Spreading Zion Southward, Part I: Improving Efficiency and Equity in the Allocation of Church Welfare Resources

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> "And let every man esteem his brother as himself and practice virtue and holiness before me. For what man among you having twelve sons. . .saith unto the one: Be thou clothed in robes and sit thou here; and to the other: Be thou clothed in rags and sit thou there—and. . .saith I am just?"
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> —D&C 38: 24-27

> "There is a state of human misery below which no Latter-day Saint should descend as long as others are living in abundance." —Elder Glenn L. Pace

> "For where your treasure is, there will your heart be also." —Matthew 6:21

THE YEAR WAS 1983. Sister Mercedes Pico de Coello was dying of tuberculosis, coughing up blood. A frail and thin 43-year-old mother of twelve, her life could probably have been saved for $200. As a missionary, I had baptized her in 1980. As a BYU student, I had just spent $850 for this return visit to Ecuador. Neither of us was aware that her illness could be fatal if untreated. With an annual family income of $1200, she could not afford the treatment she needed. I considered giving her the $200, but ultimately I did not do so. Three years later she died from the disease.

1. I wish to thank Armand Mauss for his assistance in editing this study.

By 1997, I was a trained and experienced public health physician, and I had joined with a small group of other returned missionaries from Ecuador to provide charitable assistance to church members there. My involvement in the research for this paper began during a 1999 visit for the dedication of the new temple in Guayaquil, when I heard Ecuadorian members discussing LDS congregations full of malnourished children who could not get help from the church. At first I was skeptical of such alarmist reports and rumors. Nevertheless, I did some initial investigation in the Huancavilca, Prosperina, and Cuenca Stakes of Ecuador, with the help of local physicians practicing in those stakes. I also interviewed nine current or former stake presidents in Ecuador, along with three former bishops. These key informants and the data from these stakes showed that the grim reports I had heard were by no means exaggerated. I expanded my interviews to include stake presidents and bishops, serving from 1990 to the present, in four additional Latin American countries and in the United States.

A decade ago, Elder Glenn L. Pace of the Seventy, formerly Managing Director of Church Welfare Services, posed a question which is the central question for this study: "Faced with ever-louder cries for help from the world, how do we determine where to focus our efforts?"[2] Posed somewhat more elaborately, the question is this: Considering the vast differences in wealth between church members in the less developed countries (LDCs) and those in the wealthier countries (WCs), are the welfare and fast-offering resources of the church being allocated as efficiently and equitably as possible?[3] To begin, we need to know the total annual income for LDS Welfare Services. My interviews with bishops and stake presidents established estimates of fast-offering donations, which averaged $27,000 annually per ward in the United States and $350 per ward or branch in the LDCs. Multiplied by the number of such congregations in (respectively) the United States and the LDCs, these figures would yield about $400 million for the former and $4 million for the latter. We might estimate another $100 million in donated food and clothing, but let's stay with a conservative estimate of $400 million as the total amount likely to be allocated each year between the WCs and the LDCs.[4]

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2. Glenn L. Pace, "Infinite Needs and Finite Resources," *Ensign*, June 1993, 50.

3. By "equitably" here I mean a reasonable distribution of resources that will at least provide basic living standards in light of differing local circumstances in the spirit of D&C 70:14 and 78:6. The definition of "efficient" in this situation is essentially a cost-benefit assessment, such as the "cost per disability-adjusted life year" (DALY) in the LDCs. For examples of how such calculations are carried out by international experts, see *The World Health Report 2001* (Geneva: World Health Organization, 2001), 151-55; and *How the Other Half Dies* (International Medical Volunteer Association, 2002), 6-7, at www.imva.org/Pages/deadtxt.htm.

4. I would welcome discussion by e-mail with anyone having more information or questions about these estimates. Contact me at kwalker22@aol.com.

Research Methods and Data

My main methods consisted of (a) reviewing relevant LDS publications and secondary literature; (b) searching relevant documents and reports published by governmental and international agencies concerned with public health; and (c) interviewing more than thirty current and former priesthood leaders of the church in Mexico, Guatemala, Ecuador, Peru, and Brazil, as well as ten from the United States, all of whom had held positions as stake presidents, bishops, or counselors since 1990. Three of these leaders had access to summary data on welfare spending from three different area offices in Latin America, which they were able verbally to share with me. Various documents and reports, which will be cited at the appropriate places in this article, also provided a great deal of statistical data, most of which must be stringently condensed and summarized here in the interest of space. However, the citations will be full enough that any interested reader can obtain access in libraries or on the internet to verify the generalizations made in this study.

The data from my interviews were more informal and "qualitative," in that they reflect the impressions and extensive personal experiences of priesthood leaders attempting to function successfully at the grassroots in the often agonizing effort to reconcile church policies with pressing human needs not always envisioned by those policies. I have deliberately refrained from using the names of specific informants, since none of them was anxious to attract public attention. Yet all of them, I feel sure, would verify the information I am providing here about the nature and gravity of the problems they have faced and would probably be willing to respond to Spanish-speaking inquirers who would maintain strict confidentiality.[5]

The Problem

This study will demonstrate that the Church of Jesus Christ of Latter-day Saints has at least 375,000 faithful and active members living in dire poverty in the less developed countries (LDCs) of the Western Hemisphere and elsewhere. Included among these are 50,000 malnourished and growth-stunted children under the age of fifteen, two thousand annual cases of severe, preventable disability other than growth-stunting, and nine hundred annual, preventable deaths (mainly children under fifteen). In some of the wards, 80 percent of the children are chronically malnourished and/or dying of malnutrition. Most of this suffering could be relieved by a reallocation of less than 10 percent of the $400 million re-

5. Interested readers should first contact me at the e-mail address given above for further information about the names and addresses of my informants.

ceived annually by the church in cash donations for welfare, including fast offerings. However, only 2 percent of that amount actually goes to the LDCs where 45 percent of the church membership resides. The other 98 percent is spent on members in wealthier countries (WCs), where it duplicates government programs and entitlements already paid for by their taxes. This represents an expenditure of $133 per faithful member in WCs and $5 each in LDCs. In some of the poorest congregations, per capita welfare spending is less than thirty cents, much too small to have a significant impact on malnutrition or disease.

Conditions of the Poorest Members of the Church in LDCs

Of the twelve million members of the Church of Jesus Christ of Latter-day Saints worldwide, about five million live in less developed countries (LDCs), including Latin America, Polynesia, the Philippines, and sub-saharan Africa. Of these LDC Saints, I would estimate that about 30 percent are active or "faithful" members, in the sense that they participate at least periodically in church services and activities.[6] Probably two-thirds of the faithful are women of child-bearing years and children under the age of 15.[7]

Among Latin American LDCs, where 85 percent of the church's LDC population lives, poverty is most pervasive in those countries with largely indigenous populations.[8] About 25 percent of the LDS faithful in these countries live in absolute poverty (defined here as surviving on less than about $1.25 a day), for a total of about 375,000 faithful, poverty-stricken Saints.[9] LDS poverty rates relative to rates in surrounding

6. Some observers would find this an optimistic estimate for any given week. Others have estimated "active" LDS membership in North America at between 40 percent and 60 percent, with estimates elsewhere in the world as low as 20 percent. Obviously the timeframe used in a given estimate will be important. That is, the proportion of new members still active a year after baptism is a different estimate from the proportions active during any significant periods of their lifetimes. Neither "active," "inactive," nor "less active" can be assumed to be a permanent status in any person's life. See Tim B. Heaton, "Vital Statistics," in Daniel H. Ludlow et al., *Encyclopedia of Mormonism: The History, Doctrine, and Procedure of The Church of Jesus Christ of Latter-day Saints*, 4 vols. (New York: Macmillan, 1992), 1527.

7. Heaton ("Vital Statistics," 1528-29) shows around 40 percent of the LDS population in LDCs as children under eighteen and a sex ratio of 8:10 (favoring females, who are also more likely to be "faithful"). From my experience with LDS congregations in LDCs, I would estimate that 75 percent of those attending any given worship service are women younger than forty-five with minor children.

8. *World Health Report 2000*, 196-99. See also *Advancing the People's Health—2000: Report of the Director* (Washington, D.C.: Pan American Health Organization, 2000), 3-17, 111.

9. The estimate here of 25 percent for those in absolute poverty comes from multiplying absolute poverty rates in specific LDCs by the percentage of LDS members in a given

national populations are lower than average in Mexico and Brazil, about average in Peru (and presumably the rest of Latin America), and higher than average in Africa and in the Philippines.[10]

In the stakes on which this study is based, the general definition of "poverty" was income ranging from 20 cents to $2.00 per person per day. Income in this range is not unusual in LDCs, even for those fully employed.[11] The presidents of the stakes I studied generally considered a daily wage of less than a dollar per person as too small even to obtain enough food. Unemployment and underemployment are serious problems for members in these stakes, and the poorest among them tend to live in slums and favelas, with some stakes composed almost entirely of members in dire poverty.

Such poverty, in turn, translates directly into malnutrition, disease, and death.[12] A tenth of the children under age fifteen (est. fifty thousand faithful) are chronically malnourished with their growth stunted from inadequate food intake, parasitic infections, and early weaning.[13] Each year another two thousand faithful members suffer from significant

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country or region listed in the *Deseret News Church Almanac*, 2001-2002, 271-421. The PAHO internet site at www.paho.org lists absolute poverty rates for each Latin American country. These rates were determined by using data listed in this site under "basic health indicators B9 and B10," then extrapolating for missing "country-adjusted" data from the relevant region, and multiplying by membership figures in the *Almanac*. Obviously this procedure can provide only estimates, but strict precision in these calculations is almost irrelevant in the face of the gross disparities demonstrated here in the distribution of church resources between the WCs and the LDCs.

10. Garth L. Mangum and Bruce D. Blumell, *The Mormons' War on Poverty: A History of LDS Welfare, 1830-1990* (Salt Lake City: University of Utah Press, 1993), 216-33; and James Lucas and Warner Woodworth, *Working Toward Zion* (Salt Lake City, Utah: Aspen Books, 1996), 164.

11. See Morris Thompson, "Woman among Mexico's Millions Surviving on $2/day," *Las Vegas Review Journal*, 26 May 2001, 30A, which quotes the "World Bank Report" as saying that 60 percent of the world's population survives on less than $2 a day, and in Mexico itself, 16 percent on less than $1 a day; also Zakaria Fareed, "Some Real Street Smarts," *Newsweek*, 20 July 2001, 25, reports that 25 percent of the world's population also survives on less than $1 a day. Obviously there is a big difference between surviving on one dollar a day and on 20-40 cents a day. Much of the premature death and disability comes from among those in "extreme" poverty with incomes well under one dollar per day.

12. In the calculations which follow here and later, for rates of illness, morbidity, and mortality in LDCs (but not for poverty rates), I am somewhat arbitrarily using an "offset factor" of 20 percent in comparing LDS with general rates. In other words, I am assuming that the LDS cultural expectation of abstinence from alcohol and tobacco will reduce these rates by about 20 percent. Note that such an assumption produces a more *conservative* estimate of comparative LDS suffering. We are not able to estimate whether or not these rates would be different for recent converts compared to lifelong members.

13. Mercedes de Onis et al., "Is Malnutrition Declining? An Analysis of Changes in Levels of Child Malnutrition since 1980," *WHO Global Database of Child Growth* (Geneva: WHO, 2000), 2-3, lists 12.6 percent of Latin American children as growth-stunted from malnutrition. Using a 20 percent "offset factor" for being "LDS" (10 percent instead of 12.6 percent

preventable disability other than growth stunting.[14] Death rates from malnutrition and from infectious diseases (preventable at low cost) are shown in Table 1.[15] Half of these preventable deaths occur in the first year of life, 60 percent in children under age five, and 67 percent in children under age fifteen.[16] Mortality rates under age five are about forty-six per thousand in Latin America generally, so we can assume that even among the LDS faithful, the rate in LDCs generally would be at least thirty-seven per thousand, given the "offset factor" explained above.[17]

Table 1
Communicable, Nutritional, Maternal, and Perinatal
Annual Preventable Deaths in LDCs[18]

Cause[19]	Worldwide	Lat.America	Total Church	Faithful Church
Tuberculosis	1.7 mil	57,000	456	142
Diarrhea	2.2 mil	72,000	576	180
Pertussis	295,000	14,000	112	35
Tet& Measles	1.2 mil	5,000	40	12
Meningitis	171,000	13,000	104	32
Hepatitis	596,000	14,000	112	35
Malaria	1.1 mil	2,000	16	5
Schistosomia	14,000	2,000	16	5
Leprosy	3,000	1,000	8	2
"Worms"	16,000	2,000	16	5
Respiratory	4 mil	159,000	1,280	400
Maternal	497,000	18,000	144	45
Perinatal	2.4 mil	138,000	1,120	325
Anemia	133,000	20,000	160	50
Malnutrition[20]	272,000	43,000	344	108
Total (Appr)	14.6 mil	560,000	4,500	1,337

malnourished) and assuming 500,000 faithful church children under age fifteen in LDCs (all of whom are assumed to live in Latin America) gives 50,000 malnourished children.

14. There are an estimated two to three cases of disability avoided or prevented for each death prevented. This study will later describe an intervention program which would prevent an estimated nine hundred deaths annually among faithful church members. The "2000 significant disabilities" can also be estimated from C. J. L. Murray et al., "Quantifying Disability," *Global Comparative Assessments in the Health Sector* (Geneva: WHO, 1994), 49.

15. Data in this table are adapted from "Statistical Data from World Health Report 2000, Annex Table 3: Deaths by Cause, Sex, and Mortality Stratum in WHO Regions—Estimates for 1999," *World Health Report 2000* (Geneva: WHO, 2000), 104-05. In order to estimate church total and church faithful rates, all church LDC membership is assumed to live in Latin America (and would then comprise 1 percent of the total population of Latin America). Also assumed is a 30 percent "faithful" rate and the above-mentioned offset factor of 20 percent, so the table's figures are products of two multipliers: 0.3 ("faithful" rate) and 0.8 (1.0 minus the offset).

16. C. J. L. Murray et al., "Global and Regional Cause of Death Patterns," *Global Comparative Assessments in the Health Sector* (Geneva: WHO, 1994), 49.

17. "Statistical Annex: Demographic Characteristics of WHO Regions—Estimates for

Beyond the general picture in this table, the extensiveness and gravity of child malnutrition and disease among the Latter-day Saints in LDCs can be vividly illustrated by conditions in two representative stakes in Guayaquil, Ecuador. During the year 2000, in the Las Malvinas Ward, Huancavilca Stake, with fifty children aged one to fourteen, 80 percent of the children had abnormally low height per age, and 88 percent had abnormally low weight per age; more than 40 percent were anemic and more than 80 percent had parasites. In the Colinas al Sol, Florida, and Gallegos Lara Wards of the Prosperina Stake, with one hundred children age fourteen or younger, seventy had abnormally low height per age and eighty had abnormally low weight per age; more than sixty were anemic and more than eighty had parasites.[21] In addition, physicians practicing in Cuenca, Ecuador, were able to furnish me with a list of infants who had died among the Saints in the Cuenca Stake between 1980 and 2000. Although it was only a partial list, it contained the names of ten infants, ranging in age from three days to sixteen months, who had died from pneumonia, bronchitis, amoebic dysentery, diarrhea, measles, and malnutrition.[22]

Local leaders see the implications of these figures firsthand in poignant predicaments even during church meetings. A physician and former stake president reports, "In the poor congregations in my country, the children are calorie-deficient and lack the energy even to stay awake during morning Primary. Many simply fall asleep or lie down on the floor. Most of the children get only one meal a day. It would be good if we could feed them breakfast prior to church services." Late one year, with the arrival of the holiday season, a stake president in Mexico lamented that many families in his stake had no means to provide either dinner or presents for their children at Christmas. He proposed that a charitable foundation consisting of ex-missionaries collect and bring

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1978 and 1998," *World Health Report 1999* (Geneva: WHO, 1999), 111, lists the mortality rate under age five as 46/1000 for Latin America and 10/1000 for the U.S.

18. Excluding HIV, STDs, and Chaga's Disease

19. Pertussis, tetanus, measles, hepatitis A and B, miliary TB, meningitis, and pneumonia are partly or wholly vaccine-preventable.

20. These are deaths attributed directly to malnutrition. Fifty percent of the other deaths from this table would have been prevented if malnutrition were eliminated, as discussed later in the study.

21. These data are summaries of studies provided to me by three health professionals at the Fundacion Ayuda Humanitaria who are practicing in these stakes: Dr. Marisol Navarrete (general practice), Dr. Sandra Hernandez (pediatrician), and Ms. Teresa Fuentes (e-mail teresavfuentes@yahoo.com). Height per age is the best indicator of chronic malnutrition, and "low" height or weight per age corresponds to <3rd percent on a U.S. (NCHS) growth chart.

22. Drs. Jorge and Gladys Guerrero (general practice), Cuenca, Ecuador, e-mail prodilec@cue.satnet.net.

presents for children to a big stake dinner which his stake members would provide, but then he added, "Of course, if there are others more in need, then help them out. Just let me know." A current stake president in Ecuador pleaded, "Elder Walker, please go back to Salt Lake City and tell the missionaries who worked here how desperate we are for food and medicines. I have no money to help all the hungry children in my stake. Ask the ex-missionaries to send us food and medicine."

Such conditions in the wards and stakes of LDCs tug at the hearts of any North Americans visiting there, but they are simply reflections of conditions in LDCs more generally. The following summary of the situation by the World Health Organization is apt and applicable here:

> Poverty is the main reason why babies are not vaccinated, why clean water and sanitation are not provided, why curative drugs and other treatments are unavailable, and why mothers die in childbirth. . . .Every year in the less-developed world 12.2 million children under five years die, most of them from causes that could be prevented for just a few U.S. cents per child.[23]

Expectations of Church Leaders and Members in Wealthier Countries

Most Latter-day Saints in the wealthier countries are surprised to learn how desperate the conditions of the Saints in the LDCs are.[24] We are justly proud, if sometimes too smug, about the economic success of the Western way of life generally, and of the economic progress of EuroAmerican Latter-day Saints in particular.[25] The LDS church itself has attracted much attention, usually unwanted, for its extraordinary wealth as an institution.[26] In view of such economic success, we assume—in a church committed historically to "taking care of its own"—we would not leave our brothers and sisters in LDCs to fend for themselves—would we? The answer is no, not deliberately.

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23. "The State of World Health," *World Health Report 1995—Executive Summary* (Geneva: WHO, 1995), 1.

24. Certainly the American Saints and their leaders with any firsthand experience in Latin America are not so sanguine. See Mark L. Grover, "Relief Society and Church Welfare: The Brazilian Experience," *Dialogue* 27 (Winter 1994): 29-38.

25. During the past half century, American Mormons have risen in comparative socio-economic status from generally working class and rural backgrounds to near parity with American Episcopalians and Presbyterians. See W. Clark Roof and William McKinney, *American Mainline Religion: Its Changing Shape and Future* (New Brunswick, N.J.: Rutgers University Press, 1987), 110; and Armand L. Mauss, *The Angel and the Beehive: The Mormon Struggle with Assimilation* (Urbana and Chicago: University of Illinois Press, 1994), 21-24.

26. Richard N. Ostling and Joan K. Ostling, *Mormon America: The Power and the Promise* (San Francisco: Harper, 1999), 113-29; 395-400.

Our church leaders have repeatedly called for us to share our abundance with the world, especially with those in extreme circumstances. In the words of Elder Glenn L. Pace, "There is a state of human misery below which no Latter-day Saint should descend as long as others are living in abundance."[27] In a *Church News* article only a little more than a year ago, President Hinckley declared, "I hope [and believe] the Church is good at taking care of its own. . . .It has a responsibility sure and certain that we must take care of our own and assist them with their problems."[28] In a similar vein, President Kimball once assured us, "If every member of this Church observed the fast and contributed generously, the poor and needy—not only of the Church but many others as well—would be blessed and provided for."[29]

Such then are the expectations of our leaders. What about the realities? How could these southern-hemisphere Saints, especially the children, be living in the deplorable conditions described above? The explanation lies in the operational functions and procedures rather than the intentions of the church leaders or programs. As we might expect, the present situation has an historical context. Both the fast offering system, which originated in the nineteenth century, and the welfare program, started in the 1930s, have been guided by certain philosophical—even theological—principles. These were entirely appropriate to the times and locales in which they originated and might still make perfectly good sense in the United States and in other relatively wealthy countries. In the less developed countries, however, they have unintended consequences that are not only ironic but tragic.

Philosophical Principles vs. Practical Realities in Church Welfare Programs and Policies

The Traditional LDS Welfare Philosophy[30]

One traditional ideal of the church's welfare program is that the locus of responsibility for a person's welfare should be kept as close as possible to the needy individual or family. The helping process begins with self-reliance, which by extension becomes family reliance, and then, as necessary, reliance on the local ward and stake (or branch and

27. Pace, "Infinite Needs," 54.

28. "Messages of the First Presidency: Humanitarian Aid," *Church News*, 6 October 2001, 2.

29. Quoted by Edward L. Soper in "I Have a Question," *Ensign*, September 1982, 30.

30. This philosophy was nicely summarized in the priesthood and Relief Society manual of the church for 2002 ("Providing the Lord's Way," *Teachings of the Presidents of the Church: Harold B. Lee* [Salt Lake City: Church of Jesus Christ of Latter-day Saints, 2000], 165-74).

mission). The general welfare resources of the church should be the last resort for any needy Saints (except perhaps for those not eligible—i.e., not "worthy" in the eyes of their bishops).

A second and derivative principle is "working for what you get"—putting something back into the system in return for one's assistance. This is not necessarily *quid pro quo*, since many are not able to "work off" the full material value of what they have received. The moral principle here is more important than economic parity: The beneficiary maintains his/her dignity and self-esteem through honest labor, rather than learning to live "on the dole." A third derivative principle is the temporary nature of welfare assistance. It is not supposed to be a way of life. One is expected to return as soon as possible to a self-supporting, self-reliant, and self-respecting life. A fourth principle is the moral and spiritual imperative to sacrifice for others, so that in contributing our fast offerings, our labor, or other resources on behalf of the needy among us, we are actually improving our own spiritual condition.

This general philosophy has worked reasonably well among the Saints of North America, at least in recent decades, although it must be conceded that the church has never truly succeeded in "taking care of its own," even in Utah, where public assistance rolls have always been among the largest in the nation relative to population.[31] Yet most stakes in North America have been able to cover the needs of their church members for special assistance, and many stakes have regularly sent surpluses to church headquarters as "general fast-offering" funds. One of the reasons that stakes in North America can handle their welfare problems so well is that a large proportion of those general fast-offering funds (perhaps most) are spent at bishops' storehouses and Deseret Industries, which do not exist in the LDCs to any appreciable extent. These institutions have enabled many American bishops to spend more than their entire fast-offering donations on shelter aid because they can draw on food and clothing from D. I. and the storehouses, "off budget," as it were.[32]

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31. James B. Allen and Glen M. Leonard, *The Story of the Latter-day Saints* (Salt Lake City: Deseret Book Co., 1992), 525. For the historical context and basis for this generalization, see e. g., Wayne K. Hinton, "Some Historical Perspective on Mormon Responses to the Great Depression," *Journal of the West* 24 (October 1985), 19-26, and (same author), "The Economics of Ambivalence: Utah's Depression Experience," *Utah Historical Quarterly* 54 (Summer 1986), 268-85. For book-length histories, see Mangum and Blumell, *The Mormons' War on Poverty* (cited above), and Glen L. Rudd, *Pure Religion: The Story of Church Welfare since 1930* (Salt Lake City: Church of Jesus Christ of Latter-day Saints, 1995).

32. Rudd, *Pure Religion*, 203-44. One Spanish-speaking ward of which I have personal knowledge in Las Vegas, for example, has in recent years spent as much as $25,000 a year in fast-offering funds, exceeding the total spent by half of the thirty-four stakes in Ecuador in the year 2000.

The relative prosperity of U.S. stakes has been indirectly responsible for certain ironies and inequities even among the Saints in North America. One of the ironies is that traditional church counsel to avoid the "public dole" has often put the church in the position of subsidizing local, state, and federal governments. To the extent that a church member receives ward or stake assistance in preference to public assistance in food, housing, clothing, or medical care, he or she is freeing up government funds that have been appropriated from the taxes of all citizens, including LDS citizens, needy or otherwise. In that way, church funds are being used in place of public funds to which the needy person is entitled, so the church is subsidizing government programs. This would be irony enough if the effect were limited to the U.S. The irony is compounded, however, when we realize that if church funds were not being used for such subsidies in relatively prosperous North America, they might instead be available for distribution in the stakes of LDCs, where they are desperately needed, and where most governments are not taking responsibility for these needs. Instead, the church leaders in LDCs are instructed to follow the same program and principles applied in North America—namely handle stake needs within the stake. This is often useless advice under the circumstances.

Public welfare, as we know it in the United States, does not exist in the LDCs to substitute for (or supplement) church resources. Some LDCs do have heavily subsidized prices for food, medical care, fuel, and electricity, but these subsidies are not sufficient to cover costs in the poorest countries. Furthermore, many governments in those countries are under pressure from international organizations to decrease or eliminate these subsidies. Medical care in those countries often presents an acute crisis for a family, which cannot raise even the $5 required for a prescription which would make the difference between life and death for a child with pneumonia. In Ecuador, for example, where ostensibly there is a system of public medical care for the poor, hospitals and clinics periodically just close because they run out of medicines, or because employees have not been paid on time.

Misguided Applications of the LDS Welfare Philosophy

The LDS welfare philosophy developed under circumstances quite different from those we see today in a worldwide church. It was the product largely of a pioneering, western American culture before the arrival of the welfare state. Prior to the middle of the twentieth century, the church had only a minimal presence in LDCs, and most WCs with appreciable Mormon numbers (including the U.S.) had not constructed the public welfare "safety nets" we see today. We were far less likely, therefore, to see the irony discussed above, in which the ideal of "most proxi-

mate" welfare responsibility results in directing stakes in LDCs to "take care of their own" in the absence of meaningful local resources, while wards and stakes in the U.S. sometimes duplicate public services.

As this principle of local self-sufficiency (autosuficiencia) is applied by stake and ward leaders in the LDCs, it means that a ward, on average, can expect no more than $150 annually from the general fast-offering funds distributed through the area office. One wonders why stakes and wards cannot be given more from the general fast-offering funds to relieve premature death and disability of children. Instead, instructions to stake presidents from area leaders restrict the use of such funds to "unusual or emergency circumstances," generally interpreted to mean needs for cancer treatment, extensive surgery, prostheses, and other chronic conditions.[33] Requests from stakes have to be justified in writing, and they are often turned down. In my interviews, stake presidents often made comments such as: "We know if we ask for help from the area, we'll be turned down," or "we got a letter from the area office instructing us not to ask for help unless it's an emergency," or "I asked for help but was told by the area office that they didn't have enough money this year," and so on. Not one stake president or bishop to whom I spoke had been given any funds from area offices to meet such critical needs as minimal nutrition, vaccines, de-worming, or medicines for diarrhea or respiratory infections, which are the most cost-effective interventions by far in order to save lives."[34]

A related irony can be seen in the traditional LDS welfare principle that sacrifice is good for the soul, at least as that principle is applied to LDCs. The prophet Joseph Smith himself declared, "A religion that does not require the sacrifice of all things never has power sufficient to produce the faith necessary unto life and salvation."[35] Guided in part by that principle, Elder Glenn L. Pace, then of the Presiding Bishopric, once recounted an experience with a stake president in South America, who had received only $200 from his area office during the previous three years, while half of his members were unemployed. Under these circumstances, members of extended families had helped each other, and mem-

33. In addition, the church leaders interviewed for this study had the unfortunate impression in Latin America that access to general fast-offering funds is dependent more upon personal friendships or connections with personnel in area offices than upon need, worthiness, or logic.

34. Cost-effective intervention in LDCs is the subject of intensive study and regular publication, as shown later in this paper. Furthermore, bishops and stake presidents do not have the requisite expertise to implement an effective program for nutrition and health care, even if they had the money; their roles should be limited to determining eligibility for such intervention, and worthy members should then be turned over to church health professionals.

35. Lucas and Woodworth, *Working toward Zion*, 254.

bers of wards had "shared what they had, however meager." A great increase in spirituality resulted in the stake. Elder Pace then observed, "We could have poured money into this stake from more affluent areas and felt good about it. However, in doing so we would have robbed them of the opportunity to serve each other and to become sanctified in the process."[36] He does not say what the temporal human costs were that accompanied the spiritual growth, but on the basis of the typical calculations explained earlier in this paper, I would estimate that the stake in question, over three years, would have seen the avoidable deaths of sixteen small children and the growth-stunting of forty more, in the absence of the minimal extra funds required to nourish and vaccinate these children. The ultimate irony here is found later in the same article, where Elder Pace makes the declaration I quoted earlier that "no Latter-day Saint" should have to descend into "a state of human misery. . .as long as others are living in abundance."[37]

The "flip side," as it were, of the official church concern with promoting the principle of sacrifice for spiritual growth is minimizing the risk of "economic conversions" on a large scale. As explained a few years ago in an *Ensign* article, "Historically, Christian missionaries often [converted] 'rice Christians' by offering people food and money. In [nations] familiar with the faces of hunger and suffering, the 'rice Christian' attitude persists today. People are surprised to learn that converts join [our church] to give and serve, not to receive handouts."[38] Or, in the words of Richard and Joan Ostling, "No Rice Mormons."[39] Of course, no one would advocate offering material incentives to join the church, but neither would we advocate the opposite extreme, namely that desperately needed help should be withheld to prevent "economic conversions."

Indeed, it is precisely the apparent tendency to go to extremes with the traditional welfare philosophy that seems so misguided when this philosophy is applied to the LDCs. It is as though the philosophy is applied arbitrarily, for its own sake, rather than with the practical realities of a twenty-first century global church in mind. If the philosophy calls for self-reliance, or at least keeping welfare assistance "as close to home" as possible, then we tell stakes in LDCs to look after their own, even though a fraction of the funds consumed in prosperous American stakes

36. Pace, "Infinite Needs," 54.

37. Ibid.

38. Michael Morris, "India: A Season of Sowing," *Ensign*, July 1995, 40.

39. This was the conclusion of the Ostlings after quoting Elder James O. Mason, Africa Area President and former assistant secretary at the U. S. Department of Health and Human Services. Elder Mason had been expressing some concern lest new converts in Africa might join the church "for the wrong reasons"(Ostling and Ostling, *Mormon America*, 211).

could make the difference between life and death for thousands in the stakes of LDCs. If the philosophy calls for building spirituality through sacrifices by individuals, families, wards, and stakes, then we withhold desperately needed general funds from stakes in LDCs, even though they have nothing left to sacrifice. Whatever material and spiritual benefits might result from mutual sharing among the Saints in any ward or stake, *a situation in which the poor are donating to the poor will never alleviate conditions such as malnutrition and premature death or disability in the LDCs.*

Inconsistent and Illogical Applications of the Philosophy

Aside from the question of how practical and equitable such a philosophy would be if applied churchwide, a major operational problem is the inconsistent—sometimes even arbitrary—application of the philosophy at the local level.[40] Some members in WCs are too humiliated to seek public funds to which they might be entitled or civil remedies available to them when debt burdens become dangerously large. Accordingly, they seek temporary and confidential relief from local bishops, even when they are living in half-million dollar homes. Others expect bishops to cover airfares for visits to dying relatives or moving costs to go from one job to the next. I am personally knowledgeable about such cases. When these sorts of inconsistencies exist, skillful freeloaders among the Saints are able to move from place to place in search of the most generous bishops or to put pressure on reluctant bishops by citing precedents from earlier and more accommodating local leaders.

Nor does this inconsistency occur only in WCs. I am personally acquainted with the case of a stake president in Latin America, who had an annual fast offering total of only $500 to work with, no access to general church fast offerings, and who admitted that 80 percent of the children in his stake were malnourished; but still he spent half of his fast offerings on funerals for members. Obviously, operational inconsistencies in the WCs can drain off a lot more from the total fund of the church than can the same in LDCs. Even the most consistent application of welfare policy and philosophy in LDCs would do little to offset the reality that per capita welfare spending in the United States is $133, compared to an average of $5 in LDCs, and as little as $.30 in the poorest congregations.[41] Nor is help available from the LDS Humanitarian Fund, which is established to offer

40. Church leaders are apparently well aware of this inconsistency, judging from a recent history of LDS welfare. See Rudd, *Pure Religion*, 284-88.

41. The general fast-offering funds were allocated in far greater quantity to LDC wards/stakes with higher fast-offering donations, i.e., the wealthier stakes. Many of the poorest wards/stakes have received no help from this fund over the last five to six years.

assistance only *outside* the church. This maldistribution of welfare and fast offering funds is in stark contrast to the much more equitable distribution of tithing funds, which, according to most research, represents a net transfer of tithing from WCs to the LDCs for missionary work and for capital development in land, churches, temples, and other buildings.[42]

Lack of a Churchwide Monitoring System for Health and Welfare

President Kimball once made the highly appropriate comment, "I do not worry about the members of the Church being unresponsive when they learn of the needy as much as I worry about our being unaware of such needs."[43] The disparities in church welfare resources between the WCs and the LDCs suggest just such a lack of awareness in high places. Sometimes this lack is brought to church attention in sudden and dramatic ways, as when a serious famine was discovered a couple of years ago among members in Africa.[44] While we can rejoice that the church was able to rush some food staples to alleviate the suffering there, we cannot fail to note that no such response has been forthcoming for the 50,000 chronically malnourished LDS children still waiting in Latin America and the Philippines. This juxtaposition of official expectations with such inadequate and ad hoc responses to severe crises suggests the need for a systematic program to monitor such needs around the church, especially in areas of desperate and chronic poverty.

What Can Be Done?

As we contemplate the desperate conditions of so many of our brothers and sisters in the LDCs, we recognize immediately that we cannot fundamentally change such conditions in the foreseeable future. It is within neither the power nor the mission of the church to alleviate the recurrent political and economic chaos which has historically kept the masses in these nations from enjoying more than bare subsistence, if that. However, given the current level of welfare contributions, the church could easily modify its welfare program to provide each faithful member with minimal nutrition and access to health care. If a work requirement were included where appropriate, "economic conversions" would be minimal and might even strengthen the social and spiritual connections of recipients to the church.

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42. See, e. g., Ostling and Ostling, *Mormon America*, 120-27, and Gordon Shepherd and Gary Shepherd, "Membership Growth, Church Activity, and Missionary Recruitment," *Dialogue* 29 (Spring 1996): 48-49.

43. Quoted by Soper, "I Have a Question," 30.

44. See E. Dale LeBaron, "Pioneering in Chyulu," *Ensign*, February 2001, 34.

Following is an outline of a program that could be implemented in a very short time for faithful members. It would not be a substitute for the current welfare system, but rather a supplement to it in certain LDCs. Instead of being administered by area and stake offices, this new program could be the responsibility of "LDS Family Services," while still financed from general fast-offering funds. As a general policy, it would give priority to various low-cost interventions in conditions of health and nutrition in the LDCs, with special attention to children under age fifteen and to adults with pregnancies and/or the principal infectious diseases. (About 80 percent of the health problems in LDCs are attributable to six causes, four of them infectious diseases—e.g. tuberculosis, malaria, childhood pneumonia, diarrhea—plus risks of childbirth and pregnancies, especially unintended ones).[45]

(1) As a starting point, major international health organizations, such as WHO, AID, OXFAM, and others have generally agreed on an efficient and effective program targeted in this manner.[46] One example of such an intervention showed that providing processed food supplements in a malnourished population, at a daily cost of 15 cents per person,[47] brought reductions of 50 percent or more in deaths among small children from infectious disease, anemia, or malnutrition, as well as significant decreases in maternal and neonatal mortality.[48] These food supplements are manufactured in LDCs and resemble anything from candy bars or milkshakes to mashed potatoes (but are not as palatable). They are not normal food or staples but provide a certain level of calories and vitamins (micronutrients).

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45. "Health Care in Poor Nations as Much as a Century Behind," *USA Today*, 24 March 2000, 1A-2A. By one informed estimate in this article, these major diseases could be largely eliminated among the very poor for about $15 per person per year.

46. For examples of such programs see *Improving Child Health: The Integrated Approach* (Geneva: WHO Division of Child Health and Development,1998), 1-11; J. L. Bobadilla et al., "Design, Content, and Financing of an Essential National Package of Health Services" in *Global Comparative Assessments in the Health Sector* (Geneva: WHO, 1994), 171-80; "Health Services: Well Chosen, Well Organized" in *World Health Report 2000* (Geneva: WHO, 2000), 53; and J. Rivera et al., "Implementation, Monitoring, and Evaluation of the Mexican Social Programme (PROGRESA)," in *The Food and Nutrition Bulletin* (New York City: The United Nations University 2000) 21:35-41.

47. See "Processed Complimentary Foods: Summary of National Characteristics, Methods of Production, Distribution, and Costs," in *The Food and Nutrition Bulletin* (New York City: The United Nations University, 2000) 21:41, 44, 50, 78, 95, 99.

48. See "Tackling Hunger in a World Full of Food, Tasks Ahead for Food Aid, #1.10," in *World Food Summit* (Geneva: World Food Programme, 1998), 1; "Fact Sheet #178," in *Reducing Mortality from Major Killers of Children* (Geneva: WHO, 1998), 4; and *Malnutrition Affects Productivity: Improved Nutrition/Nutrition and Maternal Health/PHN Home* (Washington, D.C.: USAID Internet site at www.usaid.gov, 2002), 2.

If this intervention were implemented in the LDCs, food supplements could be purchased locally and distributed on perhaps a monthly basis at LDS chapels or during home health care visits. Experience has indicated the importance of the role of home health workers here, who can provide clients the education they need to make the best use of these supplements as part of a broader nutritional regimen (see below). Bishops who believe that inactive members are taking advantage of the church's resources can require some level of church participation for eligibility, but this is not a likely problem, for it has been difficult to convince the Latin American poor to use food supplements, even when such have been provided free of charge by their governments. At a daily cost of 15 cents per daily ration, or about $50 annually for the 375,000 poor mentioned earlier, the total cost would be about $19 million.

(2) Going beyond the question of nutrition to medical intervention, the same international literature described a program in northern Brazil, where a reduction of 50 percent in deaths of children under age five was associated with a program of home health education visits by trained health care workers at an annual cost of $1.30 per client-year. No actual health care was provided during these visits, but clients' nutritional status was evaluated and they were referred to health care providers.[49] To adapt this kind of intervention to the church membership in LDCs, a corps of trained, local health workers (such as nurses) would offer home visits to LDS families ("active" or not) to provide health care instruction on nutrition, water sanitation (including distribution of chlorine), plus information and referrals to available local health care resources wherever they exist.

(3) A more advanced intervention would consist of opening LDS stake centers, chapels, or other buildings on Saturdays every month or two for "health fairs," where nurses and other health professionals would provide not only health education but also such periodic services as de-worming and vaccinations in areas where local governmental services did not reliably provide such. (A few stakes in Ecuador actually provided de-worming and vaccinations for a while, with donated medicines and professional time, but were eventually forced by lack of funds to discontinue these services). Other non-profit or governmental agencies could make similar use of LDS buildings on the same or other occasions to serve non-Mormon clients.

Clearly the major expense of these three kinds of intervention would be professional personnel for the home visits and the health care classes

49. E. Cutino et al., "Primary Health Care Lessons for the Northeast of Brazil: The Asentes de Saude Program," *Pan American Journal of Health* 7, no. 5 (2000): 293-302.

and services, since the LDS missionaries in those countries are usually not qualified and should not be used for such purposes. Bishops and other priesthood leaders are likewise not usually qualified to decide what health care members need or where they should be referred. However, some local (native) nurses or other professionals, Mormon and non-Mormon, are available on a volunteer basis in many of these locations, and these could eventually be supplemented by LDS health missionaries, both native and foreign. Such health workers could travel to designated LDS buildings every two months on a rotating schedule.

(4) Once this system is operating reasonably well, it could be escalated by the limited addition of clinics in the major urban areas, where eligible church members could be treated by physicians, nurses, pharmacists, or other highly trained professionals for pregnancies, pneumonia, diarrhea, tuberculosis, malaria, typhoid fever, septicemia, and other conditions that yield readily to low-cost treatments. In many of these areas, public hospitals or governmental services of these kinds already exist, so only a few LDS clinics would be necessary to supplement, or refer members to, those public services. Professional staffs for these clinics would not be very expensive: Many primary health physicians in Ecuador, for example, earn only about $200 per month. Access to LDS clinics could be limited, if necessary, to members with recommends from their bishops.

I would estimate the cost of the medical interventions (#2, 3, 4) at about $14 million per year. If the rotating home health program served as many as three million of the five million Latter-day Saints in LDCs at two dollars per capita (cf. the Brazilian program, mentioned above, at $1.30), the cost would be $6 million. Then, assuming that the 375,000 faithful members in dire poverty (cited earlier) were all to be served by the two more advanced kinds of intervention (rotating Saturday "fairs" and supplemental urban clinics), the cost for these at $22 per poor member would be about $8 million.[50] Thus, all three medical interventions would total $14 million. Adding in the cost for food supplements (#1) mentioned earlier ($19 million) would bring the total for all these relatively low-cost interventions to $33 million, or less than 10 percent of the annual church income in fast offerings and welfare funds.

Thus, reallocating general fast-offering funds from the WCs to the LDCs, even to this minimal degree (whether through LDS Family Services or otherwise), would alleviate the chronic malnourishment of 50,000 faithful LDS children, preventing nine hundred annual deaths (85 percent of them children of the faithful),[51] and avoiding two thousand

50. Bobadilla et al., "Design, Content, and Financing," 171.

51. Intervention #1 (food supplements) would decrease the under-five death rates by 50 percent, per a prior footnote. Intervention #2 (nurses visiting poor members homes to

new cases of significant disabilities annually among the membership.[53] The stakes in LDCs could then come much closer to the ideal of "taking care of our own" by continuing to provide basic food staples and shelter or housing locally for the current outlay of about $4 million annually. With the fundamentals of nutrition and medical care—which WCs are able to take largely for granted—the stakes in LDCs would have a somewhat more "level playing field" on which to apply the ideals of the LDS welfare philosophy to their specific situations. They could then deal with acute crises in food and shelter among themselves by making "sacrifices" more appropriate to their conditions, and requiring recipients to "work for what they get" in ways that make sense locally.

Perhaps then the church as a whole, both north and south, will also begin to approach the scriptural ideal of Zion as the Lord's own people, who "were of one heart and one mind, and dwelt in righteousness; and there was no poor among them" (Moses 7:18).

LOOK FOR PART II IN THE NEXT ISSUE OF *DIALOGUE*.

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provide educational services) was also associated with a 50 percent decrease in the total under-five death rates in Northern Brazil (the infectious diseases listed in Table 1 cause 85 percent of the under-five death rates in Latin America). Interventions's #3 & #4 (urban church clinics and vaccination/de-worming every two months at specified chapels with simultaneous health education classes) would decrease the death rates by an average of 22 percent, per Bobadilla "Design, Content, and Financing", 171. The sum of all four interventions is estimated to decrease the under-five mortality rate from 37/1000 to 16/1000, or prevent 70 percent of the infectious disease deaths among faithful members from Table 1 (the 1,337 infectious disease deaths from Table 1 would decrease to approximately four hundred). This would give the church an "under-five mortality rate" similar to that of Chile (16/1000), but still 50 percent higher than the U.S. rate.

52. As was previously mentioned, there are two to three prevented disabilities for every prevented death (mortality).