"We are all infected or affected": the moralities of antiretroviral treatment

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AIDS - a moral issue

When HIV/AIDS was discovered in 1984 and began to spread all over the world, it was a moral issue from the first day.[1] It spread mostly among homosexuals ("they brought it about themselves") and among intravenous drug users who shared infected needles ("they got what they deserved"). So, AIDS was the result of immorality. The contrary truth that many haemophiliacs[2] were infected and died of AIDS could be conveniently overlooked, or explained away by the truth that those who suffer the consequences of immorality are not necessarily the perpetrators.[3]

In a wider sweep AIDS could be seen as God's punishment, not just for immoral individuals, but for an immoral generation. And if a generation is punished, the punishment hits them all, irrespective of individual guilt, until God's wrath has found sufficient expression.

Others, who are trying to come to terms with the dreadful reality of AIDS, refuse to accept any association with guilt. Still, it is a moral issue for them, too. Not that those now infected are or have been immoral but immorality is found in how we treat the victims. Anything else than respect, love, and compassion would be severely immoral.

In this paper I will not be generally concerned with AIDS related moral issues, but with a specific issue in the wider HIV/AIDS complex, namely the comparatively recent issue of the morality of administering anti-retroviral drugs which do not heal the infection, but in many cases, allow someone who is HIV-positive to live

a normal and healthy life like anyone else.

I write this paper as a theologian. I specialize in Church History and Missiology, not in Ethics, but most funerals I attend look like being due to AIDS, and though that does not make me an expert, it makes me concerned, not only with funerals, but with counselling and pastoral care, too. Nobody can dare to deny the immensity of the suffering caused by AIDS, and as a pastor I have no doubt that the aim must be to reduce this suffering to the lowest possible level by any effective means.

"We are all infected or affected"

This is a common slogan used in the religious AIDS discourse. I do not like such sloganized language, but this slogan is unfortunately true. Nobody knows the details, but here in Malawi 8.8% of the population is said to be HIV-positive, which translates into anything around 20% of the younger adult population. In many hospitals, about one-third of women giving birth are HIV-positive, and in a population of 10 million there are estimated to be 100,000 AIDS orphans.

All figures seem to be conservative estimates, but whatever the exact figures may be, what is clear is that they are rising rapidly.[4] Although only 10 to 20% of the population is infected, all are affected. Many constituencies lost their MPs through AIDS; students lose their teachers; parishioners their priest or pastor. I do not know how many of the members of my (semi-rural) congregation are infected, but definitely too many of them. In the professions the death rate is so high that training can hardly cope.[5] The worst is, of course, that so many children become orphans.[6] The extended family is often still able to provide new parents, but due to AIDS the strains on the extended family system are so strong that some simply do not cope.[7]

Indeed individuals are infected - and indeed many of them - but all are affected. There is rarely an extended family that has not lost members to AIDS,[8] and that does not have many women involved in caring for the sick and the dying. AIDS has drastically increased the number of funerals one has to attend (and a pastor may have to perform) and it has increased the number of working days lost due to attendance at funerals and caring for the sick. And since the majority of those who die of AIDS are in the most productive age group, economic productivity is reduced and so is return on training.[9]

We are not only affected by the strain on the economy and the extended family, but also by severe strain on honesty. I am aware that all societies operate with a lot of assumptions, unquestioned codes and social fiction, but AIDS puts a severe strain on such societal systems and may make them difficult, or outright dangerous. In Malawi a couple of million people participate in a conspiracy to deny the reality of HIV/AIDS, by using a two pronged approach: To make a lot of noise about HIV/AIDS in general and to quietly deny the reality of AIDS when it hits close. In Zomba there is a big poster, with a big picture of the [former] President, telling the nation. "AIDS is killing Africa. Malawians change your behaviour now." In sermons in the Christian churches AIDS is mentioned often enough,[10] and the radio is not quiet either. But when someone dies of AIDS, and most deaths seem to be attributable to it (Lwanda 2004), no public mention is made of it, and even to people who are closely concerned usually nothing is mentioned. Depending on varieties of piety, the death may be ascribed to God's will, to complete surprise or to witchcraft.[11] In any case, history and truth are dispensed with and necessary actions like HIV tests and change of behaviour are successfully avoided. And at the next funeral surprise and mourning will be displayed in full. Many are indeed infected and everyone is affected.

In the beginning it was easy

When HIV/AIDS burst on the African scene, moral choices were comparatively easy, because there was no cure. Once infected there were ten years of life left in Europe, in Africa five.[12] Out of these years, about half would be symptom-free, the other half a slide to death through repeated illnesses, each of them quite harmless in itself, but dangerous and ultimately deadly with an immune system deprived of its defending power.

The most fundamental moral choice, therefore, was the prevention of infection. Force or any compulsion was ruled out as either illegal or impracticable. So information and advertisement became the main tool trying to induce behavioural change. These campaigns cost a lot of money and had some success. But while the information campaign had quite some success in America and Europe where AIDS has remained largely confined to clearly identifiable "risk groups", AIDS spread rapidly in Africa among all groups,[13] almost exclusively through heterosexual transmission.[14] For Africa any information campaign came too late, and it is also doubtful, how much people are willing to change after receiving the necessary information.[15]

Prevention strategies had two possibilities: moral and mechanical. Owing to their theology, the churches usually, and often too easily, chose moral prevention, and non-church agencies emphasized, often too easily, mechanical prevention. Both prevention approaches must have achieved something. There is individual evidence for that, but they have not prevented adult infection rates of maybe 20% in Malawi or even 40% in Botswana.

The other necessary moral option at the time of no cure was care and compassion for the sick and dying. That was usually supplied within the extended family system, and the churches, though disapproving of sexual immorality often did a lot in terms of acceptance and care.[16] A special aspect of acceptance was the fight against stigmatization of AIDS suffers. Here the churches can claim a fair share both in creating stigma[17] and in fighting it.[18]

Even at $12,000, moralities were clear

About five years ago, ARV drugs because available in Malawi, at a price of about US$1,000 per month. Moral choices were easy, though brutal. If you have the cash, buy the medicine. But there were only a few people in Malawi who could pay that for themselves or for a spouse, family member or friend.

In Malawi and elsewhere in Africa, churches and more so NGOs sometimes do have "project money" to improve health services or care for the sick, but the moral choice to commit $12,000 a year to the care of just one person and to deny the money to the improvement of health services, where much smaller amounts can sometimes save a life, was not a realistic option for them. In practical terms there was no moral choice for either churches or NGOs. But on a wider level a moral choice had to be made. Were they to accept the pricing system of the drugs or to fight it?

In the wealthy Northern countries this moral choice was not difficult, since with few people infected there,[19] the health systems could easily cope, and the argument that enterprises that had invested heavily in the research necessary to produce the life -saving drugs should be allowed a fair return on their investments could find a reasonably strong backing in the social teaching of the churches.[20]

The problem with this moral argument is that it takes no account of those who are sick. In the North they can be cared for, since they are few, but not in Africa and

the rest of the South.[21] To bring 50,000,000 HIV-positive people into the moral equation, a choice between property rights and human suffering had to be made.

Although nothing could be done directly for those infected, the churches and other concerned organizations could make a claim that the prices needed to be reduced to an affordable level, giving help to the suffering priority over the protection of property rights. On this side of the story it seems to me that churches often did not make the claim forcefully enough. Reasons, among others, may have been that in the North it did not concern them that much, in the South the fear of losing a means of moral pressure, or maybe the sheer inability to cope with all the practical and intellectual demands this epidemic has created.[22]

But churches and NGOs did campaign for a drastic reduction of the prices,[23] and by now have had some success. Prices have come down[24] to levels where treatment for the masses becomes possible or at least imaginable.[25] It is important to note that this dramatic reduction was achieved without dismantling the legal property protection system,[26] and currently some of the big companies are trying hard to sell their drugs to Africa cheaply to ward off competition from the producers of generics.

Economics is not necessarily interested in morals, but the moral argument that millions need to be treated finds support in the economic argument that probably an ARV drug at the price of $1,000 may reach a market of 50,000 people in Africa, whereas an ARV drug at $25 may reach a market there of 20,000,000, thus producing more overall profits.[27]

Antiretroviral drugs at $25

Now that the "cheap" antiretroviral drugs are here, the moral problems really start to hit us. Although they cannot, in medical terms, cure the infection, they can reduce its effects to anything like close to zero.[28] And though they are said not to be effective with everyone, they do work with most people.[29] This creates the problem: the medicine is there, but it is still expensive. Government here has a scheme to provide the drugs at 2,500 Kwacha a month[30] through a revolving fund. Like many government schemes, it does not work well, and though patients at the beginning must sign a pledge that they will take the drugs every day, they may not find it when they come to Blantyre, being told to try again next week.[31] In hospitals that do not have this scheme, the drugs cost more, and even if one combines

all the current schemes there is no way to cope with a million infected people. But is the fact that the odds are so overwhelming a reason to do nothing? Christian morality cannot go that way.[32] So what are the options, what are the choices?

Some options that are there remain unchanged, even with the advent of ARV drugs.

- The fact that curative drugs are available does not make prevention efforts less necessary. It is always better not to fall ill than to be cured.

- The fact that curative drugs are now available does not oblige the churches to change their teaching on sexual morality. Sexual faithfulness in marriage and abstention before are not taught simply to avoid the deadly HIV infection but because they are an intrinsic expression of love.[33]

- In terms of prevention of infection, the churches must make a choice between a "right" morality and an "applied" morality. I see no reason for the churches to change their moral teaching on faithfulness in marriage, but I also observe that this teaching is disregarded by many, often including people who otherwise are considered to be faithful Christians.[34] Here the churches must come to the realization (and clearly say so) that it is better to be unfaithful and neither get infected and nor infect anyone than to be unfaithful and get infected and infect every sexual partner, including the faithful spouse. Such an "applied" teaching is moral in so far as it can help save the lives of people.

- The churches must become realistic in their talk about condom use. A common argument, regularly provided in the Malawian press by church representatives, is that the use of condoms promotes promiscuity. This takes no account of the needs of people who deserve that protection, for example, in a marriage where only one partner is infected[35] or where only one partner is faithful. It also does not take into account the fact that the threat of illness and death is not a good base for Christian morality. In addition, it is better that the church demand from someone who breaks the good teaching on faithfulness, to at least protect partners and victims of such sin against infection, and be that with lots of condoms.

- The churches, through both counselling and publicity, must find ways to assist the innocent partners. This requires on one side that all blanket denunciations

are stopped (even in sermons that encourage good sexual morals) and that, on the other side, moral issues are addressed in detail. There are, for example, couples where one spouse is faithful and the other is not. To save the faithful spouse's life in such cases is a higher moral value than to avoid the use of condoms or to avoid speaking about sex.

- The church should not change her teaching on forgiveness, but needs to specify that forgiveness granted by a wife to her promiscuous husband does not imply sexual access to her.[36] In all it requires to take morals again seriously in the HIV/AIDS debate and to take people as individuals (and individual sinners), avoiding blanket condemnations ("AIDS is God's punishment for a sinful generation") as much as blanket support ("Nothing is wrong, it can happen to anyone of us").

- The church teaches that forgiveness is a reality in the other life and in this one. Therefore she should make sure that those who have asked God to forgive have a reasonable chance to live a good life even among their fellow humans (in a fellowship of forgiveness and a new start).

If there is nothing new in the seven points above, this may be due to the fact that all of them apply to a situation quite a number of years old. But the advent of antiretroviral drugs has brought up new moral problems of a magnitude defying handling in an easy and quick way. So, what I can attempt here is to point out some of the problems and try to give at least some answers.

The ARV drugs are still far too expensive

$25 for a month is still an impossible amount for most people in Malawi. Therefore the churches and all organizations of goodwill need to keep up the pressure for a reduction of the prices. The same pressure and the same arguments that have brought the price down to possible levels in Botswana and South Africa may be applied to reach a further reduction of the prices for countries like Malawi. The economic argument could be employed here too: It is better to have many customers who bring in small earnings than a few who bring in more. In this process it must be made abundantly clear that a 90% reduction of prices is still too little for the poor.[37]

The issue of the price to be paid for ARV drugs may soon be circumvented in Malawi and other countries by the willingness of the Global Fund, based in Gene-

va, to provide the drugs for all free of charge.[38]

The number of infected is far too high

There is no doubt about this. But to do nothing would be not in accordance with the Christian imperative of love. If there is a devastating fire, will there not be every effort made to save at least a few from the flames, irrespective of how the fire started in the first place and who is to blame for it?

If efforts are made to save at least some through antiretroviral drugs, the moral question of justice must be faced squarely: If all are sick, who can receive the limited amount of medicine that is available? Here possibly the only answer is: Start somewhere. To help a few people randomly is better than to argue about the justice of assistance and not help anyone. Not to do anything is more equitable, but such equity of perdition is not morally justifiable. To start somewhere by making accessible the ARV treatment to some and aim at increasing the number may have the greatest effect for the common good.

Start somewhere and build up the pressure

From the days the medicine was still much more expensive, I recall a doctor who paid for a student, who had confided his status to her, a year's supply, saying: "I cannot help everyone, but I can at least help somewhere." Her decision to spend her money for that may have been based more on intuition than on strict moral reasoning, but with a million possible recipients of help, there may be no other way to decide.

I think that such a decision, "to start somewhere", could be the base. Individuals can make such a decision, and organizations can do so. Since antiretroviral treatment is not something that can be just dispensed in big numbers like condoms or antimalarial drugs, and since close monitoring is involved, the first to receive treatment should be those who are in easy reach of the necessary institutions. Personal relationships may also be a supporting element.

As much as possible, treatment schemes should be set up. Government may not be a good agent for such endeavours, and not every effort will be immediately successful. But Malawi, as other African countries, has had two achievements: Vaccinations are carried out with very good success and pre- and postnatal care have been quite successful. And since probably a quarter of all pregnant women are infected, there could be a point in connecting antiretroviral treatment with these

endeavours.[39]

If antiretroviral treatment is made available to a small but growing number of people in a country where so many are infected, the pressure will build up to do more. The first effect will be that some more people see hope (even if they cannot yet access the drugs) and that may stimulate efforts to achieve it. Thus the vicious circle "You cannot do anything about AIDS, just hope that it will not hit you next" can thus be broken at least for some.

To "start somewhere" and make ARV treatment available to a limited number of people falls far short of the pastoral aim of helping as many people as possible, but it takes note of current reality. At this time the drugs are accessible for maybe 10,000 out of 500,000 who need them,[40] and the moral argument for the selection of those who receive the drug is that their ability to pay 2,500 Kwacha a month qualifies them to receive the subsidy for the remaining costs.[41]

While it is morally good to help some people, it would be morally bad to be satisfied with giving the scarce resources to those who can pay for them. If we are to start somewhere, the aim must be to reach everywhere. As the situation is now [June 2004], the price of 2,500 Kwacha is a serious barrier, and to work for a gradual (but consistent) increase in recipients may be the only option for the churches.

This slow process of increasing the number of recipients may be speeded up drastically, if the government fulfills its recent promise to make free ARV treatment available to everyone. Since this promise was made - at least as reported in the press - for June this year, and June has passed, I assume that the reality may not be as comprehensive as the promise. But to make ARV drugs available to people free would remove the main obstacle to treatment. But even when the drugs are free, the problem of how to administer them to half a million patients is not yet solved. Here again the moral imperative could be: Start somewhere, and expand at the fastest possible pace. To start somewhere is not to give preference to the selected few, but must be a means to reach an ever-growing section of those who are still out of reach of any substantive help.[42]

Start somewhere: individual approaches

The aim of pastoral care is to help all. Since that is, currently, beyond the possible reach of the churches, here I suggest possibilities on how to start, and thus to

build up the pressure for more.

One of the strongest moral imperatives in the Bible is to look after widows and orphans.[43] And the churches in Malawi have done quite a lot on that level, from orphanages via counselling to private help and home-based care, but the ARV drugs offer a new perspective: the perspective of helping to avoid children to become orphans in the first place. A man with six children may have got the infection due to his own sin, and it may well be him who infected his wife, but for the children it will be better to still have parents. The church does not need to (and definitely should not) condone immorality, but to keep parents alive to look after their children is a highly moral activity (and probably more rewarding than looking after their orphans).[44]

As parents who are both infected normally do not die at the same time, the death of one parent may be a point to try to intervene. If the drugs can keep a mother of three young children alive, that will give them a firm foundation in life[45] and, at the same time, reduce the strain on family solidarity and social welfare systems.

A special effort could be made to identify those that were victims of sin and not perpetrators, or who are just innocent victims like the many infected children or the few victims of blood transfusions or accidents. To save a surviving faithful spouse from death is very moral, but her faithfulness to her late husband may also be an indicator that she will be able to match the treatment she receives with proper behaviour. The moral and the medical may well go hand in hand here.

Another helpful aspect would be moral insight. A woman, after having received the drugs for months (with marked improvement of her physical condition), came to her pastor early one morning, saying: "I have been reading the Bible, and I realize that I lived a sinful life as a girl, and I want to ask for God's forgiveness." I do not propose that access to antiretroviral drugs should be based on previous repentance, but to facilitate repentance should be part of the counselling process, and repentance, once experienced, will further enhance the chances of success in antiretroviral treatment.

A different approach to select those who should be treated first could be based on the revelation of one's HIV status. If a programme of treatment is to be set up, the first step is to be tested and to give up secrecy. Such self-disclosure may be painful in a culture, which does not condone such a thing,[46] but it may also be seen as the

initial patient's investment[47] that will enhance the success of the treatment.[48]

Start somewhere: institutional approaches

In such an individual approach the churches have much chance to intervene in a positive way, in ways in which the Christian faith plays a clear part. For reasons of the same Christian faith the churches and church-related institutions should also use various institutional approaches to reduce the suffering caused by AIDS. In these, as in the individual approaches, the churches will not be the only players, but since they have means (pastoral and material) to intervene, they are obliged to do that.[49]

I see the first institutional responsibility of the churches to make ARV treatment available in their established health institutions. Here they can make use of the willingness of international charities like Medicins Sans Frontiers to provide the drugs free, so that the burden (still a considerable one) would be just to provide the logistics.[50] This approach would be even more viable once the government provides free ARV drugs for all paid by the Global Fund. Such free availability would increase the logistical problems due to the size of the pandemic, but the churches can meet the challenges in their health systems.

Simultaneously with providing the structures, the church would need to develop a pastoral approach to encourage their members to accept ARV treatment. Here the initial hurdle for many is the HIV test. Every pastor ordained or lay should do such encouraging; but since tradition does not promote this, each church should quickly develop an organized approach concentrating on overcoming stigma, on giving the spiritual means to break the conspiracy of silence,[51] and on orienting spiritually those who are now receiving treatment.[52] For such an organized approach the churches could use some of the methods they are familiar with: pastoral letters, retreats, sermons, seminars, pastors' conferences, women's groups' meetings, training for pastoral workers and the good example of leaders.

Indirect moral effects

A good thing about ARV drugs is that they reduce, in many cases, the viral load to invisibility. That does not imply that such a person will not be able to infect others, but that the chance to do so is much lower. This as such is not a moral achievement, but even if a person with ARV drugs continues with or occasionally relapses into a promiscuous life, it is a moral achievement for those who have made the treatment possible to have reduced the infectiousness and thus possibly to have

saved someone from infection. This, again, is not to condone sin but a help to reduce the detrimental effects sin has. To reduce the number of infections by any effective means is a good and moral thing.

Another good and equally indirect result is that through ARV treatment less people will die. To help avoid a parent's death will fulfill the biblical injunction of looking after widows and orphans, and of course will be in line with the broader biblical concept of promoting life and fighting death. But since AIDS puts such an immense strain on the economy, an effect of ARV treatment will also be the improvement of the economy.

And the dangers?

When the ARV drugs first came on the market, they were a complicated affair[53] that could only be managed by very sophisticated people with a sophisticated medical support system. But that has changed. In most cases treatment is just to take one or two drugs twice a day, and these drugs need no further support than availability. Therefore their complicated nature is no longer an issue.

When everyday compliance was no longer an issue, long-term compliance became a problem, with the fear that after taking the drugs for a few years an immunity could develop, either inbuilt in the drugs or by not taking them any more. But it has been proven that interruptions in taking the drugs can be a good medical procedure, so the very real chance that someone may not continue taking the drugs after a period, can no longer be seen as a real threat. A patient, after discontinuing the drugs, may deteriorate again and probably die, but is not likely to produce an immunity that will affect others.

Another development which may reduce the number of people needing treatment is the recognition, that antiretroviral drugs can even be applied somewhat late, meaning that those whose CD count is still above 300 do not need treatment yet.

Redirect resources?

There is a lot of money to fight AIDS. International donors are keen to invest in the fight, and their resources are being used. Most action plans were made when ARV treatment was not available or feasible. Now that it is there, a redirection of resources might be a moral issue. The government of the United States spent proudly a million dollars on the ICASA Conference in Nairobi, and it may well have been money well spent. The purpose of the Conference was to save lives and

I do believe that it had this effect. But I still have to question if some of the money could not have been used more effectively in providing antiretroviral drugs to some who are on the path to death. The logistics for that, though, may be more difficult than those for a big conference.

The results will also be limited: a million dollars could buy 40,000 months of drugs at $25 a month. If a person needs 10 years of treatment, that would be enough for just 333 people, logistical costs not included. If these people could be treated, the number of deaths, orphans, and infections would be reduced, and, perhaps with lasting effects; an inroad would have been made into the land of the vicious cycle. And many such inroads might in the end destroy it.

Another possibility might be to redirect resources from information to treatment. As it is difficult to measure the effectiveness of information, it is difficult to weigh the options. But they must be considered. It can also be that treatment has an information effect. It may also induce more self-disclosure, some breaking of AIDS-related taboos, values that need to be weighed against the advantages of more information. But I have no scales to do such weighing with any precision.

Any chance?

Maybe not. The pandemic has reached unmanageable proportions, and perhaps it will blow over like the Black Death after having killed a third of the population. To rely on that may or may not be realistic, but is definitely not an option for Christian moral thinking and action. For Christians there is a chance, if not the chance to conquer the pandemic but to do our share in fighting it. I hope that this article is another tiny contribution to this fight.

Notes

1. I still remember that I saw a headline in the German *Bild Zeitung*, a cheap daily in price and content, about a mysterious deadly disease that had broken out among some homosexuals in America. It was termed *Lustseuche*, plague of lust.
2. Their blood does not clot properly, an illness they are born with. Because of

loss of blood they need frequent blood transfusions.

3. This applies also to much of the *mdulo* complex, where putting salt in relish is the activating agency and the wife may become the victim of her husbands breach of taboos (DeGabriele 1999).
4. This has led the World Health Organisation to revise the average life expectancy for Malawi from 49 down to 39 years.
5. The grave shortage of qualified teachers is not only due to AIDS, but is severely aggravated by it.
6. Recently, in our church, we buried a mother who died of AIDS. The children's father had long abandoned interest and responsibility, and after their mother's death the children formed a "child-headed" household.
7. Normally aunts and uncles look after orphaned children. But that is difficult when they all have died already or maybe one is left. One of our students accumulated over 10 children within two years, only to die himself after that, the last of his brothers, a lecturer, at the University told me that he had by then accumulated 18 children from their extended family.
8. This is, of course, not much talked about. Every one dies after a short or a long illness and death comes unexpectedly and as a bad surprise. Fiction is very strong in society.
9. A University lecturer reaches PhD level around the age of 35 and should serve the academic community for another 30 years. But if AIDS kills him/her at 42, the returns on training are small. Such early deaths have, on the other hand, the advantage of providing job openings for the upcoming age group.
10. In 299 sermons collected by Hilary Mijoga, AIDS is mentioned several times. It comes in nicely as a terrible sin or danger, but it is never anything personal or otherwise concrete (Mijoga 2000).
11. In traditional Chewa society, death, except in old age, is usually attributed to personnel agency (Breugel 2001). This concept can easily be applied even now, since AIDS usually kills people who are not yet old.
12. Such figures and others I use in this paper are not precise in any academic sense, but they are a fair representation of overall reality.
13. In the Muslim countries of Northern Africa the infection rate is still low, but there is no evidence that in Malawi the HIV infection rate is lower among Muslims than Christians, nor is there evidence that polygamy reduces the infection rate. The figures quoted for Mangochi District are rather on the higher side.
14. There are of course, also infections due to blood transfusion, etc, but I have personal acquaintance with just one such case. But I do know children who

were infected at birth. A recent American study published in the newspapers here, that claims that a large percentage of infections in Africa is due to blood transfusions, seems to have no relationship to local realities here.

15. Information is not useless, and I do know people here who have changed their behaviour.
16. Mangochi Diocese is one of the many that have an HIV/AIDS programme, inclusive of herbal gardens to help people in treating secondary infections.
17. This happened more through individual behaviour and talk than through official statements.
18. A contribution in that direction, published in English, Chichewa and Tumbuka, is: *The God of Love and Compassion. A Christian Meditation on AIDS.* Zomba: Kachere, n.d.
19. All of Great Britain has currently about 35,000 cases, 20,000 of them under ARV treatment (Ham 2004: 8).
20. In the same way the more legal patent protection laws can be supported by Christian teaching.
21. Of the Southern continents, AIDS spread first and fastest in Africa, but the pattern seems to be repeating itself in Asia and Latin America. It is still to be seen if the relative closedness of Islamic majority societies can prevent the spread of HIV/AIDS in the Middle East.
22. In addition, when so many people are dying, even the imagination that that could change is not easy to sustain.
23. Probably the most prominent group here was the Treatment Action Campaign in South Africa. They had the advantage of being on the spot (and in the spotlight) in a country that has plenty of sufferers and also some economic resources to deal with HIV/AIDS and provide an economic challenge to any worldwide company.
24. Companies claim that a price reduction by 90% is a big thing, but from the perspective of the poor it makes no difference if they fail to afford a drug for one thousand or one hundred dollars a month. (In Malawi the gross national product is around $250 per year per person.)
25. In countries like Botswana and South Africa the level is "possible", in Malawi or Mozambique, the level is "imaginable" (though one may need lots of imagination for that).
26. It was only "found out" later that the TRIPS convention allows for the production of generics, for compulsory licensing and other ways to answer to emergencies.
27. The Treatment Action Campaign in South Africa was able to show that it

would be cheaper for the economy to treat all (at current prices) than not to do so. The government of Thabo Mbeki seems finally to have bought the argument, promising to include treatment for all in the national health care system.

28. As a layperson I would call that a cure. I also consider myself as healthy, though my blood pressure is kept at the appropriate level by two tablets a day.
29. I personally know a man who started the ARV drugs at a CD count of 29 and has not only survived but is now able to work fully again as a trader and to support a family. Five orphans less is a good result of the treatment.
30. That used to be about $28, with the decline of the Kwacha it is now closer to $23.
31. In addition, the fact that the scheme is administered only in Blantyre for the South, adds transport costs for any patient from outside the city. It is also not easy to get the necessary scans etc. quickly, so people are easily discouraged.
32. A high American official is reported to have decided that the supply of antiretroviral drugs to Africa is useless, since Africans "cannot keep time". A good excuse. Critics have pointed out that even the less intelligent among the Africans can distinguish between morning and evening so as to take the drugs at the right times.
33. A parallel argument has been advanced in the West that with the advent of reliable contraceptive medicines, sexual faithfulness is no longer required since no unwanted pregnancies will result. Although I do not deny that Christian teaching can be useful, this line of argument reduces Christian ethics to simple utilitarianism.
34. There are no statistics about HIV infection and AIDS death rates among the clergy, but too many deaths I have heard about or been concerned with, look very much like HIV-based. There is some popular (though incorrect) perception here that all Catholic priests die of AIDS, either sooner or later.
35. Here the Seventh Day Adventist Church recommends the use of condoms for discordant couples. The situation is more difficult for the Roman Catholic Church, which teaches that any use of condoms in sexual intercourse for whatever purpose constitutes a grave sin. Fortunately, some Catholics improve the moral teaching of their church by reality, like a faithful RC doctor in a mission hospital who prescribed contraceptive drugs to those "who wanted them to keep their marriages right".
36. I know that such advice is not easy to give and even less easy to be implemented. But there are cases. Rachel Banda reports that at a Baptist women's meeting during the nightly *chilangizo* (advice) time, a woman asked if she could forgive her errant husband. She was advised to do so, but not to resume

the marriage (Banda 2001).

37. For someone shipwrecked on the sea it makes no difference if she drowns in waters 5m deep or 5000m.
38. The government's promise-at least as reported in the press-to provide free drugs to all by June 04 has not been kept, but I have heard that the drugs have arrived in the country. It seems that the logistics of distribution are more difficult to implement than to make a statement to the press.
39. This could be enhanced by the fact that there is now a drug (Nevirapine), easy to administer that can largely prevent HIV transmission from mother to child.
40. I calculate this figure based on the estimates that there might be 1,000,000 HIV-positive people in Malawi. Probably half of them, with a CD count still above 300 or so, may not need the drug yet. Those who receive the drugs these days may be 5,000, and I add another 5,000 as an estimate for those who should take the drugs and are capable to pay for them, but are not doing that.
41. Lwanda (2004) points out that the K2,500 scheme is essentially designed to subsidize the well-to-do.
42. There is a parallel case in medical moral reasoning. Normally, in case of a catastrophe, those who are injured most gravely will receive the most urgent medical attention. In case of a major nuclear attack with a huge amount of victims, the order will be reversed: those injured least will be treated first, so as to save as many lives as possible (and it is easier to save the lives of those less injured). If the worst injured are treated first, their lives may not be saved, and if, at the cost of losing many lives of those less injured.
43. See, for example, in the *New Testament* James 2:27 "Religion that God our Father accepts as pure and faultless is this: to look after orphans and widows in their distress and to keep oneself from being polluted by the world". For the *Old Testament*, see, for example, Deuteronomy 10:18: "He [God] defends the cause of the fatherless and the widow and loves the alien, giving him food and clothing." Or Psalm 68:5: "A father to the fatherless, a defender of widows, is God in his holy dwelling."
44. In moral terms, to avoid children becoming orphans is also part of looking after orphans in their distress.
45. Here moral naivety must be avoided. In Malawian culture a grown up unmarried woman is not really expected to lead a celibate life, contrary to the perceived "cultural teaching" (and the teaching of the church). So her next marriage or intermittent sexual partners must be included in the calculation. This is not to say that there are no celibate unmarried women in Malawi. But popular perceptions are like that. When a leading Baptist woman, a widow, died,

her death was ascribed by some other women to the lack of Vitamin K, a somewhat mysterious substance that a woman can only acquire through sexual intercourse. If not married, it can be supplied by a "passing" man, a *kachiwala* [grasshopper] (Banda 2001: 169).

46. It seems to me that currently many would not be willing to do this - information from Botswana, where ARV treatment is available free to all, supports this assumption. The reluctance "to come out" will reduce the demands on treatment resources. Such refusal to be tested may be seen as an individual's right, but it has immoral consequences for infected and affected family members and for any possible sexual partners outside of marriage.
47. "The patient's initial investment" is a concept used by the psychotherapist Alfred Adler. He argues that without such a patient's initial investment, the lengthy psychotherapeutic process will not succeed. ARV treatment will probably take even longer time than psychotherapy.
48. From the information received so far it is most likely that the government sponsored free ARV drugs scheme will request the test right at the beginning.
49. This obligation was expressed by Jesus Christ's brother, James like this: "Anyone, then, who knows the good he ought to do and doesn't do it, sins (James 4:17, NIV).
50. A church hospital (Mulanje, CCAP) has already taken up the challenge.
51. In Christian morality this conspiracy is sin, since the silence kills.
52. Part of this orientation has to deal with the fact that even after the beginning of ARV treatment, patients die. I have heard of a 7% death rate in Botswana in the first year, and I have observed myself one or two cases.
53. At one point the prescription was to take drugs at 16 different times within 24 hours in different compositions, and to do so within 10 minutes of the prescribed times.

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