Passion and Compassion

"To achieve the ambitious targets of Fast-Track and end AIDS as a public health threat by 2030, the work of the faith community will be critical. This fresh and thoughtful narrative describes the central role played by the World Council of Churches, and I look forward to continuing to working closely with the faith community on the last mile of this journey."

—Michel Sidibé, Executive Director, UNAIDS

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Passion and Compassion

The Ecumenical Journey with HIV

Manoj Kurian

World Council of Churches Publications

PASSION AND COMPASSION
The Ecumenical Journey with HIV
Manoj Kurian

WCC Publications is the book publishing programme of the World Council of Churches. Founded in 1948, the WCC promotes Christian unity in faith, witness and service for a just and peaceful world. A global fellowship, the WCC brings together 345 Protestant, Orthodox, Anglican and other churches representing more than 550 million Christians in 110 countries and works cooperatively with the Roman Catholic Church.

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Preface

For the past 30 years, the ecumenical journey with HIV and AIDS has represented a remarkable pilgrimage within global Christianity. In dealing with HIV, societies and faith communities not only have been challenged in the way they think and act in different aspects of life but also have been called to be transformed.

Since the start of the epidemic, in the 1980s, it is estimated that around 78 million people have become HIV-positive, and over 30 million people have died of AIDS and AIDS-related illnesses. Currently, nearly 37 million people globally are living with HIV. There has been rapid progress in treating HIV, and as of March 2015 over 15 million people are accessing antiretroviral therapy. Yet, only an estimated 51 percent of people with HIV know their infection status. In 2014, an estimated 2 million people became newly infected with HIV and 1.2 million people died from AIDS-related illnesses.[1]

The way the disease is transmitted[2] (sexually, mother-to-child, intravenously—including through contaminated blood and improperly sterilized medical equipment or sharing of used needles[3]), the illness' impact on people living in poverty and marginalized communities, and the suffering and stigma associated with the disease have influenced the perception of HIV and AIDS in society. This means that any successful response to HIV and AIDS has mandated the involvement of a multidimensional approach, beyond addressing the biomedical aspects of the disease.

The need for a faith response to AIDS became evident as the epidemic precipitated a crisis of enormous spiritual, social, economic, and political proportions. The impact AIDS had on the lives of individuals and communities made it essential for churches to accompany their members. People of faith responding to the crisis could well follow their foundational teachings to promote

lovingkindness and compassion. But often, due to fear, ignorance, and moralistic misinterpretation of holy scripture, many faith communities stigmatized, excluded, and harmed people living with HIV. It was clear from the beginning that the church could be either part of the solution to HIV or part of the problem—or, often, both simultaneously.

The ecumenical movement has acknowledged and responded to the AIDS epidemic since 1984. It has been a journey both of suffering and of bringing succour and service to millions of people; a journey both of experiencing stigma and discrimination and of embodying the struggle for human dignity and respect. This journey has raised profound questions regarding relationships between genders in the context of patriarchy and differing power dynamics in society. It also has forced faith communities to deal with human sexuality and its diversity.

The journey has also successfully raised and coaxed responses to issues of justice and equity, with regard to access to comprehensive HIV care and support, regardless of the socioeconomic and the geographic situation of the person affected by HIV. The journey has taken us from a time of fear and despair to one of hope, discovery, solidarity, and pastoral accompaniment, expanding care and support, and significant successes in overcoming stigma and discrimination.

Apart from invoking solidarity, the journey has helped in the transformation of the church's ministry. From a predominantly charity orientation, reaching the unreached, churches and communities are increasingly approaching the vulnerable and the needy with humility and the willingness to learn from the margins of society. As the churches contribute to healing and restoration, the faith community as a whole is being healed and renewed, extending the reign of God here and now.

In helping churches and societies deal with existential challenges, bringing people together to find solutions, the ecumenical response to HIV and AIDS stands tall among other historically significant achievements of the ecumenical movement. This includes assisting with the refugee crisis in Europe after World War II and into the 1950s; the creation of worldwide ecumenical networks; the Faith and Order Commission's work on *Baptism, Eucharist and Ministry*, which has led to new worship patterns within churches; the Programme to Combat Racism, which contributed to the struggle against apartheid in South Africa; and the lifting up of the importance of interreligious dialogue and relations with other faiths as an integral part of the life of the church.[4]

This book takes you on the journey, the ecumenical pilgrimage with HIV, giving you insights into and assessing the significance of this sojourn over the last 30 years. Humanity has made great progress in dealing with HIV. With the increasing availability of treatment for HIV, the condition is increasing becoming

a chronic disease and is normalizing living with HIV. But struggles related to the relationships and life experiences of people who are vulnerable to becoming infected by HIV continue to be challenging and need to be transformed for the better. Significant proportions of the world population continue to live in fragile communities where inequities persist and where essential services do not reach the people in need. So, if HIV is seen more as a symptom of the maladies that affect our societies, success in overcoming one symptom does not always indicate victory in addressing the underlying vulnerabilities. This narrative will also help you reflect on the importance of this journey by equipping both the church and society to address the vulnerabilities we continue to face and to confront the future more successfully.

In compiling and composing this story of ecumenical engagement with HIV, I have drawn liberally from the work of my predecessors, colleagues, and collaborators in the World Council of Churches and from the many programmatic documents they have published or archived over the years. I am grateful to them and gratified that we can highlight their work in this decades-long story of engagement. I wish also to acknowledge with gratitude the many persons—interviewees, resource persons, and others who have been helpful in crafting this story—for their recollections, insights and life stories. I wish especially to extend sincere thanks Ms. Ayoko Bahun-Wilson, Dr Erlinda Senturias, Prof. Ezra Chitando, Dr. Gert Rüppell, Hendrew Lusey-Gekawaku, Prof. Dr Isabel Apawo Phiri, the Rev. Fr J. P. Mokgethi- Heath, Prof. Dr Musa Dube, Rev. Dr Nyambura Njoroge, Rev. Pauline Wanjiru Njiru, Rev. Philip Kuruvilla, and and Dr Sue Parry, to WCC publisher Michael West, for contributing texts and for going through the book meticulously and giving suggestions and making improvements. I am also grateful to Rev. Dr Nyambura Njoroge, the WCC's programme executive for EHAIA, for commissioning me to write this account and for our many years of work together.

I dedicate this book to all who have given their lives to equip faith communities to face and overcome HIV.

Chapter 1

Connectedness and Accountability: The Role of the Churches

"Bear one another's burdens, and in this way, you will fulfill the law of Christ."—Gal. 6:2

It is indeed unique in the global religious contexts, and particularly the Christian milieu, that the ecumenical movement addressed a disease such as HIV and AIDS in a forthright and balanced manner from the earliest days of the epidemic. The ability to respond was due to the very nature of the ecumenical movement: its accountability to the needs and the suffering of member churches and their congregations; its accountability to the wider international community; its capacity to process complex issues in a consultative manner; and the presence of committed and capable people to accompany the process and take specific action. The movement's mandate and willingness to connect individual and community-level experiences and challenges to the international arena and policy space have made this journey a remarkable one.

The WCC's Accountability to Its Membership and Its Convening Role

The central goal of the ecumenical movement is the visible unity of the followers of Jesus. And while "visible unity" can be understood in various ways, it necessarily involves relationships between churches.

Churches and other ecumenical partners pray, reflect, plan, and act together. As a fellowship of some 350 Anglican, Eastern and Oriental Orthodox, Old Catholic, Protestant, independent, and united churches, nurturing

such relationships is a vital facet of the WCC's vocation to support the churches and the ecumenical movement in their efforts to reach visible unity. There is no doubt that today the WCC is the most representative of all the bodies that share in the one ecumenical movement. At the same time, the WCC finds itself surrounded by a polycentric network of diverse ecumenical partners, such as nonmember churches, church-related organizations, and movements of Christian people at the national, regional, and global levels.

This concept of a polycentric ecumenical movement suggests new roles and attitudes for the WCC and its constitutional obligation to foster the coherence of the movement. It is increasingly evident that the Council deploys its programmatic and relational activities with full readiness and willingness to serve as a convener for the many players in the ecumenical movement. The WCC provides leadership to the many initiatives that its ecumenical partners undertake, thereby becoming an open space for dialogue and cooperation for the many ecumenical institutions and initiatives, and offering member churches and ecumenical partners opportunities to consider together responses to key issues, at key moments in history.[1]

The movement repeatedly has proven to be a dynamic and welcoming space of grace. This is a safe and dynamic space where participants can share experiences and concerns, both the successes and the challenges that their communities face in their faith contexts, common mission, fellowship, and sharing of resources. Unique challenges are brought to the attention of the fellowship, where qualified and committed staff members of the WCC facilitate the process of discussion, dialogue, and the discernment of these challenges. The participation and engagement of member churches, denominational networks, ecumenical partners—such as church-related development agencies and national and regional ecumenical organizations, associated international organizations, and civil-society organizations—provide a broad and deep spectrum of experiences to address any given challenge. The pain, suffering, and exclusion of people living with HIV and dying of AIDS—be they gay communities and Haitians living in the United States or those affected from Zaire (now the Democratic Republic of Congo) or Belgium—came to the attention of the WCC in the early 1980s.[2]

The WCC's Christian Medical Commission

The other component of the accountability framework is the WCC's relationship with international organizations. The relationship with the United Nations

began, from 1946, through the specialized body of the WCC, namely the Commission of the Churches on International Affairs (CCIA).

The other area of engagement with the international community has been through the WCC's Christian Medical Commission. Since the 19th century and for over a hundred years, medical work has been one of the main focuses of Christian missionary work, the others being education and preaching the gospel. As a result, by the 1960s thousands of Christian hospitals were serving the healthcare needs of the developing world. But with the changing perception of healthcare in a rapidly evolving world, international organizations began to question the fact that more than 90 percent of the resources for the healing ministry was devoted to curative medicine. The Tübingen I and II Consultations, co-organized by the World Council of Churches (WCC), the Lutheran World Federation (LWF), and the German Institute for Medical Mission (DIFÄM), in 1964 and 1968 addressed many of these questions. These processes called for an integrated witness where medical work could be correlated with social work, nutrition, and agriculture and community development, recognizing that medical care was only a component of a diversity of disciplines, all of which were necessary to promote and maintain health. This led to the formation of the Christian Medical Commission (CMC) in 1968.[3] The CMC assisted in reorienting the churches' healthcare ministry to evolve into a more comprehensive and community-oriented service.[4] On 22 March 1974, Dr. Halfdan Mahler, director-general of the World Health Organization (WHO), called together his senior staff for a joint meeting with all five senior staff of the CMC. As a result of this meeting, a joint committee was set up to explore the possibilities of collaboration and cooperation in "matters of mutual concerns." In spite of the disparity in size, the relationship between the two organizations turned out to be exceptionally fruitful. The most significant result of the CMC/WHO relationship was the WHO's formulation, in 1975, of the principles of primary healthcare. This marked a radical shift in WHO priorities, with massive implications for healthcare systems everywhere.[5] The experience of the grassroots organizations on community health issues was channelled to the international, intergovernmental body. The churches were able to influence and give quality experiential and experimental input into a joint study process—by the WHO and UNICEF—called "Alternative approaches to meeting basic health needs of populations in developing countries." Thus began the process of demystifying healthcare, where care services were tailored to the needs of the communities with the local population being involved in the formulation of the system's policy and delivery. This led to the development of the philosophy of primary healthcare.[6]

The primary healthcare philosophy stressed an integrated approach of preventive, curative, and promotive health services both for the community and the individual. The WHO adopted this in 1977, which implied a radical shift in the organization's priorities, with global implications for decentralizing healthcare and placing greater rights and responsibilities with people in managing their own health. The churches' contribution to the evolution in the thinking about and practice of primary healthcare is a lasting contribution to public health.[7]

In the 1970s Christian communities began to train village health workers at the grassroots level. Equipped with essential drugs and simple methods, these workers were able to treat most common diseases and to promote the use of clean water and better hygienic conditions. They facilitated the introduction of small health centres that offered low-cost inpatient care, as well as prenatal and early childhood health services. In these new, decentralized healthcare systems, many mission hospitals began to play an essential role by acting as intermediaries between local village health services and the centralized state-supported hospitals.

It is in this context of an ongoing, official relationship with the WCC that the WHO asked the WCC, in 1983, to raise awareness among the churches regarding the emerging disease called AIDS. It is to be noted that earlier that year, the U.S. Centers for Disease Control and Prevention (CDC) had released a statement that "persons who may be considered at increased risk of AIDS include those with symptoms and signs suggestive of AIDS; sexual partners of AIDS patients; sexually active homosexual or bisexual men with multiple partners; Haitian entrants to the United States; present or past abusers of IV drugs; patients with haemophilia; and sexual partners of individuals at increased risk for AIDS."[8]

Committed and Capable to Accompany Churches in Facing Complex Issues

For the churches, the challenge of HIV and AIDS has involved soul searching. Their pastoral calling to minister to the sick and marginalized has drawn many Christian institutions to care for people living with AIDS. But the connections between AIDS and sexuality, and between AIDS and paternalistic structures, have made it very difficult for churches to face up to the implications of HIV transmission, not just for Christians but for the churches themselves. Principally, because of the early identification of AIDS with homosexuality, there was a lot of resistance from many member churches, and many of the staff members were

reluctant to take on the issue. It took the passion and unfailing commitment of two devoted staff members to assist the WCC and accompany its executive committee in responding clearly and positively to the pain and persecution of people living with HIV and to answer the call of the World Health Organization.

Dr Cecile De Sweemer, a Belgian medical doctor with a doctorate in international health from Johns Hopkins University and with extensive experience in Asia and Africa, as the deputy director of the Christian Medical Commission at the WCC (1982–1986) took up the issue of AIDS against all the odds. She was also responsible for dealing with other significant projects, such as advocacy work related to the Chernobyl nuclear disaster, the Bhopal industrial gas tragedy, and primary healthcare in West Africa. In dealing with the contentious issue of AIDS, Dr De Sweemer had strong allies—Rev. Dr David L. Gosling, the director of Church and Society at the WCC, and Rev Dr Jean Massamba Ma Mopolo, the Executive Secretary responsible for the Family Ministries programme, who worked with her in addressing this challenging issue in a balanced and succinct manner. Dr Gosling, who was originally a nuclear physicist before ordination and with extensive interests and experience in science, ecology, and different religions, was a dynamic partner to assist in dealing with a new and unknown challenge in the form of AIDS.

Speaking of her experience with the CMC, Dr De Sweemer said, "By 1983 the first rumours of AIDS started. I had quite a number of friends in WHO, including Dr. Assaad.[9] He kept saying, 'I cannot move because none of the governments wants to talk about it, and I think they don't want to talk about it, because they are afraid of the reactions of the religious groups if they start talking about sex.'" De Sweemer added, "When this first came to light in the U.S. it was a 'homosexual problem and a Haitian problem,' and in Belgium it was an 'African' problem." Of the three staff members of the Christian Medical Commission, only De Sweemer was willing to take on the controversial topic.[10] In 1987[11] De Sweemer recollected,

> I have great admiration for Dr. Mann[12] of the WHO and for his team. I personally feel that AIDS is one of the subjects the WHO has tackled most efficiently and most effectively. They have their own limitation, . . . as an intergovernmental organisation, they can only do what the governments let them do. . . . WHO was the one who invited the WCC to involve itself officially and openly in the debate because they could not handle the many constraints that were being put on them by governments. The governments were putting on the constraints because they thought the churches were putting on constraints.[13]

The WCC's first conference on AIDS was held in Geneva in June 1984. Facing intensive challenges, the process was kept on track by the commitment and resilience of the staff members. Various consultations and discussions led to the historic consultation held in Geneva in June 1986 on "AIDS and the Church as a Healing Community." There was tremendous opposition from within the WCC and from various quarters of its constituency because of the linking of AIDS with sin and homosexuality. With this consultation, however, the dedicated and prophetic work of the team consisting of De Sweemer, David Gosling and Jean Masamba ma Mpolo, supported by Paul Evans, and their biblically based unwillingness to retreat finally paid off.

Based on the report from the consultation, the WCC's Executive Committee meeting in Reykjavik, Iceland, in September 1986, released a statement making prophetic recommendations to churches to face AIDS with a clarity of vision and in truth. Even after 30 years, the words are deeply moving and challenging. This visionary statement set a high standard, setting the tone for the next three decades. It was made in an era when AIDS was revealed to the world as a crisis of global and devastating proportions, a context in which, as Susan Davies states, "the Church was challenged with three terrifying realities: death, sexuality and otherness."[14] This statement was a statement of faith—a fresh breath of grace to a world weighed down with fear, condemnation, and death. The statement challenged churches to re-examine the conditions that promoted the pandemic, and to become more conscious of the human implications of broken relationships and unjust structures, and of their own complacency and complicity. Significantly, the statement did not shy away from issues related to sexuality and sexual orientation.

As a result of the WCC AIDS declaration, several of the major Christian denominations were challenged and energized to move forward in dealing with AIDS.

The WCC's Executive Committee, meeting in Reykjavik, Iceland, 15–19 September 1986, recommended that:

- The AIDS crisis challenges us profoundly to be the Church in deed and in truth: to be the Church as a healing community. AIDS is heart-breaking and challenges the churches to break their own hearts, to repent of inactivity and of rigid moralisms. Since AIDS cuts across race, class, gender, age, sexual orientation and sexual expression, it challenges our fears and exclusions. The healing community itself will need to be healed by the forgiveness of Christ.

The consultation called on the churches to undertake the following:

1. Pastoral Care
   - The people of God can be the family that embraces and sustains those who are sick with AIDS or AIDS-related conditions, caring for the brother, sister or child without barriers, exclusion, hostility or rejection.
   - Death is a mystery. We are angry and helpless when faced by its reality. We need to acknowledge our helplessness and not deny it. This has particular significance as we share the experience of ministry with persons with AIDS and as we are ministered to by them, as we grow with them in a Christian understanding of death in the light of Christ's death and resurrection.

2. Education for Prevention
   - To assure high-quality information on the disease, we invite the churches to participate actively with the health professions, local governments, where possible, and local community agencies in programmes of prevention education. We invite the churches to use the World Health Organisation and its networks of local resources.
   - AIDS is preventable. Society must concentrate sufficient resources on its prevention. This will involve measures that should reasonably be adopted by all: carriers, the sick, current high-risk groups and the general population since the latter includes many undetected carriers. It also calls urgently for responsible forms of behaviour by all, and for the improvement of physical and socio-economic conditions in many parts of the world.
   - Preventive measures and altered behaviour patterns must address the different factors that favour the transmission of the virus; it is necessary, therefore, that the different modes of transmission prevalent regionally should be clearly described and understood.

3. Social Ministry
   - Given the widely varying valuations of some of the issues related to the disease, member churches and ecumenical councils will have to be rigorously contextual in their response. We affirm, however, certain commonly held values, especially:
     a. the free exchange of medical and educational information about the disease within countries and across borders;

b. the freedom to pursue research about the disease;
c. the free flow of information about the disease to patients, their families and loved ones;
d. the right to medical and pastoral care regardless of socio-economic status, race, sex, sexual orientation or sexual relationships;
e. the privacy of medical records of persons with AIDS or AIDS-related Complex or positive antibodies.

- Since AIDS is a global epidemic, effective action by churches and individual Christians must extend not only to the AIDS neighbour closest at hand but also through effective global collaboration to the stranger on the farthest side of the world.

The consultation also called on the churches "to work against the real danger that AIDS will be used as an excuse for discrimination and oppression and to work to ensure the protection of the human rights of persons affected directly or indirectly by AIDS."

The Executive Committee also wishes to call to the attention of the churches these further concerns expressed by the consultation:

- to confess that churches as institutions have been slow to speak and to act, that many Christians have been quick to judge and condemn many of the people who have fallen prey to the disease; and that through their silence, many churches share responsibility for the fear that has swept our world more quickly than the virus itself.
- to affirm and support the entire medical and research community in its efforts to combat the disease.
- to affirm that God deals with us in love and mercy and that we are therefore freed from simplistic moralizing about those who are attacked by the virus.

The Response and Periodic Follow-Up

Through the 30-year journey, critical consultations on the issue were held at regular intervals, to assess the churches' response to HIV and AIDS, to issue guidance, and to mobilize support to churches to adapt and bring coherence to their responses.

As the spread of HIV infection and AIDS continued at a relentless and frightening pace, by the end of 1996 the estimated number of people living with

HIV was 23 million. With just one antiretroviral drug, zidovudine (AZT), available as a treatment for HIV, which was not widely available and against which drug resistance was rapidly developing, and with AIDS testing kits not easily available, the fear and the stigma associated with HIV spread even faster.

As a response of the call from the ecumenical movement in 1986, the WCC developed and distributed widely key educational and pastoral resources in multiple languages, promoting awareness regarding HIV and AIDS in the context of faith communities. The three popular key resources were *What Is AIDS? A Manual for Health Workers* (1987), and *Learning about HIV and AIDS: A Manual for Pastors and Teachers* (1989, with later revised editions published in 1994, 2002, and 2006), both written by Dr. Birgitta Rubenson, and *A Guide to HIV/AIDS Pastoral Counselling* (1990), edited by Rev. Jorge Maldonado, with support from the AIDS Working Group guided by WCC Executive Secretary Dr Erlinda Senturias, who coordinated the HIV and AIDS Program from 1989 to 1997. Dr Senturias, together with Ms. Yvonne Kambale Kavuo, coordinated the participatory action research on AIDS and the community as a source of care and healing in Uganda, Tanzania, and Zaire from 1991 to 1993. The result of the research was reported at the WCC Central Committee meeting in Johannesburg in January 1994.

In Africa, encouraged by the WCC, the Tanzanian, Ugandan, and Democratic Republic of Congo (DRC, then Zaire) Protestant medical agencies set up an experimental Participatory Action Research (PAR) programme. PAR enabled communities to do their own research, identify the issues that needed to be addressed, and develop strategies for dealing with those issues. This system was succinctly described and presented in a handbook called *Confronting AIDS Together: Participatory Methods in Addressing the HIV/AIDS Epidemic.*[15]

Women and HIV

Even at the onset of the AIDS epidemic, when the crisis was overwhelmingly perceived as primarily concerning homosexual communities, staff at the WCC lifted up the vulnerability of women.[16] To correspond with the fourth World Conference on Women, held in Beijing in 1995, the WCC drew together experiences of women's health and the challenge of HIV from Brazil, Argentina, Costa Rica, Chile, India, Thailand, Papua New Guinea, Uganda, DRC (Zaire), Tanzania, and the USA. The consultation was held in India because China refused entry to people with HIV. It revealed the fact that attitudes to women were (and still are) so ingrained in the cultures of communities that, for most of the world's population, it was almost impossible for individuals to change their behaviour except in the context of a general decision within the community, where such transformation must occur. These further challenged churches to

advocate for policy changes that make women less vulnerable to being affected by HIV. The findings of this programme, and the stories of many of the people who took part in it, appear in Gillian Paterson's *Love in a Time of AIDS*.[17] The topic was also addressed comprehensively in an issue of *Contact*, titled "Women and AIDS: Building Healing Communities."[18] (*Contact* is a publication focussed on the health-related work of the World Council of Churches, being published since 1970).

Consolidating an Ecumenical Policy on HIV and AIDS

Deeply concerned about the rapidly unfolding epidemic, in 1994 the WCC Central Committee meeting in Johannesburg, South Africa, mandated the formation of a consultative group to conduct a study on HIV and AIDS. The group, headed by Dr Christoph Benn, of the DIFÄM, consisted of medical and nonmedical professionals, clergy, religious and laypersons, all of them either living with or working with HIV and AIDS. They were charged with looking into the pastoral, ethical, human rights, prevention, care, and support issues of people living with HIV and AIDS, as well as related matters of human rights and justice. When the two-year process began, the group set out with apparently irreconcilable differences of approaches. But, during the process, the members of the consultative group experienced a high degree of convergence and common vision. Members describe a sense of unity and inspiration in listening to each other, in worshipping together, and in the various encounters with the reality of HIV and AIDS in different cultural contexts. The process became a good example for the difficult task of combining the disciplines of systematic theology, pastoral care, and sexual and moral ethics to formulate principles to help Christians and churches worldwide in developing their own strategies to respond to the AIDS epidemic.[19]

The landmark result of the global study was reported to the WCC Central Committee in 1996, which in turn adopted a statement based on the WCC consultative group on AIDS study process and report, in September 1996. The results of the study were also published in various languages as a WCC study document, *Facing AIDS: The Challenge, the Churches' Response*, in 1997.[20] The study elaborated clear policy guidelines for the churches to implement in order to face the challenge of HIV and AIDS effectively and in an inclusive manner.

WCC Study Document: *Facing AIDS: The Challenge, the Churches' Response* (1997)

Conclusion: What can the churches do?

Points for common reflection and action by the churches:

A. The life of the churches: responses to the challenge of HIV/AIDS

1. We ask the churches to provide a climate of love, acceptance and support for those who are vulnerable to, or affected by, HIV/AIDS.
2. We ask the churches to reflect together on the theological basis for their response to the challenges posed by HIV/AIDS.
3. We ask the churches to reflect together on the ethical issues raised by the pandemic, interpret them in their local context and to offer guidance to those confronted by difficult choices.
4. We ask the churches to participate in the discussion in society at large of ethical issues posed by HIV/AIDS, and to support their own members who, as health care professionals, face difficult ethical choices in the areas of prevention and care.

B. The witness of the churches in relation to immediate effects and causes of HIV/AIDS

1. We ask the churches to work for better care for persons affected by HIV/AIDS.
2. We ask the churches to give particular attention to the conditions of infants and children affected by the HIV/AIDS pandemic and to seek ways to build a supportive environment.
3. We ask the churches to help safeguard the rights of persons affected by HIV/AIDS and to study, develop and promote the human rights of people living with HIV/AIDS through mechanisms at national and international levels.
4. We ask the churches to promote the sharing of accurate information about HIV/AIDS, to promote a climate of open discussion and to work against the spread of misinformation and fear.
5. We ask the churches to advocate increased spending by governments and medical facilities to find solutions to the problems—both medical and social—raised by the pandemic.

C. The witness of the churches in relation to long-term causes and factors encouraging the spread of HIV/AIDS

1. We ask the churches to recognize the linkage between AIDS and poverty, and to advocate measures to promote just and sustainable development.
2. We urge that special attention be focussed on situations that increase the vulnerability to AIDS such as migrant labour, mass refugee movements and commercial sex activity.
3. In particular, we ask the churches to work with women as they seek to attain the full measure of their dignity and express the full range of their gifts.
4. We ask the churches to educate and involve youth and men in order to prevent the spread of HIV/AIDS.
5. We ask the churches to seek to understand more fully the gift of human sexuality in the contexts of personal responsibility, relationships, family and Christian faith.
6. We ask the churches to address the pandemic of drug use and the role this plays in the spread of HIV/AIDS and to develop locally relevant responses in terms of care, de-addiction, rehabilitation and prevention.

The study places the onus of response to AIDS on the churches. The very relevance of faith communities is manifested by their reflection, openness, contextual interpretations, and provision of an enabling environment for the AIDS response. The churches and Christians are challenged to be empathetic, compassionate, and helpful, to protect the rights and dignity of the vulnerable, and to advocate for treatment and care in the wider society. The study also marks a dramatic and notable shift of emphasis from "personal sin" (which was the dominant interpretation) to "structural sin" in the context of HIV and AIDS. The study lifts up the responsibility of churches and faith communities to work at reducing the vulnerability of marginalized sections of the populations to the effects of HIV and AIDS, implying the sin of not doing the right thing. Here, the ecumenical movement demonstrated creativity and leadership in a context where older notions of sin were prevalent.

One of the important aspects linked to the study was the insight that fact finding and presentation have to go along with information, enlightenment, and education. This insight led to the collaborative work of the CMC–HIV

Study Programme, led by Dr Senturias of the WCC, and the WCC Education in Mission desk, headed by Dr Gert Rüppell, in developing a manual to accompany the study. Two factors were decisive in the production of this manual. First, the meeting of the consultative group on HIV and AIDS in Delhi, India, in February 1996, where a special group of educators focussed on transforming the study insights into educational materials. The second factor was the vital contributions made through the group's cooperation with the Evangelical Lutheran Church of Chile's Program for Health Education (EPES), focussing on HIV and AIDS-related work, which ensured that the education material was accessible and illustrated. The final version of the manual *Facing Aids: Education in the Context of Vulnerability*, identified as "Study Guide Accompanying the World Council of Churches' Study Document on HIV/AIDS,"[21] was produced in three languages (English, Spanish, and French) in collaboration between the WCC and the EPES in Santiago, Chile, under the leadership of Karen Anderson (EPES) and Gert Rüppell (Unit II/WCC). The study material contains a structured framework for group learning sessions, designed to equip resource group leaders to undertake HIV and AIDS awareness building. It has been a very popular and effective tool for the enlightenment of pastors and congregations in dealing with HIV.

Responding to the Call of Churches from Africa

Most of the available epidemiological data indicate that the extensive spread of HIV started in sub-Saharan Africa in the late 1970s. By the early 1980s, HIV was found in a geographic band stretching from West Africa across to the Indian Ocean; the countries north of the Sahara and those in the southern cone of the continent remained apparently untouched. By 1987, the epidemic began gradually to move south.[22]

In 1987, De Sweemwer, who worked for CMC-WCC, said, "Africa has to act now. And that was my undivided advice, for example, to the Minister of Health in Nigeria, Prof Ransome-Kuti, an old colleague of mine with whom, for the past 20 years, I have been struggling to build up primary healthcare in Nigeria. My reason is that AIDS is different from most of the other conditions in that it has a long latency time. It is a time bomb where waiting means that the problem will increase, where not informing the population means that the problem will increase, and basically the people will become victims of their own lack of knowledge. . . ."[23]

By 1998, sub-Saharan Africa was home to 70 percent of the 5.8 million people who became infected with HIV. It is also the region in which four-fifths of all the 2.5 million AIDS deaths occurred in 1998. It was the global epicentre, continuing to dwarf the rest of the world on the AIDS balance sheet, though only a tenth of the world's population lived in the region. The sheer number of people affected by the epidemic in sub-Saharan Africa was overwhelming. AIDS being responsible for an estimated 2 million African deaths that year meant 5,500 funerals a day. And, despite the scale of death, there were 21.5 million adults and a further 1 million children living with HIV. While no country in Africa had escaped the virus, countries in the East and especially in Southern Africa were more severely affected than others. Societies and churches were paralyzed.[24] Villages and schools were empty and farms were lying fallow. But even in that devastating situation, women in the churches started home-based care by attending to the sick and dying as part of their service.[25]

At the eighth WCC General Assembly in Harare, Zimbabwe, in 1998, there was a clear call from Christians and churches in Africa to the global fellowship of churches to journey with them in overcoming the overwhelming HIV pandemic. As a response, following the assembly, the Health and Healing programme of the WCC conducted several regional consultations on HIV and AIDS, with church leaders and ecumenical partners, including, notably, in East Africa, in January 2001, in Mukono-Kampala, Uganda (in collaboration with All Africa Conference of Churches); in Southern Africa, in March 2001, in Johannesburg (in collaboration with South African Council of Churches); and in West Africa, in April 2001, in Dakar, Senegal (in collaboration with All Africa Conference of Churches and Medical Assistance Programme [MAP] International). The series concluded with the "Global Consultation on the Ecumenical Response to the Challenge of HIV/AIDS in Africa," held in Nairobi, Kenya, 25–28 November 2001. The consultation involved three groups of partners: churches, ecumenical groups, and church-related organizations in Africa; churches, ecumenical groups, and church-related organizations in Europe and North America; and the World Council of Churches. The consultation clearly identified stigma and discrimination as a fundamental impediment to overcoming HIV. The global gathering condemned discrimination and stigmatization of people living with HIV and AIDS as a sin and contrary to the will of God.

The consultation produced a paradigm shift in the ecumenical response to HIV and led to a visionary and groundbreaking "Plan of Action" (2001) on ecumenical HIV response, with commitments that later paved the way for the launching and implementation of the Ecumenical HIV and AIDS Initiative in Africa (EHAIA) by the WCC in 2002. The Plan of Action identified HIV and

AIDS as major threats to dignity, human development, social cohesion, political stability, and as devastating to the economic sustainability of families and society at large in sub-Saharan countries. The consultation also highlighted harmful cultural practices and theological and ethical fault lines in the practice of ministry in the churches and theological institutions. The initiative also launched a global effort to stimulate theological and ethical reflection, dialogue, and exchange on issues related to HIV and AIDS.

In 2001, the WCC joined forces with the Christian medical relief organiation MAP International–Eastern Africa, under the leadership of Dr Peter Okaalet, to conduct two consultations in Kenya sponsored by the Joint United Nations Programme on HIV/AIDS (UNAIDS), on HIV and theological education. In 2002, based on the input received from the two consultations from academic deans, principals, and theologians of various denominations from 20 theological institutions in 14 countries, the WCC, under the leadership of Dr Musa Dube, fully revised and published a new "HIV and AIDS Curriculum for Theological Institutions in Africa,"[26] based on a first version of a curriculum published by MAP. This work eventually progressed to be developed into WCC-initiated Theological Education by Extension Modules, in the context of HIV.

After the Nairobi consultation, the Ecumenical HIV and AIDS Initiative in Africa (EHAIA) was created and launched to provide a service—to sharpen skills, to break the silence and shame, and to bring down barriers of discrimination and stigma that divided the community—so that churches would be transformed to channel hope and life in its fullness. WCC-EHAIA's two-pronged approach involved promoting HIV competence among churches in Africa and working with theological institutions to integrate and mainstream HIV into theological curricula. Ecumenical partners such as the Brot für die Welt, ICCO, Norwegian Church AIDS, Christian AID, Hilfswerk der Evangelischen Kirchen Schweiz, Evangelical Lutheran Church in America, and many others have played a crucial role in ensuring that this initiative is funded and engaged and present on the ground.

Until 2006, WCC-EHAIA was housed in the WCC Health and Healing programme, but following the WCC General Assembly in Porto Alegre, Brazil, it became a separate entity under the Justice and Peace work of the WCC. Christoph Mann, with great sincerity and in a systematic manner, helped establish the initiative and served as the first project coordinator of WCC-EHAIA (2002–2007). He was followed by Rev. Dr Nyambura Njoroge in 2007, and at the time of writing this book she continues to guide WCC-EHAIA with passion and dedication. WCC-EHAIA has been guided by an International Reference Group (IRG), consisting of church leaders, religious leaders living with HIV,

ecumenical partners, and technical experts from international organizations. Musa W. Dube was the theology consultant to WCC-EHAIA from 2002 to 2004. She played a major role in mobilizing theological institutions to transform their curricula to address HIV and AIDS. Her role was effectively taken over by Professor Ezra Chitando (2004 to date) and Rev. Charles Kaagba (2004–2015). WCC-EHAIA was always close to the churches and people in the different regions, attentive to the needs of churches in the AIDS response and accompanying them in their journey to be competent and compassionate. The regional work has been guided successfully by regional coordinators and their regional staff. These include Dr Sue Parry (2002–2014) in Southern Africa, Hendrew Lusey-Gekawaku (2002 to date) in Central Africa, Ayoko Bahun-Wilson in West Africa (2003 to date), Ms. Jacinta Maingi (2002–2008) and Rev. Pauline Wanjiru Njiru (2009 to date) in East Africa, and Rev. Deolinda Dorcas Teca (2007–2012) and Rev. Dr Luciano Chanhelela Chianeque (2012 to date) for Lusophone Africa. WCC-EHAIA has greatly benefitted from the conscientious contributions of the administrative staff based at the WCC, namely, Ms. Tania Zarraga (2002–2008) and Ms. Lona Lupali (2008 to date).

The churches and people of Africa are the wellspring of hope to the world in facing HIV, bringing faith, courage, innovation, and expertise. At the tenth WCC General Assembly, held in Busan, South Korea, in 2013, WCC-EHAIA was given the mandate to expand beyond Africa, to begin in Jamaica, Philippines, and Ukraine, countries where churches have reached out and requested that WCC-EHAIA share its experience and expertise from Africa. The name was therefore changed in 2014 to Ecumenical HIV and AIDS Initiatives and Advocacy, thus retaining the WCC-EHAIA acronym.

International Commitments and Outreach

Continuing and building on the relationship of the WCC with the WHO, a working relationship was developed with UNAIDS, formed in 1996. In 1999, with the financial support of UNAIDS and the guidance of Ms. Aurorita Mendoza (the person in UNAIDS responsible for gender issues and faith-based organizations at that time), the WCC's education module *Facing AIDS: Education in the Context of Vulnerability*[27] was implemented in five countries in Africa and Asia.

The WCC and its partners also participated actively in the first major AIDS conference held outside Europe and North America in July 2000, in Durban, South Africa. This conference highlighted the problems sub-Saharan Africa and other low-income countries face in tackling the HIV and AIDS epidemic. This

was immediately followed by the UN Security Council passing a resolution recognizing the threat HIV and AIDS poses to international and regional stability, and a call for further action on HIV and AIDS prevention and care went out to all member states (U.N.S.C, 2000). This was reiterated at the Millennium Summit in September 2000, where the UN General Assembly voted to have an emergency special session to tackle the HIV and AIDS problem (G.A. Resolution, 2000). Following the Millennium Summit, with only nine months of preparation time, UNAIDS organized the UN General Assembly Special Session on HIV and AIDS (UNGASS), held in June 2001. This was the first conference dedicated exclusively to HIV and AIDS and also the first UN conference to explicitly involve civil-society groups in the entire process.[28]

The WCC participated in UNGASS 2001. Dr Christoph Benn led a plenary presentation, stating that the church's commitment to work cooperatively with all people living with HIV and AIDS and with people of other religious communities, community-based organizations, governments, and UN agencies in responding to HIV and AIDS. He offered the resources the churches have in the community: their local community presence, influence, the spirit of volunteerism, and genuine compassion facilitated by their spiritual mandate. He reiterated that governments alone could not achieve the goals set out but would have to coordinate with UN organizations, civil society, and NGOs, including faith-based organizations, to tackle the HIV and AIDS problem effectively and decisively.[29]

When WCC-EHAIA was formed in 2002, UNAIDS nominated Mr Calle Almedal as an advisor to the initiative and as a member of the International Reference Group. He gave critical input to WCC-EHAIA and the wider ecumenical and Catholic HIV interventions. Mr Almedal was the first person to promote the concept of "HIV-competent faith communities." He felt that faith communities were doing well in "outreach" in responding to the challenges posed by HIV in communities. But he challenged churches and faith communities to reflect deeply on the HIV and to invest in "in-reach," to transform the hearts and minds of the congregations. UNAIDS, with the guidance of Mr Almedal, was instrumental in organizing a global theological workshop focusing on HIV- and AIDS-related stigma, in Windhoek, Namibia (2003).[30] The consultation offered an effective framework for theological reflection to deal with HIV- and AIDS-related stigma. Almedal also encouraged WCC-EHAIA to engage more intentionally and creatively with the theme of human sexuality in the context of HIV and AIDS.

In that tradition, Ms. Sally Smith, the UNAIDS adviser on faith-based organizations at the time of this writing, continues to provide crucial leadership

within the UN family, bringing greater collaboration and synergy with faith organizations and communities. Ms. Smith is a member of the strategy group that advises the WCC-Ecumenical Advocacy Alliance (WCC-EAA).

Mobilizing Churches across the World

In 2000, the WCC along with its ecumenical partners, initiated the Ecumenical Advocacy Alliance (EAA) as an international network of churches and church-related organizations committed to campaigning together on common concerns. The ecumenical partners chose HIV and AIDS as one of the two pressing issues around which to do global advocacy. HIV remains one of the two campaigns to date. The Global Campaign on HIV, called "Live the Promise," facilitates fighting stigma and discrimination, promoting prevention, mobilizing resources, advocating universal access to treatment, and promoting accountability of governments and churches. The Alliance equips and ensures that churches have the much-needed capacity to undertake this advocacy. Linda Hartke, the first executive director of the EAA (2000–2009), and later Peter Prove (2010–2014) with the support of the EAA team—communications officer Sara Speicher, and campaign coordinators Thabo Sephuma (2006–2009), Ruth Foley (2009–2013), and currently Francesca Merico (2015 to date)—and the strategy group focusing on the HIV campaign, ensured the global convergence of the campaign, bringing the different denominations and participants together as a recognizable force in international advocacy on HIV. Since 2004, the EAA has coordinated faith-based events at every International AIDS Conference, including ecumenical and interfaith pre-conferences. At UN meetings, particularly at High-Level Meetings, the EAA has organized joint events, including an interfaith prayer breakfast at the 2011 High-Level Meetings in collaboration with UN agencies and other faith-based organizations. WCC hosted the EAA administratively for the first seven years of its existence. After a stint as an independent organization from 2008 to 2014, the EAA was reorganized as an ecumenical initiative within the WCC. The Alliance's most recent efforts on HIV and AIDS have focused on access to treatment and advocacy to overcome stigma and discrimination, particularly through dialogue between religious leaders and people living with HIV.

Key commitments were taken by churches, facilitated by ecumenical organizations, spurring them to action in all regions of the world, making significant progress in establishing initiatives, and providing practical support on the ground. This global response found their voices at ecumenical gatherings of: Asian churches at Chiang Mai, Thailand, in November 2001, and in Colombo,

Sri Lanka, in July 2002; churches and ecumenical organizations of Eastern Europe and Central Asia in St. Petersburg, Russia, in December 2002; churches of Africa in Yaoundé, Cameroon, in November 2003; churches in the Pacific in Nandi, Fiji, in April 2004;[31] a regional meeting, "The Church and HIV/AIDS in Latin America and the Caribbean," facilitated by the Latin American Council of Churches (CLAI) and WCC in Panama City, Panama, in February 2004;[32] churches and church-related organizations of Latin America, in Quito, Ecuador, in December 2004;[33] and the churches in the Caribbean, in Georgetown, Guyana, in January 2005.[34]

The WCC Central Committee, meeting on 6 September 2006, in Geneva, reviewed the work of the ecumenical movement and recommitted the churches to become more compassionate and competent in the response to HIV and AIDS. The Central Committee also exhorted the faith-based communities to take up their responsibility to advocate for antiretroviral treatments as well as treatment for other opportunistic infections to be made available and accessible to all. The leaders of the churches were encouraged to exercise their role as advocates for just policies and to hold governments accountable for their promises.[35]

Breaking the Silence across Denominations

The first decade of the 20th century saw a great awakening of churches, denominational networks, church-related networks and development partners, and interreligious networks. They gathered, reflected, made statements at the highest level, and formulated commitments and plans to act, thereby breaking the silence on HIV and AIDS, working against stigma and discrimination, and committing to care and accompaniment.

In the year 2001 the Church of Norway Bishops Conference, the Southern African Catholic Bishops Conference, and the Anglican Communion across Africa took a prophetic stand on HIV. The latter group called their plan "Our Vision, Our Hope: The First Step."[36] In 2002 the Pan-African Lutheran Church Leadership, the Lutheran World Federation (LWF), the Anglican primates on HIV/AIDS (Canterbury), the Council of Anglican Provinces in Africa (CAPA), and the World YWCA committed to breaking the silence on HIV.

The year 2003 saw myriad responses to the HIV and AIDS crisis across denominations. The Lutheran World Federation's Latin America region developed a plan of action for "Compassion, Conversion, Care," and in the same year, at their tenth assembly in Winnipeg, Canada, the LWF took a public and

prophetic stand on removing barriers that exclude people living with HIV. In the same year, the Anglican primates sent a pastoral letter to the entire Anglican Communion on HIV and AIDS, declaring that the "Body of Christ has AIDS." The letter asserted, "AIDS is not a punishment from God, for God does not visit disease and death upon his people," and went on to say, "it is rather an effect of fallen creation and our broken humanity."[37]

Also in 2003, the global network of Protestant churches, known as the Council for World Mission, also committed to becoming more caring, welcoming, and healing communities that would no longer stigmatize, exclude, and discriminate against our brothers and sisters living with HIV and AIDS. The World YWCA made a World Council Resolution that addressed HIV from the perspective of reproductive health and sexuality. Norwegian Church Aid acknowledged that HIV and AIDS had hindered development at all levels and committed, as an organization, to work to overcome stigma, promote prevention, care and support, and advocate for transformation.

The Symposium of Episcopal Conference of Africa and Madagascar (S.E.C.A.M) declared solidarity with brothers and sisters living with HIV and AIDS. They identified those affected and living with HIV as part of the body of Christ (1 Cor. 12:12) and committed to making available the church's resources, including educational and healthcare institutions and social services, to the AIDS response.

The East Central Africa Division of the Seventh-day Adventist Church committed to ensuring the rights, dignity, care, and support for people living with and affected by HIV/AIDS. They also committed to fundraising for prevention and care and support programmes in the local churches and communities. The Church of Nigeria (Anglican Communion) declared itself as a caring church in a hurting world and established policy guidelines for the national church response to HIV and AIDS.

In Asia, the Catholic Bishops of Myanmar and Catholic Bishops of India sent pastoral letters on HIV and AIDS to their national constituencies, guiding them to respond as followers of Christ. Asian Church Leadership, coming under the umbrella of the Lutheran World Federation and the United Evangelical Mission, also committed to the AIDS response, calling it the "Covenant of Life" in Indonesia.

In 2004 the Patriarch of the Romanian Orthodox Church, His Beatitude Teoctist, in his message urged love and tolerance for those suffering from AIDS and HIV. In the same year, the World Alliance of YMCA developed Global Capacity Building Forums on HIV and AIDS and a Strategic Framework for a Global YMCA Action Plan on HIV and AIDS.

Also in 2004, the United Methodist Church (UMC) resolved to establish "The United Methodist Global AIDS Fund" to raise resources to assist local congregations and conferences in identifying and creating global partnerships for mutual HIV and AIDS ministry. In the same year, the UMC highlighted the connection between alcohol, drugs, and HIV and AIDS, urging the Office of the Special Program on Substance Abuse and Related Violence (SPSARV) of the General Board of Global Ministries and all boards and agencies of the denomination to work cooperatively on issues related to drugs and AIDS.

In the same year, the United Evangelical Mission (UEM), in its HIV/AIDS Programme Policy, adopted by UEM's general assembly in Manila, looked at HIV from a theological frame, reaffirming the role of the church as a healing community, and frankly addressing human sexuality and human dignity.

In 2002, the African Network of Religious Leaders Living with and Personally Affected by HIV and AIDS (ANERELA+) was formed by the group of inspired leaders that included Rev. Canon Gideon Byamugisha, the Rev. Fr J. P. Mokgethi-Heath, Rev. Christo Greyling, and Rev. Phumzile Mabizela. The movement has since spread to other regions and in 2006 evolved into INERELA+ (International Network of Religious Leaders—lay and ordained, women and men—Living with, or Personally Affected by, HIV). The ecumenical movement, WCC-EHAIA and many church-related organizations such as Christian AID and World Vision have been accompanying this vital movement through its journey of service. The leadership of ANERELA+ and later INERELA+ have also been torchbearers in the ecumenical journey with HIV and AIDS and have been vital in breaking the silence on HIV within the churches and other faith communities.

Ecumenical work catalyzing national and international church-related AIDS movements

In countries such as Germany, Sweden, Norway, the Netherlands, the United Kingdom, and the United States of America, the churches have played a crucial role in combating HIV and AIDS both nationally and internationally. Their ecumenical commitment and engagement have been a catalyst for contributions to combating HIV and AIDS. One example is Germany. The churches in Germany and related organizations such as Brot für die Welt ("Bread for the World") have had strong partnership with churches, communities, and civil society in different regions in the world, including sub-Saharan Africa. So, with the onset of the AIDS epidemic, in solidarity with their partners, the churches' engagement with HIV and AIDS began at a very early stage, be it in South Africa, Kenya, Tanzania, or the Democratic Republic of Congo. Simultaneously,

the churches in Germany began engaging with HIV both at the level of the congregation and nationally. In 1994, the first AIDS pastoral-care centre in Hamburg opened, sponsored by the local church district of the North Elbian Evangelical Lutheran Church (Nordelbische Evangelisch-Lutherische Kirche [NEK]),[38] and the Evangelical Church in Württemberg began providing AIDS pastoral care with study days, worship services, and help provided by church-appointed AIDS counsellors.

Support for these projects is provided by representatives of the AIDS working group of the Deutsches Institut für Ärztliche Mission (DIFÄM; "German Institute for Medical Mission"), which acts as a national centre of health expertise for German Protestant aid agencies. The group was founded in 2001 upon the recommendation of the Evangelische Kirche in Deutschland (EKD) Council (Evangelical Church in Germany, a body of 20 Lutheran, Reformed, and United Churches). Brot für die Welt has also appointed additional advisors to work on HIV and AIDS.[39]

The continued solidarity and partnerships ensured that the churches and organizations in Germany had a finger on the pulse of the communities affected by HIV in different regions. They were quick to discern positive movements, support ecumenical initiatives, and encourage the sharing of lessons, by lifting up best practices and positive leadership and cutting down duplication of efforts. The international ecumenical engagement further enriched the experience and influence of the churches and ecumenical organization in Germany both nationally and abroad. An example of this is the creation of "Action against AIDS" (Aktionsbündnis gegen AIDS), which was founded in Germany in 2002, inspired by the Ecumenical Advocacy Alliance. Since 2002, Action against AIDS Germany advocates with the German government to meet its responsibilities as an economically privileged country by making an appropriate contribution to the global fight against HIV and AIDS. In particular, this implies the provision of universal access to HIV prevention, treatment, care, and support to all people—especially in disadvantaged regions of the world. Action against AIDS Germany has grown to become a nationwide network of about 300 groups and organizations, local AIDS assistance groups, Protestant and Catholic churches and communities, as well as organizations working in the field of development cooperation, humanitarian aid, HIV and AIDS, and health issues. They mobilize public opinion in Germany to lobby national and international political decision makers to make greater allocation of resources for fighting AIDS.[40]

The Core Attitude of Accountability

The connectedness, inclusivity, and responsiveness to the pain and joys of the people in communities and the possibility of converging their voices to affect change globally has been a unique strength of the ecumenical movement. But this strength will only remain if the movement remains accountable to the foundational values of Christianity, to its membership, and to the wider international community.

Rev. Dr Olav Fykse Tveit, general secretary of the World Council of Churches, speaking at the "Religious Leadership in Response to HIV: A Summit of High Level Religious Leaders," in Amsterdam, in March 2010, addressed the other global religious leaders as "fellow travellers on the journey of faith." He pointed out that "the core attitude of accountability is appropriate when we talk about the past, but also what shall bring us forward together; to give quality to the formation of cultures and our relationships. If anything, what we are here to discuss and improve are our human relationships—in so many dimensions."[41]

In the case of HIV and AIDS, the ecumenical movement has provided the effective platform for interchurch collaboration, a dynamic environment for discussion, dialogue, and joint action, in order to bring about change both in the local community and the international arena. The ecumenical movement has brought out the prophetic voices and set high standards, in a very public manner, as demanded by Christ's teachings in the face of a crisis such as AIDS, for denominations and Christian communities to face the pandemic with a reflective and contrite heart.