugs thus increasing the likelihood of drug resistance, counsellors need to pass this information on to their clients.

This research update (808KB) is available from: www.popcouncil.org/pdfs/horizons/kevctalcoholru.pdf

5. Ethics: Seeking justice for all

“Seeking justice for all” (729KB) is Tearfund’s latest PILLARS guide which presents a number of common situations of injustice based on the UN Universal Declaration of Human Rights. It seeks to help people to learn about their human rights and to discuss ways of promoting them in different local situations. Each topic includes Bible references that help us to understand God’s compassion and passion for justice, to challenge unjust laws, to become familiar with our human rights, and to promote and defend the rights of others. It is available at: <http://tilz.tearfund.org/Publications/PILLARS/Seeking+justice+for+all/>

PILLARS Guides are designed for use in small community groups such as youth groups, church groups, women’s groups, farmer groups and literacy groups. A trained leader is not required. They aim to increase the knowledge, skills and confidence of group members by drawing out and building on existing knowledge and experience, and empowering members to take charge of their own development. They can be downloaded free at: www.tearfund.org/tilz Printed copies are available from: Tearfund Resources Development, PO Box 200, Bridgnorth, Shropshire, WV16 4WQ, UK. Email: roots@tearfund.org

6. Making it known – Micah Network consultation + prevention resource

1. The Micah Network, together with host organization CREDO, are excited to announce details for a Francophone Consultation on “*Integral Mission and the Church*” to take place in Burkina Faso, 19-23 November 2007. Objectives are to:

- encourage a new understanding and practice of integral mission
- encourage the church to respond to HIV & AIDS
- introduce Micah Network to the region
- introduce Micah Challenge and to explore the possibility of national campaigns

The consultation will include plenary sessions, case studies and workshops on integral mission, HIV & AIDS, advocacy and the Micah Challenge. A consultation flyer and registration form will soon be available for download from www.micahnetwork.org For further information or to register your interest please email the Micah Network African Coordinator, John Wesley Kabango at johnwesleyk@yahoo.fr.

2. Dr Manoj Kurian, Programme Executive Health and Healing, World Council of Churches, writes, “Thank you for the AIDSLink #59. I would like to bring your attention, a recent publication (August 2006) of the 'World Council of Churches' (Contact Magazine Issue No-182) on ‘*HIV Prevention. Current Issues and New Technologies*’.” This is available (2.5MB) at <http://wcc-coe.org/wcc/news/con-182.pdf>

7. Tip of the Month – The most significant change

The “most significant change” is a story based evaluation tool that describes an important change that has happened due to an HIV&AIDS activity. It is useful to understand the impact the activity or project is having on people; what has changed as a result of project activities and the reasons for this change; to explore what people think about this change (Is it good or bad?); to identify what changes are seen as significant by communities and what are not, and how to improve project activities.

1. Agree how often to use the most significant change tool and with whom. This could be at the end of a project or every three or four months with the all project stakeholders to monitor progress.
2. Ask what they feel has been the most significant change related to the project during the time period.
3. Ask stakeholders to describe the most significant change and why. Drawing pictures of the most significant change may also be appropriate. The most significant change may be for:
 - themselves as individuals
 - peer groups
 - the community as a whole
 - services in the community
5. Use what is defined as ‘the most significant change’ to set community-based goals for a future project. For example, if people say that a significant change for them was ‘the community works closer together now’, then ‘the community works closer together’ can become a new goal.
6. Share the most significant change stories

This tool has been reproduced from *Tools Together Now, 2006* (250 pages) by AIDS Alliance and is available for downloading (2.9MB) at: www.aidsalliance.org/sw36326.asp

For a detailed description of how this technique can be used in research see: *The Most Significant Change (MSC) Technique: A guide to its Use (2005)* by Rick Davies and Jess Dart available online (1.2MB) at www.mande.co.uk/MSCGuide.htm

Co-worker with you,
Diane Marshall, Consultant for HIV&AIDS
Email: international.aids-consultant@sim.org
Mail: 120 Herring Rd, Eastwood NSW 2122. Australia
Tel: (61-2) 9870 8208

Championing HIV & AIDS ministries and helping SIM and its partners respond more effectively to growing epidemics in Africa, Asia, and South America



The opinions and views expressed in AIDSLink do not necessarily reflect the views of SIM. Technical information in AIDSLink is AIDSLink is a publication of SIM International. This edition is made freely available through ICMEDA and "Dignity and Right to Health" The opinions expressed in this edition do not necessarily reflect the views of these organizations. Technical information is crosschecked as thoroughly as possible however we cannot accept responsibility should problems occur.