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Practicing Hope
A Handbook for Building HIV and AIDS Competence in the Churches

Sue Parry
Show me Your ways, O LORD
Teach me Your paths; guide me
In Your truth and teach me, for
You are my God, my Saviour, and my
Hope is in You all day long.
—Psalm 25:4-5
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INTRODUCTION

HIV and AIDS constitute a global emergency, pose one of the most formidable challenges to the development, progress and stability of our respective societies and the world at large and require an exceptional and comprehensive global response.¹

HIV and AIDS have been described as a health issue, a development issue, a humanitarian issue, and many other issues.² Fundamentally, though, HIV and AIDS remain an issue of justice, rights, and responsibilities, both for those affected and for those seeking to prevent the spread and mitigate the impact. In the absence of natural immunity or an effective vaccine, the reality today is that everyone who is exposed to the virus is susceptible to infection. Exposure to the virus is most often determined by the risks taken: inadvertently, in ignorance, by choice, by coercion, or by force. Vulnerability to the risk of infection, and subsequently to the impacts, is all too often not a straightforward choice and may be heavily influenced by the prevailing circumstances. Infection with HIV and the subsequent impact of AIDS have been devastating in the lives of individuals, families, and communities over the past 30 years.

The church and faith-based organizations (FBOs) have been in the forefront of response since the earliest days of the epidemic and continue to be amongst the principle providers of care and support globally. Considerable progress has been made on the scientific and biomedical front and the advances made in diagnosis and treatment have changed this disease from a death sentence into a chronically manageable condition, restoring people living with HIV to active life and once more giving hope. While such treatment access is being rolled out universally, there is the disturbing reality that two new infections occur for every one accessing treatment. Not only do new HIV infections continue to outpace response but the current global financial and economic challenges threaten to undermine the gains so far achieved. It is increasingly important to constantly reevaluate the way
we do things in order to respond more appropriately, effectively, sustainably, and to an enhanced scale, hence the need to “mainstream” HIV and AIDS. It is an essential process for developing a more inclusive and holistic approach (internally, within the church/FBO sector, and externally, in the responses), which should lead to more effective and comprehensive scale-up, accompanied by both the implementer and especially the primary stakeholders having a sense of ownership.

UNAIDS has suggested that the terminology HIV be used alone and not coupled with AIDS. A person with HIV does not necessarily also have AIDS. HIV is what they are infected with, while AIDS complications is what they die of. The terminology “AIDS” should only be used when specifically referring to AIDS. In this book, however, HIV and AIDS are used together for the specific rational that, while we still have people succumbing to AIDS-related complications, there remains need to be both HIV- and AIDS-competent.

Mainstreaming is an evolving process that has been around for some time, but it is a relatively new concept in the area of HIV and AIDS and even more so within the faith community, for which there is limited specific documentation. For a number of years, the World Council of Churches (WCC) has worked on and has been promoting mainstreaming of HIV and AIDS in theological education. Several accompanying publications have been produced. There are credible initiatives, such as that of the AIDS Constellation promoting the Life Competence Process, and the work of Tearfund (Sue Holden), from which inspiration has been drawn, together with the many life examples and heart-warming initiatives carried out by churches and faith groups around the world—some of which have been included here as practical examples of what can be done and what is being done.

This handbook seeks to provide guidelines for a possible approach to mainstream HIV and AIDS, as well as guidelines to simultaneously mainstream HIV competence into the life and ministry of the church. An HIV- and AIDS-competent church denotes a well-informed, inclusive, proactively responsive, and accompanying church. To achieve this involves strong leadership, accurate, up-to-date knowledge, appropriate resources and networks, transforming theology, and compassionate solidarity that restores dignity and hope. To mainstream HIV and AIDS competence is to focus not only on seeking to halt transmission of the virus and to mitigate the impact of infection and of AIDS, but also to focus on those issues that are making people more vulnerable to HIV infection and its subsequent impact. It is looking “upstream” at the causes: the socialization process and gender scripting of girls and boys, women and men, that may render each
more vulnerable. It involves considering the socioeconomic conditions that promote inequalities, injustices, and poverty, as well as the altered family dynamics and the changing values, fast technology, and media-dominated world in which young people are being raised. It is recognizing the marginalization of minorities and all those considered “different” from ourselves, whereby they are kept in the shadows and are either unable to gain or are denied access to life-giving services. It is challenging the sexual and gender-based violence pervasive in society, where women have little control over their bodies, where girls and women are raped, stigmatized, and made vulnerable to more than HIV alone. It is also recognizing that not only does HIV exist in the church, but also that some people may be made more vulnerable to HIV because of working in and for the church and that some of our activities may inadvertently increase risks for those we seek to serve.

Mainstreaming also means reviewing critically what actions and activities are currently being undertaken and what needs to be done: looking downstream to mitigate the impact of AIDS.

By mainstreaming HIV and AIDS competence the church can ensure that we do not miss any opportunity to make a significant difference in the lives of individuals, families, communities, and society as a whole. It is “being church.” This has been affirmed by Archbishop Anastasios of Tirana and Durres, Orthodox primate of Albania and a WCC President:

The Mission of the church, and every living member of it, means the obligation and the necessity to share the gifts which we have each received from God. This means to proclaim the truth, love and power revealed by Christ, the crucified and the resurrected one. To share with all everywhere, by the power of the Holy Spirit, with our presence, silence, speech, our acts of love, the fullness of life, the longing for justice and peace all over the world.4

HIV has been and remains a kairos moment for the church: to be church to humanity and to bring transforming love, health, healing, and restoration of hope and dignity to each and every one, regardless of HIV serostatus, colour, culture, creed, ethnicity, or sexual orientation, for all human life is created in the image of God, is sacred, and is worthy of that promised “abundant life” (John 10:10).

This handbook is divided into ten sections:

- Sections 1 and 2 outline the background to the document, objectives, intended users, and the current scope of HIV and AIDS.
- Section 3 examines why the church should be involved in mainstreaming HIV and AIDS issues and explores the question: “Who is the church?”
• Section 4 discusses what HIV “competence” represents and how this is a fundamental prerequisite to effective mainstreaming.

• Section 5 introduces mainstreaming from a faith perspective where the individual, and the dignity of the individual, is paramount and competence is at the core. The principles, practices, and processes of mainstreaming are described and the distinctions between the internal and external domains of mainstreaming are explored. The *internal domain* represents the internal life and relationships of the church, the “workplace,” with the church as an employer, and the recognition that all those who work for and with the church (the “staff”) also face risks and vulnerabilities to HIV and impacts of AIDS. The process requires identifying and responding to those factors that are likely to increase vulnerability of church staff and their families to HIV infection. Further engagement requires working to preempt, reduce, or mitigate any possible impacts on the same people. The *external domain* represents the area where the church undertakes activities based on its mandate and core business. Such action is defined by its knowledge of the local context and its available capabilities. Engaging in the external domain requires identifying and then responding to any factors that are likely to increase vulnerability to HIV infection of the individuals and communities with whom the church works and serves. It also involves identifying and reducing possible impacts of HIV and AIDS on these same communities.

• Section 6 introduces the concept of mainstreaming HIV and AIDS into theological institutions.

• Section 7 is devoted to the importance of equipping and journeying with leadership in the understanding and acceptance of HIV, the determinants to its spread, and the magnitude of the impact. Inner transformation is a prerequisite to empowering any technical capacities that may subsequently be developed in order to respond adequately and appropriately.

• Section 8 outlines the process of mainstreaming HIV and HIV competence into specific areas of the church and its various ministries. These include the liturgy, sermons, and homilies, as well as faith formation and moral education in Sunday schools, confirmation classes, and many other associations within the church such as men’s, women’s, and youth groups, engagement and marriage encounter groups, and various support groups. This section also looks at several programmes that are specifically focused on HIV activities and, in addition, considers the value of ecumenism and interfaith cooperation.
• Sections 9 and 10 are reminders of the necessity of stewardship of time, finances, and resources and the importance of monitoring, evaluation, and information sharing.
• The conclusion completes the document.

The whole document is underscored by three vital issues:

1. The importance of understanding the local context, not only in terms of the specific risks and vulnerabilities present, but also in terms of availability of strategic and important capacities, resources, and services.

2. The value of the appropriate involvement of church staff, congregants, and community, particularly those living with HIV, in a nonjudgmental and respectful manner in the development and implementation of appropriate policy documents and plans.

3. Since no one sector, institution, or individual can address all the aspects of the epidemic, there is need to develop and foster strategic partnerships. Mainstreaming does not require that all components of a comprehensive response to HIV and AIDS be included; however, mainstreaming HIV in the church does require a rational and contextual approach. Activities must be determined on the basis of (a) identified strengths and priority needs, (b) the comparative advantage of the church to respond, and (c) its human and technical capacity to implement. This may require functional partnerships, networks, and alliances to be formed for appropriate and sustainable implementation and impact.

It should also be remembered that communities do not need to be given dignity, power, or authority; they already have those, though they may need reaffirmation. In all circumstances, there is need to recognize the strengths that are already present in communities, the dreams they have, and their resilience and inherent coping capacities. Sometimes communities are unaware of these strengths, as most programmes are “needs”-focused, and too often focused on perceived needs, so that communities become recipients of our solutions rather than being supported, affirmed, accompanied, facilitated, and trained where necessary to find their own solutions. Too often communities have been made to feel that they are victims of their circumstances and that they need to be beneficiaries of our expertise, without which they are unlikely to be capable of any degree of success. They are our partners and resources, not our targets.

The HIV and AIDS epidemic has taught humanity, perhaps more than anything else before, that a threat to one is a threat to us all: rich and poor, gay and straights, black and white. Let’s keep up the good fight. . . . we are one another’s neighbour.
Faith-based groups are to be found everywhere, from highly urbanized settings to the most remote rural village. Mainstreaming HIV and AIDS competence is possible in all these settings, and this handbook seeks to outline principles to be followed. Within each local setting, the context may differ, hence the importance of actively engaging with locals to identify priority issues faced within their context: risks, vulnerabilities, availability of alternative choices, back-up services, and specific strengths or needs. The principles remain the same, whatever the context.

I am come that they might have life, and life more abundantly.
—John 10:10, KJV
ACKNOWLEDGMENTS

Beacons of Hope: HIV Competent Churches—A Framework for Action was printed and released in 2008. The book promotes the principles of HIV competence, principally for churches. Considerable interest was shown and the book has been used widely across the globe. Requests started to come on a regular basis on how to turn the principles it expresses into practice. At the same time, the need to mainstream HIV has become more evident. This book has been a “work in progress” ever since and has been presented at various meetings, conferences, and workshops over time. I am extremely grateful to the many people, religious leaders, academics, laypeople, people living with HIV, faith-based organizations, and others, from all over the world, who have contributed ideas, stimulating the thought process, and have generously shared of their experiences.

Grateful thanks go to the many people who have read the different sections and contributed valuable editing advice and ideas, in particular Michael West, Prof. Ezra Chitando, Ben Purcell Gilpin, Ricardo Walters, Lyn Van Rooyen, Fr. Robert Igo, Dr. Manoj Kurian, Calle Almedal, Rev. Dr. Nyambura Njoroge, Rev. Dr. Veikko Munika; Rev. Nelis du Toit, Talitha Rooney, members of the AIDS Constellation process, and many others. Special thanks to Stephanie Purcell Gilpin for help in the design of the diagrammes to accompany the text. Finally, I am indebted to the many organizations and churches who have provided examples of their experiences and programmes, many of which have been included within the text as living examples.

While every effort has been made to identify, contact, and appropriately acknowledge quotations, definitions, and sources of information, any omission is unintentional and sincerely regretted.
Section 1

Why This Handbook?

The World Council of Churches (WCC) has been actively engaged in HIV and AIDS issues since early 1986. In 2002, it established the Ecumenical HIV and AIDS Initiative in Africa (EHAIA) to accompany churches in Africa to respond more effectively and appropriately to HIV and AIDS. This would involve building the capacity of church leadership to eradicate stigma and discrimination through knowledgeable and critical understanding and skills to address the key drivers of the epidemic. It was to be backed up by a transformational life-giving theology that would ultimately create the “AIDS-Competent Church.”

1.1 Background

Since 2002 an HIV and AIDS curriculum has been developed and implemented for religious leaders in formation, working in theological institutions, colleges, and universities. Concurrently, extensive training on HIV and AIDS issues has taken place across the continent for religious leaders already in service. This has continued, and expanded, beyond the borders of Africa.

The necessity to mainstream HIV and AIDS into the life and ministry of the church was identified early on and a number of efforts were made in this direction, both by the WCC and by other faith-based organizations and churches. Resource materials have been developed and many consultations have been held in Africa, Southeast Asia, and elsewhere in the world.

In 2008 a WCC-EHAIA resource book entitled Beacons of Hope: HIV Competent Churches—A Framework for Action was developed to explore the principles of HIV competence for the churches. As the necessity to create HIV-competent churches has become a growing challenge and reality, the need for accompanying guidance on the practice of how to mainstream HIV competence into the life and ministry of the church became very evident. Hence, this current handbook has been developed as a follow-up to the first book. It seeks to explore what mainstreaming HIV means, especially for the church, determine what the practice of
mainstreaming involves, and suggest ways to actually implement the process into the life and ministry of the church. It is based on experiences and lessons learned in this field from numerous agencies, faith-based organizations, nongovernmental organizations, and from WCC-EHAIA. It is complemented by examples of various good practices existing in churches all over the world but principally from Africa, which has borne the brunt of the epidemic and has suffered greatly from the impact of AIDS over many years. Included in the document are “checklists” or “benchmarks” to ease understanding and to act as reference points.

HIV is a dynamic, fast-moving epidemic, and the responses to it change with the evolving knowledge, experiences, and emerging treatment options. Mainstreaming, too, is an evolving process, not a one-off event, and it is in the same light that this handbook should be viewed. It remains a work in progress, to be complemented by the many experiences of the reader and of events still to come. We are all on a journey.

1.2 Objectives of This Handbook

These are summarized as follows:

- To provide information on approaches to and the importance of mainstreaming HIV into the life of the church;
- To provide practical information on “how to do it” or to strengthen what has already started (when, what, why, where, who, and how);
- To describe how mainstreaming HIV competence into the life of the church is an extension of the HIV Competence Process that is based on inner competence, outer competence, and the bridge between the two of leadership, knowledge, and resources.¹

1.3 Intended Users

- Leadership of religious institutions and faith-based organizations (FBOs)
- HIV and AIDS focal persons, programme and project staff
- Member churches
- Partners of churches, religious institutions, and FBOs
- Congregants
- Others
In 2011, world leaders gathered at the United Nations for a General Assembly High Level Meeting on AIDS to restate their commitment to ending the HIV and AIDS epidemic worldwide. In the Political Declaration, they stated: “HIV and AIDS constitute a global emergency, pose one of the most formidable challenges to the development, progress and stability of our respective societies and the world at large and require an exceptional and comprehensive global response.”

Michel Sidibé, head of the UNAIDS Programme, in 2012 stated, “It has been 30 years since the first reported cases, 15 years since treatment became a reality, 10 years since the first UN General Assembly Special Session on HIV/AIDS and five years since the commitment to achieve universal access to HIV prevention, treatment, care and support.”

The vision for the future is: zero new HIV infections, zero discrimination, and zero AIDS-related deaths; to which I believe we should add a fourth goal: that of zero tolerance for sexual gender-based violence.

2.1 The State of the HIV Epidemic

By the end of 2011, 34.2 million people, including 3.4 million children less than 15 years of age, were living with HIV. During the previous 30 years, almost as many (25 million) died of AIDS. This rapidly, relentlessly expanding global epidemic was, by 2006, claiming the lives of more than 2.2 million people each year.

The “revolution” in HIV treatment, resulting from combination anti-retroviral (ARV) therapy released in 1996, forever altered the course of the disease for those living with HIV in high-income countries. It had little impact on low- and middle-income countries, where treatment only reached a fraction of people in need. It is these regions that bear the brunt (90 percent) of the global HIV burden. Significantly, 22 million of the global total of 34 million living in sub-Saharan Africa.
Activists, community leaders, scientists, and health-care providers increasingly demanded access to treatment for all those in need, as well as closure of the gap in health access between the North and the South. Such pressure eventually resulted in increased political and financial commitments to the HIV response, demonstrated in Millennium Development Goals, UN General Assembly Special Sessions on HIV and AIDS, and the creation of funding mechanisms such as the Global Fund, PEPFAR, and UNITAID. These events paralleled the strategic scientific and technical innovations taking place, and so the “impossible” began to look “possible.”

A fundamental shift in thinking took place about the feasibility of funding and delivering anti-retroviral (ARV) and other drugs for people in resource-constrained settings. The ensuing rapid scale-up of ARV therapy to eight million people in low- and middle-income countries resulted in a dramatic and significant reduction in the number of people dying from AIDS-related causes, from 2.2 million to 1.8 million per year. Fifty-seven percent of HIV-positive pregnant women received effective therapy to prevent mother-to-child infection. Globally, the annual rate of new infections dropped by 26 percent and the incidence declined in several countries.

The AIDS response saw remarkable progress in 2011, so much so that it has been described as “a game-changing year.” The UNAIDS vision of “getting to zero—zero new infections, zero discrimination, and zero AIDS-related deaths” has been embraced by countries, partners, and people around the world, who are working to make it a reality. All UN member states have endorsed the goal of achieving universal access with a package of HIV prevention, care, treatment, and support interventions for all who need them. Former U.S. President George W. Bush stated at ICASA 2011: “We are breaking the grip of AIDS—but this is only the beginning. There is a lot of work to be done. There is no greater priority than saving a human life.”

At the 19th International AIDS Conference in Washington, DC, in July 2012, considerable optimism was expressed at the remarkable scientific progress made in the past years, and, for the first time, prominent leaders were beginning to talk about “turning the tide of the HIV epidemic” and the beginning of the end of AIDS, and moving toward “an AIDS-free generation.” This would not imply an HIV-free generation, for a cure is yet to be developed. It would mean that no child anywhere would be born with HIV; there would be a significant reduction in the chances of HIV transmission through combination prevention strategies integrating behavioural prevention with biomedical interventions; and for those infected, universal access to sustainable and affordable treatment, care, and support.
Challenges

In spite of the extraordinary achievements, the fresh optimism is also clouded by harsh realities, of which funding is only one. Many challenges remain:

- There are stark regional variations in the HIV seroprevalence and in the responses to the challenge of HIV and AIDS. The seroprevalence in Eastern Europe and Central Asia is noted to be rising again, where the primary mode of transmission is among injecting drug users and their sexual networks, and where deaths from AIDS-related causes increased by 1,100 percent in the past ten years. The annual number of people newly infected with HIV is currently also rising in the Middle East and North Africa.

- Globally, for every person starting ARV therapy, two additional people are infected with HIV. The rate of new infections still outpaces the response.

- Only ten low- and middle-income countries are currently achieving universal targets for ARV therapy.

- The majority of people living with HIV in middle- and low-income countries still do not know their serostatus and hence are not accessing appropriate care and treatment.

- Still less that 50 percent of people in need of ARV treatment are accessing it. Some 30 million will need treatment by 2030 and without significant progress, there will be millions more who are infected in the interim who also in time will require treatment.

- Fewer than one-quarter of children in need of treatment are actually accessing therapy—substantially fewer than adults—a serious situation and justice issue.

- Some 20 percent of people who start on treatment fail to continue and may be lost to follow-up, thus putting themselves at risk and increasing the possibility of developing drug resistance.

- Women are disproportionately affected, especially in Sub-Saharan Africa, principally because of gender inequity and several culturally perpetuated gender norms that increase risk and vulnerability to young girls and women.

- Key populations at higher risk of HIV infection and transmission—injecting drug users, men who have sex with men, transgender people, sex workers, prisoners, and migrants—remain marginalized, face violence, social stigma, and poor access to HIV services. Criminalization in some countries further drives them “underground” and away from care and support.

- Finances: “At a time when mounting evidence indicates that political and financial commitments in the first decade of the 21st century are paying enormous dividends, concerns are growing about the sustainability of the response, the continued upward trajectory of costs and the millions of peo-
ple in need.”5 “It does not matter how many people can access treatment if we cannot keep them alive and receiving treatment.”6

• Sharing the burden: There is pressing need for countries to share the responsibility for the global response and take more financial ownership of national AIDS responses by increasing domestic investment in HIV. “Sharing the burden, however, is more than investment—it means collectively tackling the political, institutional, and structural barriers that impede progress. It means ensuring that resources are going where they can have the greatest impact.”7

New scientific evidence and innovations have continued to expand the tools to deliver on goals. Vaccine research and development continues, with the aim of complete prevention. The scientific community is actively engaged in exploring approaches that may lead to an eventual cure for those already infected. However, we cannot treat our way out of this epidemic and, as UNAIDS concludes in its 2011 Global Report, “innovation goes well beyond scientific discoveries. It is also vital to improve and to bring to scale existing technologies while designing new approaches that can best leverage available resources and optimize outcomes.”8

As then-U.S. Secretary of State Hillary Clinton stated at the IAS Conference: “This is a fight we can win. We have gone too far to stop now. The USA has made it a priority and we will not back off from achieving this goal.”9

We know what to do, we know what works, we know the impact of good visionary leadership and the strengths of relevant partnerships, the value of committed advocacy, and the difference that a sensitized, knowledgeable, enabling, and stigma-free environment can make for the lives of all those affected by HIV. If we want to make the difference, we can.

In essence, this is what this handbook is seeking to address. It is not about “doing different things, but it is about doing things differently.” We want to do the best we can, to the highest standard, in the most relevant and effective ways possible, with maximum use of our resources, time, and effort, reaching both inwards and outwards, and to make a significant, life-affirming difference in the process. In this case, it is about mainstreaming HIV and AIDS issues into the life and ministry of the church; and more, it is about mainstreaming HIV and AIDS competence in what we do.

2.2 Determinants of the HIV Epidemic

HIV is no longer seen in terms of being just another medical condition but as an epidemic within other social epidemics of injustice and as a major developmental crisis. It is a disease that affects every aspect of our cultural, spiritual, economic, political, social, and psychological lives.10
In countries with a generalized HIV epidemic (where more than 1 percent of the total population is infected), the dominant mode of transmission is through heterosexual sex. In this environment the range of underlying vulnerabilities, in combination, become drivers of HIV infection as well as have an impact on the length and quality of life of those infected and their families. As is evidenced, young women are especially susceptible to HIV infection and vulnerable to the wide-reaching impacts of HIV infection.

Risk factors that are key drivers to the epidemic include:

A. **Structural and social factors**: Individual behaviour is profoundly influenced by the degree to which individuals have financial stability, social control, order, and social cohesion, as well as by the broader contextual factors such as social norms, service accessibility, and public policy. These factors have a considerable influence over their ability and their choices in situations that may present risks of HIV infection. Generally, unequal power relationships; peer pressures; disparity in access to services; physical, cultural, and language barriers; lack of education and employment opportunities; social isolation from familiar support networks (as experienced by migrants, migrant workers, foreigners, truck drivers, displaced persons, and even students) increase vulnerability and affect the choices people make that may put them at risk of HIV infection. Discrimination, inequalities, lower educational status, economic dependence on men, and formidably defended cultural and social norms make it difficult for disempowered women to refuse sex or negotiate for safer sex.

B. **Political factors**: These include governance challenges and the wider implications of national access to (international) resources and services. Access to services may be restricted or barred based on political affiliations and complicated by lack of an enabling environment in which to provide services and support. Conflicts generate and entrench many of the conditions and human rights abuses in which the HIV epidemic flourishes. Conflicts are closely associated with physical and sexual violence, forced displacements and separation from family members, sudden destitution, collapse of social structures, and increased poverty and powerlessness. In addition to the physical and psychological trauma that rape causes, it can also create a cycle of rejection for the victim within her own family and community. All of these challenges can affect delivery of effective HIV services and, again, these invariably have a more severe impact on women.

C. **Biological factors**:

- Gender: Biological, behavioural, and social factors contribute to the increased vulnerability of women—particularly young women—to HIV infection. Anatomically, they are more susceptible to HIV infection, par-
particularly younger girls with more immature vaginal tracts. Hence, HIV has been described as a feminized epidemic with the numbers of women infected exceeding the numbers of infected men.

• Age: The risk is higher among younger women. The peak of seroprevalence for women is between the ages of 25 and 30, but for men, it is between the ages of 30 and 40.

• Concurrent infections: The risk of HIV infection is substantially increased in the presence of a concurrent sexually transmitted infection.

• Circumcision: Voluntary medical male circumcision offers a partial reduction in HIV risk (68 percent) that, once performed, is lifelong. It does not do away with the need for protected sex in a risky environment, and there is a latent danger in the misconception that circumcision affords complete protection against HIV infection, thus doing away with the need for protection strategies such as condoms.

D. Behavioural factors:

• Choice of partners: Whether in a heterosexual or homosexual relationship; whether monogamous and faithful with both partners being aware of their HIV status; or whether in multiple concurrent relationships.

• Choices of sexual practices: Both particular sexual acts and whether or not protection strategies, such as condoms, are used.

• Substance abuse: Excessive alcohol or illicit drug use, particularly injecting drugs and possible use of unsterile needles and syringes.

• Gender formation: The “gender scripting” with which people have been raised that may render them more vulnerable to HIV infection. For instance, in many places, girls are raised to be subservient and submissive to men. They are often left without control over sexual choices. Boys are raised as the machos of society, encouraged to be dominant in relationships and sexual decisions. To have multiple relations is a sign of manhood and power. Both sexes are thus made more vulnerable in an era of HIV.

• The head versus the heart: There is also duplicity in human nature, especially when it comes to sex, between what is known and what is done. There is tension between head knowledge and the “desires of the flesh,” and the danger of throwing caution to the wind when the lights go out. The bottom line is that HIV is predominantly transmitted through sex and this is an area we fail to adequately address in our churches.

E. Gender-based violence (GBV): This refers to a range of harmful customs and behaviours against girls and women, including intimate partner violence, domestic violence, assaults against women, child sexual abuse, and rape. It generally
derives from cultural and social norms that imbue men with power and authority over women.\textsuperscript{13}

GBV can include physical, sexual, and psychological abuse. It is a serious risk factor, which must be acknowledged and addressed if prevention strategies are to have any meaningful effect. Both men and women are exposed to forms of gender-based violence, depending on the circumstances and context in which they find themselves. Increasing evidence connects the expanding HIV epidemic with gender-based violence, particularly among young women.\textsuperscript{14}

There should be zero tolerance for abuse of any person or child—whether it occurs in the home, in institutions, on the streets, in the church, in schools, in police stations, in prisons, in refugee centres, or in the area of conflict/war. Regrettably, such abuse often extends to little children, seen as a means of “cleansing” an infected man by sex with a virgin child; this criminal practice is of particular concern.

F. \textit{Negative cultural practices}: Insufficient attention is paid to cultural fundamentals that script women’s and men’s sexual roles and thus their behaviour patterns. There are also negative cultural practices that increase vulnerability to HIV infection such as: underage marriages, female genital mutilation, unhygienic male circumcision, wife inheritance and widow-cleansing practices, and polygamy coupled with unfaithfulness. Many African Independent Churches, syncretic and traditional religions, which command large adherence, do not have a clear stand on these cultural practices, which are still widely practiced and which can expose people to infection risk.

G. \textit{Economic risks}: These include poverty challenges and insecurity in food, health access and services, housing, and vital transport access. Poverty influences the choices people make, particularly in the case of women resorting to transactional sex work, where HIV risks are manifest, for survival. It may also be connected to behaviour that increases risk of HIV infection such as alcohol abuse, multiple sex partners, and sex for money. Though poor people may not be more at risk to HIV infection than others because of their poverty, it is also true to say that poverty may be coupled with poor underlying nutrition, food insecurity, unsanitary conditions, and unaffordable basic education and health services. HIV is more easily transmitted in these settings. The impact of HIV is most felt at the household level and probably most noted in the area of food insecurity.\textsuperscript{15} Widespread movement and migration of people can occur as a consequence of economic pressure, employment availability, climate change, conflicts, and natural disasters. Subsequent isolation from traditional culture and social networks frequently results in risky behaviour.


2.3 Risk, Vulnerability, Susceptibility, and Impact

Throughout the following chapters, there will be reference to risk, vulnerability, susceptibility, and impact. For the purpose of this book, the meanings of these words are explained as follows:

Risk
Risk is the chance taken on an action or activity that potentially could have a negative or harmful outcome. In most instances, taking this chance is a free choice but may be accompanied by ignorance of the likelihood of a negative outcome or the significance of the consequences. It may also be taken under undue pressure or impaired cognitive functions (such as under the influence of alcohol or drugs). In other situations the choice to take the risk is influenced by greater negative circumstances such as, in particular, poverty (which may severely limit freedom of choice), threats of abuse, inability to protect oneself, and cultural practices and beliefs. There are also situations of risk where the person affected does not have any control such as rape, in which there is the possibility of becoming infected with HIV.

Risk is objective. It is not dependent on who you are as a person but what choices you make. It depends on your freedom and ability to make decisions, especially sexual decisions.

Most-affected populations (previously referred to as “most-at-risk populations”) have generally tended to be sex workers; sexual minorities, including men who have sex with men; injecting drug users (IDU); prisoners; migrants and mobile populations; truckers; refugees; and internally displaced populations (IDPs). They tend to have a higher prevalence of HIV infection than do the general population, because (a) they engage in behaviors that put them at higher risk of becoming infected and (b) they are among the most marginalized and discriminated-against populations in society.16

Vulnerability
Vulnerability is more subjective. It takes “risk” a step further and examines “how” and “why” some groups of people are exposed to much higher levels of risk in their lives. It is the multidimensional situations (biological, social, economic, political, and environmental) that individuals, or communities, experience that may enhance the probability of their being affected by an undesirable outcome. In the case of HIV, vulnerability is a measure of how much control people have over themselves and their sexual health and the risks they take or to which they are exposed. For instance:
• Women whose sexual lives are totally controlled by their partners, who may be abusive and unfaithful, are more vulnerable to the risk of HIV infection.
• The physical trauma caused to a child who is raped renders that child more vulnerable to HIV infection.

Vulnerability also implies the likelihood of HIV having collateral negative impacts, for instance, poor households supporting ill relatives are driven into deeper poverty as the costs of care and treatment may consume all available resources and assets.

Susceptibility
Susceptibility is the fact of being exposed. In the absence of a vaccine or natural immunity, everyone is susceptible to HIV infection if exposed to the virus. You can be susceptible but not necessarily vulnerable. For instance:
• Use of a condom reduces susceptibility to infection.
• The poorer you are, the more predisposed or susceptible you are to suffer problems when negative events occur.

Impact
Impact represents the long-term consequences of HIV and AIDS on an individual, family, community, or society. The presence of HIV inevitably results in profound effects in the lives of those infected and affected. For the individual, these range from the physical, emotional, psychological, and economic aspects. At a family level, the presence of HIV in a household may consume all financial resources for health-care expenses; children may be withdrawn from school to care for ailing parents or to act as domestic charges of younger siblings (thus increasing their long-term vulnerability to HIV). Lack of physical manpower and financial resources may increase food insecurity. Orphanhood creates many other challenging dynamics. Timely interventions at the household level with access to effective treatment regimes may result in completely different outcomes and significantly altered impacts.

Even greater impacts may have significance for society as a whole, such as shifts in traditions and societal structure and cultural practices—both positive and negative. Examples include the abandonment of widow-cleansing practices, wife inheritance, and the sex-with-a-virgin myth. On a national level, macroeconomic performance and social policies are also likely to be affected where the epidemic is severe.
2.4 The Need for Mainstreaming HIV and AIDS Competence

It is not knowledge alone that will bring about change. It is not care alone that will ease the plight. A comprehensive response integrating prevention, care, support, and treatment for the HIV-infected and affected is needed within the social reality of the communities we serve. At the same time, we must seek to improve the social and economic circumstances of all, breaking down stigma and challenging injustices. Investment in stigma elimination creates a ripple effect involving whole communities. Recognizing that HIV exists within the church and within the faith community breaks down the barriers and destroys an attitude of “us” and “them.” We are all affected in one way or another. By mainstreaming HIV and AIDS into the life and ministry of the church, responding to HIV becomes everyone’s business. The battle against HIV will not be won in conference halls, but in homes and communities.

A complete state of competence is not a place we will ever reach. It implies, rather, being on a journey, where we are in progress toward where we want to be. In this, it has the eschatological character of Christian hope.