

BEACONS OF HOPE
HIV COMPETENT CHURCHES
A FRAMEWORK FOR ACTION

DR SUE PARRY
WORLD COUNCIL OF CHURCHES
ECUMENICAL HIV & AIDS INITIATIVE IN AFRICA (EHAIA)
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HIV COMPETENT CHURCHES A FRAMEWORK FOR ACTION

INTRODUCTION

Coming to terms with HIV, AIDS, the resulting impact, and developing appropriate effective responses, has been a hard learning curve especially for faith-based organizations.

In many countries, faith-based organizations have been in the forefront of care and support initiatives since the onset of the impact of HIV. However, with the progression and unfolding of the epidemic, social fault lines have been exposed through which HIV has moved relentlessly and silently. In many instances, faith-based organizations have also been a factor in the fault lines.

HIV has challenged the way we think, operate and our traditional way of dealing with contentious or challenging issues. It has flourished in a milieu of stigma and discrimination, increasing the isolation and suffering of those living with the disease. HIV has brought us back to re-look at our core value system, and our faith mandate.

As faith-based organizations, we have been challenged to look 'inwards' and to recognize that HIV is right inside our ranks. We have also been challenged to re-look at our attitudes, the language we use, judgments which have been made and assumptions which may have overlooked the reality faced by so many for whom HIV may seem more like an unavoidable destiny than an avoidable disease.

As HIV statistics have continued to soar unacceptably, even in the face of so many efforts, programmes and initiatives, we have learned that half-measures do not work. Considerable numbers of programmes have focused on the epidemiology of HIV and on behaviour change and in the process have neglected cultural, traditional, socio-economic and political challenges which have effectively undermined so much effort.

Unbalanced responses fail. Knowledge alone does not bring about behaviour change. Sound technical know-how, improved infrastructure and human capacity and sufficient resources will still be deficient without committed leadership, recognition of the social drivers of the epidemic and appropriate engagement. A prerequisite to an authentic competent response is recognition of the problem and then getting past denial and resistance to change, beyond exploration to acceptance and action. Resistance to change can be individual, social, institutional, cultural and traditional. It may require a paradigm change in the assessment of the situation and the way we respond, but respond we must. It requires also acknowledging shortfalls in our own understanding and abilities and, within our organizations, deficiencies in capacity to effectively deliver. There is the need to reach in to correct our own shortcomings before reaching out in charity, justice and with compassion.

In reaching out, we need to ensure that our actions are socially relevant and culturally appropriate as well as being theologically and technically sound.

Thus, more is needed: we *have* to be competent in our activities if we are to be truly effective.

This handbook is a framework for action designed for those who have leadership roles in churches, particularly for those who are already involved in responding to HIV. It seeks to explain what HIV competence is, why the need for competence, what is often missing, and to challenge the reader to seek to develop such competence. The principles outlined here are not confined to church leaders and may have relevance to anyone involved in this demanding field who may feel that 'something is lacking'.

The book is divided into four parts and complemented by annexes and reference guides.

Part 1 focuses on background information to HIV competence: why churches need to be competent, a working definition of competence for churches and what is involved in becoming HIV competent.

Part 2 describes what 'inner competence' means. It discusses the internalization of the risks of HIV and the need to face stigma and discrimination within ourselves, as well as in our churches. We are called to assess risks to vulnerability in an open manner and to recognize the long-term consequences of this epidemic, for ourselves personally and for our churches and society as a whole.

Part 3 focuses on three essential steps in a bridge between inner and outer competence. It looks at the process involved in moving from inner transformation to outer action. It is a process which must be rooted in the reality of the virus and the realities faced by people and communities thus affected.

Part 4 describes seven processes involved in developing outer competence. It moves through theological and technical competence to looking at the relevance of our response to the scale of the problem and to sustainability and scale-up. The prophetic voice of the church must be heard and the uniqueness of the Christian response and mandate brings an added dimension to the response to HIV. We are called to bring more than programmes and medicines to the affected, we are called to restore dignity and to bring hope compassionately.

The final chapter summarizes the processes described, exhorting churches actively to seek to become competent and concludes with the role that churches can play as beacons of hope.

Within the annexes are resources, as well as references and links, to provide more information on topics alluded to in the main text. In addition, there is a 'Bench Marks and Self-assessment Tool' which can be used in groups or individually, to review practically different HIV responses reflected in the life of the church. By considering these activities in a focused and specific way, it may help to highlight gaps and challenges within the current responses. It may also serve as an encouragement for many already well on the way to HIV competence.

This book is not meant to be an exhaustive blueprint, but it may serve as a guide.

Dr Sue Parry

Ecumenical HIV and AIDS Initiative in Africa – World Council of Churches

April 2008

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

The cover image of a lighthouse is courtesy of Anthony Kelly.

PART 1
HIV COMPETENCE
WHY AND WHAT?

WHY CHURCHES NEED 'COMPETENCE'

"The significant problems we face cannot be solved at the same level of thinking we were at when we created them." Albert Einstein

Nearly three decades into the HIV¹ epidemic, we remain in a situation whereby "important progress is seen in tackling AIDS, but the epidemic continues to outpace response."² Whilst the overall rate of new infections per year may be declining, the need for prevention, treatment and care and support is increasing. Each and every day, 8000 people die of AIDS related conditions whilst 11,000 new HIV infections occur.³ Every year we are appalled by the growing statistics, the human toll, the tragic consequences for individuals, families, communities and society at large, and the lack of visible, substantial impact on the containment of the disease. "We have to find new ways to fill existing gaps, notably around HIV prevention and the volatility of development assistance, because if we don't find ways to address those gaps now, we will not be able to sustain the AIDS response over the longer term."⁴

"HIV remains an exceptional threat."⁵

"AIDS remains the leading infectious disease challenge in global health."⁶

Today, more than ever, there is global awareness and commitment to tackling HIV, not just as a disease but as a multi-dimensional condition affecting every aspect of our lives, directly and/or indirectly. There are more resources committed to HIV-related activities than ever before and more projects, programmes, plans and collaboration between sectors than the world has previously experienced in responding to a disease. Yet when we measure the level of effort expended in responding to HIV against the failure in prevention and mitigation of impact, it becomes clear that what is being done is falling way short of the desired outcome.

1 *As language shapes beliefs and may influence behaviours, considered use of appropriate language has the power to strengthen the response to AIDS. UNAIDS now suggests that the terminology HIV is used alone and not coupled with AIDS. A person with HIV does not necessarily also have AIDS. HIV is what they are infected with, whilst AIDS complications is what they die of. The terminology 'AIDS' should only be used when specifically referring to AIDS.*

2 UNAIDS Executive Director: Pieter Piot 2008.

3 *"The global epidemic is by no means over. At the end of 2007, an estimated 33.2 million people were living with HIV. Some 2.5 million people became newly infected that year, and 2.1 million died of AIDS. AIDS remains the leading cause of death in Africa." Dr Kevin M. De Kock Director: Dept HIV/AIDS WHO 12/06/08.*

4 UNAIDS Executive Director's Message to Partners: 13 Feb. 2008.

5 UNAIDS, Report on the Global AIDS epidemic, 2006.

6 *Dr Kevin M. De Kock, Director Dept of HIV/AIDS WHO; Dr Paul De Lay, Director Dept of Evidence, Monitoring and Policy UNAIDS: Threat of global AIDS epidemic not yet over. Rejoinder from UNAIDS /WHO 12 June 2008.*

With the availability of so much knowledge and information, examples of sound practice and with so many resources committed to tackling HIV, why are we failing to build on our existing strengths to respond both more effectively and efficiently and with less wastage of time, experience, people, infrastructure and finances? Is this because there is a lack of competence in what we are doing whereby our efforts are too piecemeal, haphazard, un-collaborated, insufficiently monitored and evaluated, and fail to respond to the full reality of the impact of HIV?

Questions may be asked:

- Are we not doing the 'right' things?
- Why do we shy away from discussing and teaching about sexual matters, as the main driver of the pandemic is sex?
- Is our response comprehensive or do we tend to focus predominantly only on prevention or care issues?
- Are we ignoring risky behaviour that increases HIV vulnerability?
- Do we focus principally on the behavioural aspects of HIV, with insufficient regard to the broader socio-economic and political environment?
- Are we failing to recognize and address key driving determinants to the condition?
- Do we fail to build on successes and strengths or fail to learn from each other, by sharing best practices?
- Do we still lack resources and how do we access what we need?

Like the parable of the sower and the seed (Matt. 13:3-8; 18-23), can it be that three quarters of our scattered seed (or efforts) remain fruitless? If so why? Is the groundwork insufficiently prepared? Are the seeds scattered by people sufficiently skilled? Is there a real compatibility between seed and terrain? Is the process of scattering carefully and consistently prepared for or is it a one-off effort and soon abandoned? How much follow-up and nurturing occurs, do we share our successes? Is our timing and targeting right?

- Platitudes and vague promises will not win the fight against AIDS. AIDS could kill 31 million people in India and 18 million in China by 2025, according to projections by the UN. In Africa, the toll could reach 100 million. To prevent this nightmare from

unfolding, we have to admit that the problem today is not primarily technological or medical. It's that we are still not bringing to this fight the level of seriousness and resolve needed to overcome the problem.

- We as people who care about the millions suffering and dying have to go beyond mere candlelight memorials for those who have died. Instead, let's declare the next 25 years a zone of zero-tolerance for empty rhetoric and insist on results.⁷

There are many stakeholders in the response to HIV. The crucial role of the faith-based organizations (FBOs), in the collaborative response, is now well recognized and acknowledged. Worldwide, the World Health Organization (WHO) estimated in 2004 that one in five organizations engaged in HIV programming is faith-based and the Catholic Church alone is said to be responsible for providing up to one third of that entire care.⁸

FBOs are an integral part of life in most societies throughout the world. They hold credibility with the people because of their presence at the grassroots, their involvement with people in every aspect of their lives and for the many services they offer. They have the widest network coverage globally, the largest constituency of people and an enviable infrastructure, extending from the international community to the most marginalized. Right across Africa they are responsible for significant education and health care. Their role in promoting social and moral norms and their involvement at some of the most significant moments in life: birth, sickness, marriage and death, give them an unparalleled advantage over other sectors in the field of HIV. In this respect Christian faith-based communities can be instrumental in promoting an ethic of care as well as challenging and altering prejudicial behaviour. It is a massive resource waiting to be tapped.

In the era of HIV, many criticisms have however been levelled against FBOs. They have been accused of being a sleeping giant; of promoting stigmatizing and discriminating attitudes based on fear, ignorance and prejudice and of thus pronouncing harsh moral judgments on those infected. They have been accused of obstructing the efforts of the secular world in the area of prevention and of reducing issues of HIV to simplistic moral pronouncements, which have made churches, and mosques, places of exclusion rather than places of refuge and solace.

Whilst, in too many instances, these accusations have tragically and regrettably been justified, it has not been always or everywhere. Whilst the moral debate – particularly

⁷ Eric Sawyer, Co-founder ACT-UP New York: "What 25 years of AIDS Has Taught Me", 10 June 2006.

⁸ Report of Catholic Medical Missions Board 2006.

around the condom issue – has raged in many circles, stalemating action and, in many eyes, discrediting the FBOs' commitment to tackling HIV and saving lives, congregations and parishes have themselves been in the forefront of care and support. A great number of these initiatives did not wait for funding in order to begin, they just responded. Their courage and determination in the face of so many obstacles is a humbling challenge and is a reflection of deep compassion in a world of real suffering.

Yet despite years of experience with HIV and AIDS, and a plethora of responses, the overall sense of urgency and level of response, quality and coverage, is in no way commensurate with the size of this growing epidemic.⁹

Numerous factors are contributory including financial constraints, lack of technical assistance, absence of clearly defined HIV policies, and poor networking and collaboration. This occurs within and between denominations, as well as with the wider secular and international agencies. There is a lack of serious theological debate and a meaningful process for inter-faith dialogue. Improved communication is needed to share experiences and good, replicable practices. Greater collaboration maximizes efforts, coverage, quality of service delivery and better utilization of resources: human, structural and financial.

“A significant number of challenges remain. Among these are the need for improved planning, sustained leadership and reliable long-term funding for the AIDS response.”¹⁰

“The very relevance of churches will be determined by their response. The crisis also challenges the churches to re-examine the human conditions, which in fact promote the pandemic, and to sharpen their awareness of people's inhumanity to one another, of broken relationships and unjust structures, and their own complacency and complicity. HIV/AIDS is a sign of the times, calling us to see and understand.”¹¹

“If the church does not take care of AIDS, AIDS will take care of the Church.” (Anon).

Thus the need to become 'HIV competent' and churches should be in the forefront of such a process if they stay true to their faith.

This guideline seeks to provide a framework for action to assist churches and organizations to recognize and address some of the core components needed to become HIV competent. These are:

- Attitude changes and elimination of HIV-related stigma and discrimination.

⁹ Sue Parry: *Responses of the Faith-based Organisations to HIV/AIDS in Sub-Saharan Africa*, World Council of Churches, 2003.

¹⁰ UNAIDS: *Report on the Global epidemic*, 2006.

¹¹ World Council of Churches: *Facing AIDS: The Challenge, The Churches' Response – A World Council of Churches study document*, 1997.

- Courageous leadership to acknowledge difficult and unpopular topics.
- Reflecting theologically on the pastoral and spiritual demands of HIV and what should be the compassionate Christian response.
- Careful strategic planning that is relevant, long-term and backed up with substantial commitment.
- Open dialogue on taboo subjects such as human sexuality and sexual matters, particularly those facilitating the transmission of HIV, as well as intravenous drug use.
- Exposure of accepted practices and traditions that increase vulnerability, particularly those surrounding gender.
- Challenging injustices and inequalities at the local, social, political and international level and lack of respect for human rights.
- Recognizing the evolving course of the epidemic and expanding responses appropriately.
- Predicting the social impact and responding proactively.
- Accompanying those in need – whatever the impact on popularity or financial cost.

We need to be serious, and very professional about our response. Lives are at stake. HIV is not only a short-term emergency. It has long-term implications for our families, communities, congregations and the very fabric of society at large.

As Susan Hunter stated: *“In an epidemic, failure to respond is a response.”*¹²

If we do not respond, it is by choice and we are responsible for the choices we make.

Our relevance is at stake.

The questions are: Why, as church, do we need to be HIV competent? What does it mean to be HIV competent? How do we build HIV competence?

HIV AND AIDS IMMUNO-COMPETENCE¹³

In medical terms, “HIV and AIDS immuno-competence refers to a functional and effective immune system in a patient with HIV/AIDS. This is important because HIV/AIDS

¹² Susan Hunter: *Who Cares? AIDS in Africa*, 2003.

¹³ THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) *The Human Immunodeficiency Virus, or HIV, is a virus which invades the immune system of the body, taking over and replicating from within the genetic material of the immune cells, destroying them in the process and ultimately leaving the body deficient of these protective cells. Without the protective role of these cells, and with the rapid*

primarily affects T-cells of the immune system, rendering them unable to respond to even minor infections, thus putting the patient at life-threatening risk to even benign illnesses. As long as the patient is immuno-competent though, they can respond to infections.”¹⁴

The body needs to build its immuno-competence in order to survive with HIV, and hopefully in time with the advance of medical science, to defeat HIV entirely. The church too needs to build competence to deal effectively with HIV and its impact and thus to build communities that can cope with HIV, defeat AIDS, and bring healing and hope to both the infected and the affected.

DEFINITIONS OF HIV AND AIDS COMPETENCE

Over time various stakeholders and organizations working in the field of HIV have developed different definitions of HIV and AIDS competence. In reality it can mean different things to different people and it changes with the evolution of the epidemic. Indeed experience has revealed that the actual terminology that we sometimes use concerning this pandemic can itself often be deficient and defective. In July 2007, a working group on HIV Competence met at the Ecumenical Centre in Bossey, Geneva, Switzerland. A definition was developed from a faith perspective that encompassed the various fruits of the Spirit present in St Paul’s letter to the Galatians in which we can find the characteristics of a living; healing and serving church (see Annex 1).

multiplication of the virus, the body easily succumbs to any infection. Eventually infections will overwhelm any defence mechanism left and death ensues. This is the stage known as AIDS and is the normal progression, which takes place when there is no intervention to halt the replication of the virus, or to boost or protect the immune system of the infected body.

14 Yahoo 2007 survey of best answers to describe immuno-competence.

For the purpose of this book, the following definition was developed by the author:¹⁵

AN HIV COMPETENT CHURCH is a church that has first developed an *inner competence* through internalization of the risks, impacts and consequences and has accepted the responsibility and imperative to respond appropriately and compassionately. In order to progress to outer competence, there is need for *leadership, knowledge and resources*. *Outer competence* involves building theological and institutional capacity in a socially relevant, inclusive, sustainable and collaborative way that reduces the spread of HIV, improves the lives of the infected and affected, mitigates the impact of HIV and ultimately restores hope and dignity.

THE PROCESS TOWARDS HIV COMPETENCE

INNER COMPETENCE

Acknowledge the scope and risk of HIV: attitude change

1. Personalize/internalize the risk in an honest open way
2. Recognize the impact and consider long term consequences
3. Assess the risk factors that increase vulnerability
4. Confront stigma, discrimination and denial associated with HIV

Accept the imperative to respond appropriately and with compassion.

THE BRIDGE BETWEEN INNER AND OUTER COMPETENCE

- Leadership
- Knowledge
- Resources

OUTER COMPETENCE

1. Develop theological competence on HIV
2. Develop technical competence through building institutional capacity to plan, implement, monitor and evaluate and coordinate HIV programmes effectively
3. Ensure social relevance, inclusivity and seek to build social cohesion
4. Network: seek allies and collaborate for increased scale and sustainability
5. Advocate and reclaim the prophetic role of the church
6. Restore dignity and hope, with compassion, to all who are infected and affected

¹⁵ Dr Sue Parry, *HIV Competent Church*, April 2007, EHAIA documentation.

It is acknowledged that competence is not a single act,¹⁶ but needs to be continuously refined and redefined through the experiences that are learnt, and thus this definition too may change over time. There is no short cut to competency.

WHAT DOES HIV COMPETENCE INVOLVE?

To become competent requires first and foremost a change in attitude and a committed desire to make a difference. Frequently there is strong denial of the problem and a resistance to change. This resistance may be individual, social, institutional, cultural or traditional. It demands an honest and open acceptance of earlier failures or misconceptions as well as contrition. It may require a paradigm change in the assessment of the situation and the way we respond, but respond we must. It requires also admitting that we are lacking in accurate and up-to-date information, our level of understanding may be limited, and may even be prejudiced, our attitudes may be stigmatizing and, within our organizations, there may be deficiencies in capacity to deliver effectively. There is the need to reach *in* to correct our own shortcomings before reaching *out* in charity, justice and with compassion. All our responses must be firmly rooted in the realities experienced by those most affected, and a visible reflection of their expressed needs. Involvement and meaningful collaboration with the same people, and other key stakeholders, brings authenticity to our decisions and our actions.

What should make our responses different from those of secular society are our deep-rooted spiritual values that arise from our faith in Jesus Christ. It is our responsibility and privilege to accompany those who suffer, to bring comfort and relief wherever possible, to stand together in the hour of need, to be the voice for the voiceless and above all, to restore hope, which is the essence of living. These values cannot be reflected adequately in our activities if we have failed to come to terms with them and failed to be solidly grounded before seeking to tackle HIV in a programmatic way.

“I am come that they might have life and life more abundantly.” John 10:10b

As people of faith it is essential that we do not seek to become only technically competent, well resourced and socially relevant but, equally important, we should seek to become theologically, pastorally and spiritually competent as well. This involves developing both ‘inner competence’ as well as ‘outer competence’.

¹⁶ UNAIDS: Technical Note No.1: “Local responses to HIV/AIDS. A strategic approach towards an AIDS- competent society.”

PART 2
INNER COMPETENCE

AN HIV COMPETENT CHURCH IS A CHURCH THAT:

ACKNOWLEDGES THE SCOPE AND RISK OF HIV

1. Personalizes / Internalizes the Risk in an Open and Honest Way

“We need to begin the journey towards ourselves before we begin a journey towards the other and towards God.”¹⁷

Inner competence implies a need to acknowledge and personalize the serious risks that HIV poses. Internalizing these issues means to consider personal risk factors for ourselves and for our church. It means consideration of sexual behaviours, mind-sets, attitudes and values as well as the acceptance that anyone can contract HIV, even within our own ranks. HIV should not be seen as ‘out there’ but ‘right here’. It is not a question of ‘those out there with HIV’ but of ‘those amongst us who are HIV+’. If one of our members has HIV then we are all affected. “If one part of the body of Christ suffers, we all suffer.”

Facing these issues in an open and honest manner adds credibility and authenticity to any subsequent response.

We seek an inner transformation in our attitudes and approach to HIV, both within our own lives, our families, our communities and our society and within the life of the church.

HIV-related stigma and discrimination needs to be identified for what it is and eradicated from our attitudes and our practices.

2. Recognizes The Impact and Considers Long-Term Consequences

Inner competence recognizes the impact that HIV has had, is having and will have on individuals, families, communities, our churches and on society as a whole. HIV is a major threat to human development, worsening already fragile coping mechanisms and deepening poverty levels. HIV is a threat to institutions’ performance in the different sectors. In the employment sector there is loss of production due to frequent absenteeism of workers. In the educational sector there are loss of teachers, disruption of the teaching and learning process in schools and frequent absenteeism of pupils who are caring for ill relatives or siblings. In the health sector there are increasing numbers of patients, illness and death of health workers and burnout of health professionals. Within the church, with

¹⁷ Justa Paz Organization, Maputo, Mozambique.

the illness and death of its members, churches may find that they are burying more people than they are baptizing. Mainline churches, which ignore issues of HIV and fail to help those within their ranks to feel supported and welcomed, may find they lose members of the congregations to more charismatic churches, who offer anonymous 'healing services' as part of their regular service. The burgeoning numbers of orphans needing help are already causing great concern in many churches. What to do, to help this growing number of children sustainably, is presenting an unresolved challenge.

3. Assesses the Risk Factors that Increase Vulnerability

Inner competence also requires identification and appraisal of the risk factors facilitating the spread of HIV within our communities and within society as a whole. Over time, there have been shifts in the global understanding of HIV. No longer is it seen in terms of being another medical condition but an epidemic within other social epidemics of injustice and a major developmental crisis. It is a disease that affects every aspect of our cultural, spiritual, economic, political, social and psychological lives. Risk factors requiring consideration include:

- **Structural and social risks:** 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 which may put them at risk of HIV infection. Discrimination, inequalities, lower educational status, economic dependence on men, and the formidably defended cultural and social norms make it difficult for disempowered women to refuse sex, or negotiate for safer sex. 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 (such as experienced by migrants, migrant workers, foreigners, truck drivers, displaced persons and even students) increase vulnerability and choices which people make which may put them at risk of HIV infection. 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 address adequately in our churches.

- **Gender imbalances and norms:** the gender scripting with which people have been raised 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 particular vulnerability of women must be understood and acknowledged. Biological, behavioural and social factors contribute to the increased vulnerability of women – particularly young women – to HIV infection. For example: the emerging evidence connecting the rapidly expanding HIV epidemic and gender-based violence, particularly among young women.¹⁸

- **Gender-based violence (GBV):** 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.¹⁹

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. There should be zero tolerance for abuse of any persons – girls, boys, men, women and even little children – 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.

- **Negative cultural practices:** insufficient attention is paid to cultural fundamentals that script women and men’s sexual roles and thus their behaviour patterns. In addition, it is important to acknowledge, and challenge where necessary, negative cultural practices which 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 practised and which can expose people to infection risk.

18 S. Maman et al. “The intersections of HIV and violence. Directions for future research and interventions.” *Soc. Sci. Med.* 2000:50 (4)459-78; *AMJ Public Health* 2002 92 (8) 1331-7.

19 R. Goldberg, *Power in Sexual Relationships. An Opening Dialogue among Reproductive Health Professionals*, New York Populations Council, 2001.

- **Economic risks:** including poverty challenges and insecurity in food, health access and services, housing and vital transport access. Poverty influences choices people make, particularly in the case of women resorting to survival transactional sex-work, where HIV risks are manifest. 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 basic education, and health services may become unaffordable. 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 security.²⁰ Widespread movement of people can occur through labour or forced migration as a consequence of economic pressure, climate change, conflicts and natural disasters. Isolation from traditional culture and social networks frequently results in risky behaviour.
- **Political challenges:** such as governance issues and the wider implications of national access to (international) resources and services, violence, restricted access to services based on political affiliations, and a 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.²¹ All these challenges can affect delivery of effective HIV services.

4. Confronts Stigma, Discrimination and Denial Associated with HIV

Inner competence faces the reality of issues of stigma, discrimination and denial. HIV stigma reflects human values, heart issues, and stems from fear, ignorance, anxieties, prejudices and rigid attitudes. Those who stigmatize often want to be seen as people of high moral standards. These attitudes are to be found within our churches and within ourselves, negating our authenticity and credibility as people of love seeking to serve others.

Stigma is a powerful discrediting and tainting social label that devalues individuals who display attributes that violate acceptable standards in society. It infers something unusual and wrong about the moral status of the person affected. “The presence of a stigmatized condition evokes disgust or fear or discomfort in the members of the non-stigmatized group.

²⁰ S. Parry: *Responses of Faith-based Organisations to HIV/AIDS in Sub-Saharan Africa*. WCC 2003.

²¹ As above.

It arouses deep human responses such as avoidance, reticence, denial and scape-goating. Stigma has inevitable moral implications: it tells us who is considered evil or wicked and it tells us much about the limits of a society's understanding and compassion."²²

If churches are to engage effectively with responses to the epidemic, then issues of stigma and denial have to be confronted not just at the level of church organization and practice, but at the level of what is taught in seminaries, what academic theologians write and think about, what the faithful believe and do, and what values inform the pastoral formation of pastors and lay people.²³

Acquiescence to patterns of exclusion and marginalization, based on free choice, can be called "forms of social sin". Failure to correct them when it is possible to do so is a sinful dereliction of Christian duty.²⁴

Stigma can effectively kill just as the HIV virus can ultimately lead to the death of an HIV positive person, if corrective remedies are not expeditiously put in place. As people of faith, it is our moral duty to examine our own attitudes and have the courage to challenge misguided beliefs and attitudes, to confess our failings and to be the first to stand with those who are marginalized, excluded, denied their rights and who have been made to feel lesser human beings on the basis of the judgmental attitudes and discriminating hurtful actions of others, especially when it has come from within our own ranks.

Language can be a potent tool for stigmatizing and excluding. Terminology such as 'us' and 'them' in sermons and documentation discriminates against the body of the church, which includes people living with the virus.²⁵ Language can be more inclusive when we refer to "those of us with HIV" as opposed to "those with HIV" – the latter implying "those *out there*". There are also distinctive gaps between the language of the church and that of developing agencies. Lack of understanding between the two can result in exclusion of the other to mutual detriment. For example: development agencies might talk of 'multiple partners' whilst the church speaks of 'promiscuity'. There is the need to find a common ground on these issues, to ensure our language is not excluding those we seek to help as well as our allies. It in fact goes beyond common ground and spills over to respect for each others' differences and different opinions.

22 Rev. Bryan Massingale S.T.D. "Stigma: The Other Virus", Marquette University National Catholic AIDS Network, 2 June 2006.

23 Report of a Theologians' Workshop focusing on HIV and AIDS-related stigma. Windhoek, Namibia, December 2003.

24 US Bishops. *Economic Justice for All*.

25 Gillian Patterson. *Church leadership and HIV/AIDS. The New Commitment. Discussion Paper 2003*.

ACCEPTS THE (GOD-GIVEN) IMPERATIVE TO RESPOND APPROPRIATELY AND WITH COMPASSION

Having come to terms with inner issues, there is then a need to channel energies into responses which are informed, evidence-based and compassionate.

HIV is not a stand alone health issue. It is related to the social and economic environment in which we live. It is a dynamic epidemic; until the rate started levelling off it was described as a 'feminizing epidemic' where more women, generally the caregivers of society, than men were being infected; it is creating generations of orphans and it will affect every aspect of our society.

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.

These responses need to be proactive as well as reactive in order to:

- Prevent further spread of HIV
- Maintain and improve the quality of lives of all who are infected and affected
- Overcome stigma, denial and discrimination associated with HIV and which ultimately facilitate spread
- Mitigate against the impact of HIV
- Compassionately restore dignity and hope to our communities.

PART 3
THE BRIDGING CONNECTION

