

BEACONS OF HOPE
HIV COMPETENT CHURCHES
A FRAMEWORK FOR ACTION

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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

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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

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.

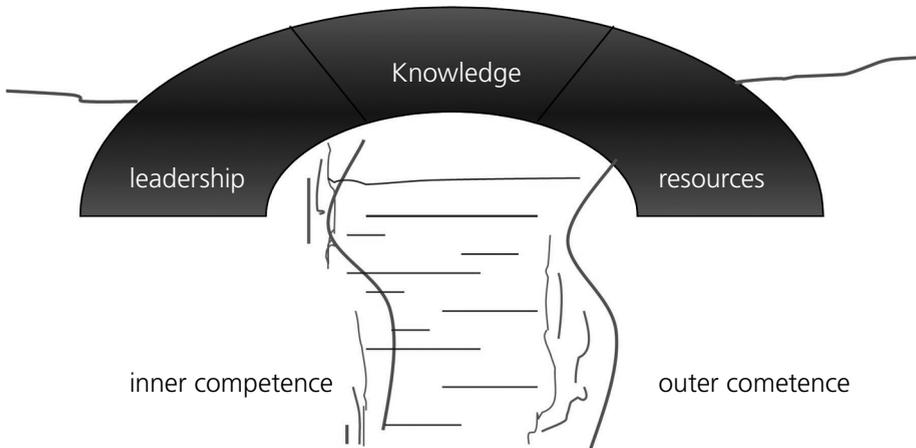
PART 3
THE BRIDGING CONNECTION

THE BRIDGE BETWEEN INNER AND OUTER COMPETENCE

The bridge between inner competence, described above, and outer competence is made up of three key cornerstones, which need to be recognized, developed and strengthened. These are represented by *leadership, knowledge and resources*.

These three need to be rooted in the communities that are being served, reflecting their experiences, challenges and expressed needs. Meaningful involvement of those who are most affected, coupled with collaboration with other key stakeholders, ensures respect and the development of responses that are appropriate and based on lived reality of the recipients and not on the perceived reality of those who are seeking to respond.

Competence Bridge



The three keystones forming the bridge between inner and outer competence: *leadership, knowledge and resources*.

LEADERSHIP

There are people who have been assigned positions of leadership; however they may not necessarily demonstrate leadership. Equally, there are those people who show leadership who have not necessarily been given such roles. Leadership is about both the individual and the cause. It involves commitment, passion, and courage, going the extra mile, having audacity, showing the way and staying the course. True leadership cares about the most vulnerable.

'Leadership' has been chosen as the World AIDS Day theme for 2007 and 2008, to complement the campaign slogan: "Stop AIDS. Keep the Promise". This theme was chosen because of the clear evidence that where there is strong and committed leadership significant advances in the response to HIV have been achieved. "Leaders are distinguished by their action, innovation and vision; their personal example and engagement of others; and their perseverance in the face of obstacles and challenges."²⁶ However, leadership requires more than just commitment for it needs to be expressed in solid actions with the adoption of specific programmes and plans and the allocation of resources and support for HIV and AIDS initiatives.²⁷ At the same time, it must be in touch with the realities faced by those whom it seeks to lead.

We need leaders everywhere to demonstrate that speaking up about AIDS is a point of pride, not a source of shame. There must be no more sticking heads in the sand, no more embarrassment, no more hiding behind a veil of apathy... Leadership means daring to do things differently, because you understand that AIDS is a different kind of disease. It stands alone in human experience, and it requires us to stand united against it.

UN Secretary General Kofi Annan, 15th ICASA 2004.

Leadership needs to be all embracing and evident at all levels. It does not imply only the hierarchy. The only way the epidemic can be reversed is through a total social mobilization. Leadership from above needs to meet the creativity, energy and leadership from below. The best of the global HIV response to date has shown the absolute necessity of both leadership and of teamwork.²⁸

Leaders need to be accurately educated about the epidemic; its causes, manifestations, impacts, and they must have the mandate to respond. This information must be imparted in a captivating and motivating way to encourage involvement in a full and comprehensive

²⁶ *World aids Campaign: Leadership: The World AIDS Day Theme 2007 and 2008.*

²⁷ *UNGASS on HIV/AIDS: 2003.*

²⁸ *UNAIDS Global Strategy 2001.*

response. However, whilst all leaders need to be well informed in order to take a strong stand on advocacy and for effective action on the epidemic, it is not reasonable to assume that they have all the information needed in order to communicate adequately and effectively to a wider audience. They too need access to training and accurate information to counteract irrational fears and discrimination. Examples of Uganda and Senegal clearly demonstrate that even the most conservative cleric can become an agent for change when properly informed and involved.²⁹

Within governments and civil society, legislators and community, religious, media, youth and the private sectors, all leaders have an opportunity and responsibility to assure success by creating an environment of:

- **understanding**, based on reasoned public dialogue and supportive public policy;
- **accountability**, where responses to the epidemic are underpinned by learning from experience through periodic situation assessments, analysis and performance monitoring; leaders are accountable to their flock;
- **commitment**, by substantially increasing those efforts within their mandates and areas of influence which have the most direct impact on the course of the epidemic;³⁰
- **engagement (involvement)**.

Leaders should be called to account and held responsible to fulfill their roles and responsibilities. Governments should be held accountable to their constitutions and to the many conventions to which they are signatories. They should create the enabling environment in which appropriate responses to HIV can be more easily implemented and in which stigma can be eradicated. Good governance is reflective of true leadership.

All leaders must be fully accountable for the funding received from resource partners. For credibility, and sheer responsibility to those whom we are representing, there must be complete transparency and accountability.

As Christians, our model of true leadership is Jesus. He turned upside down the prevailing notion of leadership in his time, which was one of domination and control (Mark 10:42). He taught his followers both by word and example that a *true* leader, despite all access to power, is one who chooses not to *rule* but to *serve* in humility (Mark 10:42; John 13:2-15). Many leaders have failed in this task.³¹

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

30 UNAIDS *Global Strategy 2001*.

31 *Churches in Manicaland: "The Truth Will Make You Free." A Compendium of Christian Social Teaching*. Sept. 2006.

Within many churches, congregants and volunteers do most of the actual implementation of care programmes. It is extremely empowering to them to know that the leadership of the church solidly backs their activities.

KNOWLEDGE

The second cornerstone in the bridge between inner competence, coming to terms with the reality of HIV, and outer competence, which involves building capacity to effectively respond, is knowledge.

Factual knowledge of itself is an academic exercise. It needs to be translated into practice and action. Whilst it is essential to have a working understanding of the HIV virus, its modes of transmission and what facilitates its spread; its physical effects; management and treatment issues, it is of equal importance to understand its impact on the individual, on the family and on society. In order to achieve some level of such understanding, it requires acquiring appropriate knowledge of the people concerned, their circumstances, the context in which they live and what contributes to their vulnerability to HIV infection. It requires consideration of cultural heritage including negative aspects of culture that may expose a person to risk; and of gender scripting which renders both sexes vulnerable. The impact of religion on moral mores, the effect of age and the different social pressures experienced at differing ages within the community dynamics and the presence or absence of support structures, all have considerable bearing on people's responses and choices. The context in which people live also influences the circumstances and freedom of choice, such as the political environment, governance structures, conflict zones, economics, poverty and food security; mobility, displacement and migration; equity in access to services including health, education and social welfare as well as the sociological and technological context.

KNOWLEDGE: HIV AND ITS IMPACT

Summary table

Acquisition of and provision of accurate up-to-date and relevant information concerning the virus and its:

- transmission
- detection
- effects
- management

determinants to its spread, including both structural and social factors such as inequality or lack of access to health and care services, gender imbalances, negative cultural practices, mobility, migration, displacement, conflict, poverty.

Acquisition of accurate up-to-date and relevant statistical information concerning the impact of HIV in our communities such as:

- numbers of people at risk
- numbers of orphans / widows / people at risk
- size of problem in terms of numbers of sexually transmitted infections, people living with HIV, opportunistic infections

availability and accessibility of services that provide information, communications on behaviour change for risk reduction and prevention, testing centres, counselling centres, medical management of concurrent infections, prevention of mother to child transmission programmes and anti-retroviral therapy, nutritional support and referral systems

Up-to-date, accurate and factual information needs to be communicated to leaders. Language that uses correct terminology and is not stigmatizing nor judgmental must be learned. It requires access to and availability of appropriate resource material and the sharing of good, sound practices. Networking is fundamental to this.

Thus, not only is academic information required concerning the virus, what facilitates the spread and how it can be managed, but also local reality-based information must be

sourced concerning who is doing what, where, how and with whom and what are the challenges. There is the need to be knowledgeable on the availability of community resources, referral channels and what is most hurting the communities we seek to serve. It involves *“changing the mindset from trying to control to facilitating, listening and involving.”*³² It also should call for our compassion.

Accordingly, the depth of knowledge required is considerably more than previously recognized and, in an era of information availability and ready exchange, there is less and less room for excuses from leadership not to understand the issues of HIV.

RESOURCES

The third component to the bridge between inner and outer competence is resources.

Too often resources are equated with financial assets and needs. Structural and social capital is over looked, as well as the less definable yet immensely valuable other assets, including the spiritual. Too often the perceived lack of resources creates inertia towards action and becomes the excuse for inaction.

For example: When anti-retrovirals (ARVs) became the treatment of choice for HIV, right across Africa voices were raised concerning unequal access, prohibitive cost factors, lives being lost and a host of other issues concerning the need for ARVs now. When the WHO gave the directive to ensure that 3 million people with advanced HIV infection in low and middle-income countries, needing ARV therapy, were to have access to it by 2005, very few countries and even programmes were ready for it, and not only because of a lack of resources but also because of a lack of proactive planning. Few had fully utilized the resources they had to the maximum so that the availability of ARVs could be an add-on to an already effective programme. Such a programme would have included community mobilization, voluntary counselling and testing (VCT) services, support groups, treatment protocols for opportunistic infections and tuberculosis, treatment literacy awareness, development of accompaniment systems for people on ARVs to ensure compliance, established referral and follow-up channels and appropriate networking between service providers to ensure a comprehensive sustainable service. By 2005 only 1.3 million people were accessing the treatment availed. By December 2006 there was a 54 percent increase to over 2 million on treatment, yet still far short of the vast numbers in need. An example of one such programme that did put in place these pre-requisites for successful roll-out is the South African Catholic Bishops Conference AIDS Desk. Their ‘Called to Care

³² *African Development Forum 2000: AIDS: the Greatest Leadership Challenge: ‘Scaling up the response to HIV/AIDS’ Theme III.*

Initiative', currently operating in five countries, has been identified as a UNAIDS 'Best Practice'.

The lesson here is clear – don't just focus on what is not there, maximize the use of what is already there and make preparation for the time when the constraint is no longer there.

1. Financial Resources

The scale of the problem is outstripping traditional sources of funding, particularly for faith-based organizations. FBOs are being encouraged, and expected, to expand their services to meet the demands of the multi-dimensional HIV crisis and are finding it increasingly difficult to run expanded programmes looking only to their traditional source of core funds. Many do not receive external support and have to raise their own support locally in resource-constrained settings.

Churches need to have a budget line for HIV. All too often, leaders undergo specific training and return, very motivated and committed to implementing programmes within the church. However, no budget and thus no resources for programme implementation can undermine and even destroy enthusiasm.

Churches previously were trusted with funding from traditional faith-based donor support and the level of accounting was, at times, minimal. Seeking to access larger funds from non-traditional sources may now involve being in competition with other agencies for the same funds. In order to compete equally and competently, it calls for a high standard of documentation, reporting, transparency and accountability. If a programme is worth doing, it is worth doing well and being adequately financed.

2. Structural Resources

FBOs generally already have buildings and properties. These facilities can be made available for training and for the care and support of people living with HIV. FBOs own hospitals, clinics, outstations. They also own and run educational faculties stretching from pre-schools to tertiary institutions. Their outreach activities are to be found contributing to virtually every institution, not only medical and educational, but also social welfare and justice and peace. Support for orphans and vulnerable children extends from community-based initiatives to institutional care. They also offer care in correctional facilities, poverty alleviation schemes, agricultural projects, feeding programmes, homeless shelters and support for street children as well as being widely involved in development work.³³ In this

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

era of HIV, with its enormous impact on the very fabric of society, are these structural resources being as fully utilized as they might be?

Institutionally some churches are in fact enormously wealthy, owning financial investments of substantial worth, yet the trickle down to church workers may be minimal and there is a high expectation on free voluntary services. Whilst the latter is a noble service particularly noticeable in churches, it also should not be exploited. If such churches do not have HIV responsive programmes themselves, there are innumerable opportunities to twin with less resourced churches locally or internationally to ensure that help reaches those most in need.

3. Human Resources

FBOs are in the enviable position of having members from all walks of life and professions, who can be called upon for technical expertise or as volunteers.

The church often has qualified personnel in literally all fields. Churches need to value and respect this, their greatest resource, the human resource. Mentoring youngsters and developing multiple layers of leadership is critical. *Training, retraining and retaining* staff is as critical in the church-run institutions, as it is in the government and the private sector.

Moreover, if the task at hand requires expertise not available within the ranks, then it is imperative to find the right person from 'outside the ranks'. Collaboration with other stakeholders can highlight gaps and opportunities.

All these structures and infrastructural networks are hugely valuable resources which churches need to factor in as assets in their planning and programming. They are also now recognized as valuable assets in national strategic planning, as is demonstrated in the strategic plan of Lesotho where it is declared:

Using the one thousand community and church health care workers to offer VCT, treatment and care utilising existing local facilities, such as schools, polling stations and church buildings, would boost the over-stretched capacity of Government health workers and at the same time, reach every Mosotho rapidly.³⁴

Structural, human and financial resources need to be used to maximum efficiency and effect.

³⁴ 'Turning a Crisis into an Opportunity: Strategies for scaling up the National Response to the HIV/AIDS Pandemic in Lesotho.' Partnership of Gov. of Lesotho and the Expanded Theme Group on HIV/AIDS, Lesotho 2004.

4. Spiritual Resources

There are both tangible and intangible ways in which religion contributes to health and well-being. The tangible ways may include compassionate care, material support and curative interventions whilst the intangible may include spiritual encouragement, moral formation and imparting knowledge. Spiritual encouragement includes such factors as hope, faith, prayer, trust – all of which build an inner resilience and inner strength to deal with crises in which people may find themselves.³⁵

The strength of these intangible religious health assets³⁶ is now being recognized and there are various studies underway to try and quantify them, particularly as religion is ubiquitous to so many African cultures, and it is the combination of the intangible and tangible that brings health and well-being. The value of prayer and intercession for those who are suffering, and for those who suffer with them, cannot be underestimated. Laying-on of hands, anointing and reconciliation are all examples of spiritual assets which bring inner healing and relief. There are countless testimonies to the inner peace experienced, even in the absence of physical healing. These are assets whose worth cannot be measured.

5. Resource Materials

Whilst there is a plethora of HIV documentation, especially in the North, there is a gap in theologically-based HIV and AIDS resource materials. Many organizations, such as the World Council of Churches, have sought to fill that gap by developing relevant liturgical resources and HIV-sensitive sermon guidelines. Resources are available from the Internet and cooperation between North and South is resulting in production of some mutually beneficial and useful materials for the church.

There is also a lack of such useful resource materials in local languages and a high demand and need for translation into local languages, as well as the development and documentation of local experiences in the local languages.

35 *African Religious Health Assets Program for the World Health Organisation: Appreciating Assets: Mapping, Understanding, Translating and Engaging Religious Health Asset in Zambia and Lesotho.*

36 *"Religion is so overwhelmingly significant in the African search for well-being, so deeply woven in the rhythms of life and so deeply entwined in African values, attitudes, perspectives and decision making frameworks." (Sieve De Gruchy 2006). The contributions made by religion and religious entities, rooted in communities, to the struggle for health and well-being have the potential to increase in strength and value and become more effective in the long-term sustainability, recovery and resilience of individuals, families and communities. The WHO has called for an unprecedented humanitarian effort to stem the tide of the HIV pandemic and to alleviate the suffering of millions through universal access to HIV treatment, care and prevention services by 2010. Potential key partners in this effort are religious entities, including organizations, initiatives, congregations and individuals that hold a considerable portion of the medical infrastructure in Sub-Saharan Africa and an even greater degree of health-promoting religious assets. ARHAP African Religious Health Assets program: www.arhap.uct.ac.za*

In addition to the lack of HIV theological material, there is also a paucity of quality data from the faith-based sector in spite of numerous operational programmes. Data is required to justify action and to support project proposals, monitoring, evaluation and reports. FBOs can be useful data collectors. "With their unparalleled coverage and human resources, especially large numbers of committed volunteers, they could collect good data on HIV and the social manifestations of the epidemic such as orphaning, unemployment and psychosocial distress. There is a compelling argument to be made for involving young people in this data collection. It transforms them from passive receivers of HIV messages to active participants in the fight. As enumerators, they will find the information they gather to be far more compelling than any messages directed at them. Best of all, they could use their natural talents with computers to do something really useful."³⁷

6. Resource Links to the International Community

Churches have relational links that stretch from the grass-roots to the international community. These are channels for solidarity between churches of the North and South, as well as conduits for resources, both financial and human. If the church is to truly live 'the Body of Christ' as an organic truth and not just as a metaphor, then there should be considerably more evidence of a more substantive commitment from the churches in the North to the churches in the South.

"The resources of religious communities are often overlooked by governments and non-governmental organizations, but religious communities and their leaders can be powerful actors on the front-lines combating poverty and advancing development."³⁸

³⁷ S. Parry: *Responses of Faith-based Organisations to HIV/AIDS in Sub-Saharan Africa*. World Council of Churches, Nov. 2003.

³⁸ Dr William F. Vendley, *the Religions for Peace Secretary General: Religious leaders call for cooperation to combat poverty and achieve Millenium Development Goals*. London, 9 June 2008.

PART 4
OUTER COMPETENCE

Acquiring leadership skills, appropriate knowledge and sufficient resources will not necessarily translate into effective and competent action.

As churches, the effectiveness and relevance of our activities, our outer competency, are directly related to the extent to which we have become:

1. Theologically competent
2. Technically competent
3. Inclusive and build social cohesion
4. Socially relevant
5. Allied with others who are working in similar fields
and with whom we can network, collaborate and coordinate
6. Advocates and use the prophetic voice of the church
7. Compassionate in restoring hope and dignity

It is frequently part of human nature, and particularly the church, to jump into situations of need, to respond to crisis, to assume the response required and to do our best to meet that perceived need and bring some relief to the problem. In the situation of HIV, whilst all the components listed above are necessary to become an HIV competent church, perhaps one of the most important qualities necessary is to learn to listen with love before we initiate our response. Many good intentions can cause harm and hurt through misguided ignorance. Even the language used, in all ignorance, can reinforce stigma. If we allow love to be the guiding motivation, perhaps we can overcome the tendency for the faces of HIV to disappear behind all the statistics of HIV. In that way, perhaps each and every person included in the responses may feel that they still have dignity, they still are people worthy of love, and above all – they may find a restoration of hope to go on to reach their potential.

The ultimate object is to prevent, mitigate and to share best practices, to bring relief but most of all, to *accompany* those of us infected and affected on the journey of HIV. This solidarity and support can help to restore dignity and hope, and a valued place in society. Our objective also is to ensure that no one else has to go through the same pain again.

The following sections outline, in more depth, the various components mentioned above. Each of these sections could be a book in itself and there are plenty such resources available. This book attempts to highlight the issues at stake, to provoke thoughtful reflection on a possible way forward, and to encourage a more strategic professional response to HIV. The church has a long history of care and support. It is this history that needs to be capital-

ized on, not exploited, and taken to a higher level of expertise because of the seriousness of this epidemic. HIV is tearing the heart out of families, communities and society. Lives are at stake. There are more orphans than at any other time in history and the numbers grow daily. We must safeguard the future whilst we care for the present and learn from our mistakes of the past. Let us accomplish this by maximizing our efforts, on time, with no wastage, to the highest possible standard and with joy.

OUTER COMPETENCE: THE SEVEN COMPONENTS

1. THEOLOGICAL COMPETENCE ON HIV³⁹

“HIV and its impact challenge us to the core of our faith as this disease goes well beyond the realms of mere technical responses and medicine. Faith communities the world over, and especially in the developing world, have initiated many worthy projects reacting to HIV but we need to probe deeper to find an understanding as to:

Why this pandemic demands our response and what our faith essentially brings to the lives of those infected and affected?

Christian churches have an important challenge in the theological context of the global pandemic of HIV. We are to examine the theology and the spiritual vitality that fuels our ministry. Offering people knowledge or technical competence is not enough. We must facilitate an encounter with God, for theology is after all not primarily concerned with the presentation of comfortable theories but making sense of the lived experience.

HIV provides an opportunity for the whole Christian family to rediscover its roots and to re-focus on the divine commission to become living centres of love, recalling human beings to their true destinies and dignity. HIV is devastating but it is also a window of hope as it challenges us to question our very vision of what it means to be human and motivates us to search for ways to fulfill our deepest desires and dreams.

Towards a Theology of HIV

Speaking in Munich in September 2006, Pope Benedict simply proclaimed: “The world needs God. We need God. But what God do we need?”

³⁹ This section: ‘Theological Competence’ has been adapted from an article specifically written for this manual by Fr Robert Igo OSB, Christ the Word Monastery, Macheke, Zimbabwe, Jan. 2007.

HIV and AIDS invite us to discover what kind of God we need. It raises many deep spiritual and theological questions central to our faith:

- What is the meaning of our continued existence?
- How does this meaning, that Jesus brings, empower me to make choices for life?
- Why am I suffering?
- Where will this disease lead me?
- How can I live positively with my HIV sero-status?
- How can I choose to remain uninfected?

Christians who find themselves immersed in a ministry of care and compassion to those infected and affected by HIV, are engaged in bringing the ointment of faith to the wounds of people's lives and are challenged in two specific ways:

1. To examine critically how we bring our theological and spiritual understanding of our relationship with God to bear in our work of prevention.
2. How we effectively bring Christ's healing presence to those infected and affected.

Our faith encounter with the Father, Son and Holy Spirit provides us with a genuine reason to live and a concrete foundation for the choices we make.

Throughout the history of the Christian faith we can see clearly that the encounter with Christ is a life-changing event, whether in a dramatic or less dramatic form. To come to a true knowledge of Christ means that we cannot remain the same, nor can our faith remain on the level of our intellect alone. In fact, coming face to face with Jesus unsettles the very roots of our thinking. For an example of this radical change in outlook, look at the story of the visit of the Magi in Matthew chapter 2. The three had set out on a physical journey to discover the new-born king. In reality, however, a new inner journey began for them. This new king turned out to be quite different from what they were expecting. In this way they, like all pilgrims, needed to discover that God is not what we usually imagine him to be.

The encounter left them changed in their ideas about God, themselves, and the purpose of life. They could no longer return home the same way, not only because of Herod, but because they were changed people. In our ability to pass on the Good News we need to be competent in introducing people to a life change encounter with a Jesus that is more than ideas. Faith is far more than a collection of abstract truths concerning the mystery of God, humankind, death and our ultimate future. Faith consists in a relationship with Christ based on love (1 John 4:11). This is the gift and challenge that a theologically competent

church must make in the contribution towards an HIV and AIDS-free world. It is the strongest prevention message we have.

Following on from this a Christian congregation who desires to become 'AIDS Competent' must of necessity reflect theologically on some key issues, which this pandemic raises. What are these issues? First and foremost our concept of God is brought into question. Who is this God and what place does the Trinity have in my daily life? Secondly, the nature of suffering demands an answer. If there is a God, then what kind of God do we worship when millions have had to undergo dehumanizing experiences? If God is a reality, more still, if this God is love, then how can love remain silent and inactive in the face of torture, needless death and disease?

At the heart of the call for Christian congregations to become 'AIDS Competent' is the necessity to begin to reflect theologically on some of the key issues which this pandemic raises.

Time and again, throughout the Christian centuries, there have been attempts to give answers to the ready question "WHY?" Unfortunately sickness and suffering became too closely linked to sin and punishment. It follows therefore that people ask now whether HIV is a punishment from God, a simple result of personal sin? Christians must look at moral issues surrounding HIV; they must clarify what scripture *means* when it talks of sin and punishment. They must explore the growing realization that sin has social, structural roots just as it has social consequences. To look therefore at the nature of God is of course to reflect on the purpose of creation. We move easily from looking at what kind of God do we worship to asking why God has created us at all. What purpose do we serve? The opening chapters of the book of Genesis provide an ancient answer. We are created to reflect the life and love of God. We have dignity and destiny. But so many features of life seem to steal from people a sense of self-respect. There are many cultural beliefs, as well as religious practices, that seem to promote inequalities between the two icons of God, male and female. In the world at large there would appear to be a gender warfare that needs to be radically addressed from a Christian perspective and there are social injustices that the Gospel of Life cannot allow to go unchallenged.

With regard to more specific issues like sexuality, forgiveness, healing, care and compassion; all these have an important place among those who seek to speak credibly to people who daily have to live with HIV in their bodies or in their families and neighbourhood. Theological competence, therefore, invites each Christian and particularly those whose task it is to minister, and to teach future ministers, to search for the presence of God in

the context of a virus that desires to destroy hope and steal life. Theological competency will certainly want to address these basic questions:

- What / who is God?
- Where is this God to be found in my life?
- How does my faith influence and inform the life choices I make?
- Why did God create human beings, what is our purpose?
- Why did he create us male and female?
- Where is this God to be found in the lives and experience of people living with and affected by HIV?
- How can God look at people suffering and do nothing?
- Is suffering and sickness a cause of moral irresponsibility?
- Do we deserve to suffer because of sin?
- Can suffering ever have a hidden meaning?
- In the face of people dying of HIV-related illness should we pray for healing?
- What kind of healing can we hope for in the context of HIV?
- If baptism has taken us into Christ, where is Christ in the life of someone infected with HIV?
- When someone has been faithful to one partner and that partner has infected him or her, how can we learn to forgive?
- When we have been involved in risky behaviour how can we forgive ourselves?
- How can I help myself to daily 'choose life' when I have been diagnosed as being HIV-positive?
- Does the encounter with Jesus Christ empower me to remain free of infection? If so, how?

These are some of the questions that Christians have to wrestle with competently in the light of the present pandemic. The World Council of Churches has already produced an admirable curriculum for Theological Instructions in Africa. Since November 2001 it has been calling for teaching on HIV to be integrated into all levels of theological formation. The curriculum provides a basic syllabus which could easily be adopted and improved

upon by seminaries, houses of formation of religious brothers and sisters, theological colleges and more importantly, in Christian communities large or small.

Any programme that seeks to be theologically competent would need, in summary, to explore the following topics:

- The Christian understanding of God.
- The meaning of creation and especially gender.
- What place has sin and punishment in the 'Good News' of Jesus Christ?
- Forgiveness as a route to inner peace and harmony.
- The place of Christian ethics in learning to make life choices.
- How Christians view healing in a world where there is sickness and death.
- An appreciation of the theology of the body so as to teach an authentic Christian understanding of human sexuality.
- The place of prayer and worship in leading us to a deeper vision of life and destiny.
- The use of scripture as a response to social injustice and daily living.

Becoming More Theologically Competent

As mentioned above, theology is not fundamentally concerned with finding solutions or answers to difficult questions. Rather it is truly concerned with learning to ask the right kind of questions and to courageously reflect upon them. We may never find the answers that satisfy us completely, but a church that is theologically competent will never tire in its search. The search for truth is not an option for us as Christians and so with this in mind if we really desire to be competent in our theological endeavour we will need:

- To challenge all Christians to embrace the gospel message and to live it out in all areas of life. To live faith, not simply to talk about it.
- In this way the Christian fellowship opens to others the most powerful means of hope. It encourages each person to choose life, by choosing well.
- To invite those living with and affected by HIV to come and share their stories and the issues that are of paramount importance.
- Through this careful listening we need to deepen our own understanding concerning the interface between HIV and our Christian faith.

- We need a resolute commitment to prayer and study of scripture so that we begin to read the Word of God through the eyes of this pandemic.
- To build up within the formation of those who minister an integrated approach to their study and their preaching. Learning how to apply their theological knowledge to the wound of HIV and AIDS.
- To encourage those tasked with preaching to share on topics related to HIV, to openly discuss questions related to sexuality and sexual behaviour, and to incorporate these issues in their pastoral programmes.
- Within our Christian communities systematically to break down the walls of prejudice, stigma and discrimination, thus to create safe and compassionate places for people to experience love and genuine support.
- Through careful preaching and discussion to empower our Christian communities to feel comfortable in discussing and confronting all the issues that HIV brings to light.
- To train many more pastoral counsellors among our Christian congregations in order to provide spiritual and psychological support.
- To encourage people infected and those affected to meet regularly for prayer and reflection.

Theological competence is more than having the composite knowledge. It is having the ability and commitment to apply that knowledge in the experience of life. If the Christian communities throughout the world are to truly become 'HIV competent' then they must look to the presentation of the faith in a way that speaks to the difficulties and challenges of people's life experience. There is no doubt that our faith has an important part to play in fighting this deadly violation on human existence. We need among ourselves the focused commitment to reflect, pray and study so as to be a credible channel of God's love, an instrument of radical change.

2. TECHNICAL COMPETENCE

The second component of Outer Competence is to develop technical competence through building institutional capacity to plan, implement, coordinate, and monitor and evaluate HIV programmes effectively.

HIV is an epidemic within other social epidemics and a stigmatizing condition which affects every aspect of life of the individual, the family, the community and society as a whole. Responding to the disease, whether in prevention or in care, support or mitigation

of impact, requires a whole range of activities and technical competence. HIV is not a simple time-bound condition which will disappear with a concerted effort. Those of us alive today are unlikely to ever live in a world without HIV again. We would hope to at least make it AIDS free. The global statistics of rising infection rates, mortality rates and orphan numbers are so vast as to be incomprehensible. Such numbers can induce a state of action-paralysis. However a “journey of a thousand miles begins with the first step” and a city is built one brick at a time. It is imperative though to respond strategically and with proficiency. Our plans, programmes and all activities need to be well thought out, carefully planned and based on sound knowledge of the context and the condition, prioritized and actioned efficiently, aiming for measurable success in what we do. This process requires us to become technically competent and is made easier by following through certain principles to achieve competence.

There are many excellent resource materials available on the Internet, from FBOs, non-governmental organizations, and agencies and from commercial outlets, which deal with specifics in developing policies, plans and monitoring and evaluation techniques (see some example sites in annex).

Vision, Mission And Values

The fundamental principles of who we are, why we are, what we stand for and what we hope for in the future, as a consequence of our presence and unique contributions, are usually described in the vision, mission and values statement of the church. HIV is an issue that will be with us all for a very long time to come. It may be that these vision, mission and values principles will need to be re-visited and revised towards competence in order to include HIV as a cross-cutting issue.

An HIV Policy

An official policy on HIV for an organization or church is an essential starting point. A policy denotes commitment, focuses action, is motivating and empowering to the implementers. It should include a vision, mission statement, goal and objectives. Most of all, it needs to be implemented.

The very process of formulating an official and accepted policy can make a critical difference to the attitude of the members and leadership, as it can involve widespread collaboration, encourage ‘buy-in’ to the process, create a sense of ownership and thus become a motivating force for action. It can also serve to highlight strengths and weaknesses as well as expose critical gaps and thus serve as a challenge to the church/organization. Often it is

helpful to ensure participation of all with outside professional guidance to assure that all stakeholders (hierarchy, positive people, and church groups) have a voice.

- While formulating policies, it is important to:
- Have an overview of the policies on HIV of related organizations and other faith communities.⁴⁰ This helps us to build on the experiences of others, to avoid errors and to improve on others' experiences.
- Be aware of the minimum standard that is expected from civil society.⁴¹ Being part of a faith community does not make us above the law. In fact the standards that we apply to ourselves need to be even more stringent than those applied generally, and need to be a beacon to the rest of society.
- Be aware of areas where policy-making has to pay special attention – such as the workplace.⁴²

Example of an HIV Policy: There are many excellent examples of HIV policies, which have been developed by FBOs. Some of these policies are available on the WCC web-site and on other faith-based web-sites. (See annex for examples of such web-site connections).

(See also Annex 3: The Ecumenical HIV and AIDS Initiative in Africa (EHAIA))

Strategic Planning

“Commit to the Lord whatever you do, and your plans will succeed.” Proverbs 16:3.

Very often churches do not have a strategic plan. Actions emanate from responding to obvious need. Churches are largely implementers: they are the doers. Responses tend to be reactive rather than proactive. There is frequently little monitoring or evaluation of the effectiveness and appropriateness of the actions. Consequently good responses may be under-funded, too piecemeal, and of limited potential impact.

Whilst such actions may have sufficed in the past, HIV is “an exceptional condition requiring an exceptional response.”⁴³ This calls for proper planning and yet all too often there seems to be little conceptual or programmatic guidance.

40 *Declarations and policy statements on HIV/AIDS by churches and faith-based organizations from 2001 to 2005 (a compilation found on the WCC web-site).*

<http://wcc-coe.org/wcc/what/mission/hiv-aids-statements01-05.html>

41 *Renewing Our Voice: Code of Good Practice for NGOs Responding to HIV/AIDS:*

<http://www.ifrc.org/what/health/hiv/aids/code/>

42 *Towards a Policy on HIV/AIDS in the Workplace in Churches and Related Organizations – Working Document:* <http://wcc-coe.org/wcc/what/mission/hiv-aids-workplace-e.html>

43 *A quotation used on several occasions by both Dr Pieter Piot (UNAIDS) and Kofi Annan (former Secretary General of the UN).*

It is important to plan well as a great plan with no action is of little use, just as no plan but much action is equally of limited use. It is extremely important to set criteria for prioritization and then define and agree on priority areas. This is followed by developing or mapping out the strategies to attain these objectives.

Planning an effective response to the challenges presented by HIV is vital, but given the complex nature of HIV, poverty, the socio-economic and political environment, and with so many other unknown factors, planning needs to be sufficiently flexible to allow for ongoing learning and revision. Have the courage to change the way activities are implemented or the type of activity if the need is there. Do not perpetuate an activity because traditionally it has always been done that way if it is no longer appropriate or if evidence and circumstances suggest a change is required.

“The plans of the diligent lead to profit as surely as haste leads to poverty.” Proverbs 21:5.

To begin with, the church needs to know exactly where it stands at the outset, before determining where it wants to go and how it shall get there. The resulting document is called a ‘strategic plan’.

Core principles in strategic planning – for an HIV competent church

There are some fundamental principles to be considered by churches, when developing a strategic plan. Frequently these can be overlooked and as such may compromise the sensitivity, effectiveness, sustainability and credibility of one’s work. It also may undermine one’s ability to attract the required finances.

These principles are illustrated in the box inset:

Core principles for strategic planning

1. Respect for Human Rights
2. Grounded in one’s faith
3. Evidence Based Decision Makings (EBDM)
4. Openness to the stated objectives
5. Participatory
6. Accountability

1. Respect for Human Rights

Ensure that the proposed programming does not stigmatize, debilitate or otherwise negatively affect the dignity of the very people the programme serves, including people living with HIV and AIDS (PLWH and A). As people of faith, the call is not only to respect the rights of people but also to call to mind the responsibilities of one for the other.

2. Grounded in One's Faith.

All our plans should follow the basic teachings of our faith:

- Unconditional love which manifests itself in our work and interactions – respecting and treating others as we expect them to treat us (Mark 12:29; Matthew 22:37-40; Luke 10:25-37)
- To be able to see God in the other, and to see humanity and our local community as part of one body (Matthew 25:35,36; 1 Corinthians 12:12)
- *“To act justly and to love mercy and to walk humbly with your God” (Micah 6:8)*
- In line with the values and social teachings of the church.
- In primary prevention strategies, churches should not be required to compromise their doctrines with the secular world. At the same time, secular partners should not be required to justify their approach from the ‘moral high ground’ of churches. Accurate evidence-based information should always be provided. There are plenty of non-confrontational ways in which each can respect the standpoint of the other, and not undermine each other's efforts.

3. Evidence-Based Decision Making

Evidence-based decision making is based on the synthesis of evidence gained from:

- Knowledge and training
- General accumulated experience
- Specific experiences
- Valid research information and data

An evidence-based decision making process provides a more rational, credible basis for the decisions you make. Objective evidence is difficult to ignore or neutralize and “objective evidence helps to even the playing field in an arena where politics often distorts the decision making process. Objective evidence elevates the discussion and helps to profes-

sionalize the debate. Ultimately, a case built on credible, objective evidence strengthens your advocacy.”⁴⁴

Utilizing the church’s unique links with communities, it is important to increase this evidence base by documenting the many experiences, the knowledge gained of the communities being served by the church, the challenges and all results achieved, both positive and negative, in the outreach and the programmatic response. This will also help to expose weaknesses in the responses and help to strengthen what makes a difference.

4. Openness

Openness in stating objectives and expected results. Churches are recognized as service providers. Where there is clarity about the objectives planned, there is less chance of unrealistic expectations being created and the possibility of more cooperation, collaboration and assistance from the communities being served.

5. Participatory Process

Broad participation in planning and implementation is one of the most critical lessons learned world-wide. Communities need to own the process and this will only happen when they have been involved in the identification of the problem, explored the causes and been involved in the development of an appropriate response. There are many branches and committees within any church, having direct and indirect contact with community members as well as exposure to expressed and felt needs. There is also an awareness of some of the community assets and capabilities to respond to their own needs. This is all very valuable information which can add richness to discussions and prioritization of responses. Programmes tend to best develop and expand in scope when they are driven by community needs and demands rather than by national frameworks or external policies. It is important also to consider that there are many technical experts who can be called upon to provide valuable and objective input to complement that of communities. Planning in collaboration with other stakeholders may be of mutual benefit and enhance the range and value of the service provided.

“Plans fail for lack of counsel, but with many advisors they succeed.” Proverbs 15:22.

⁴⁴ Chris Lewis: “Evidenced-based Decision Making” developed in partnership with NCDVRS used as a job aid for RSA SRC Training Initiative 2004.

6. Accountability for Decisions and Funding

Whether at global level or at programme level in a local church, accountability is central to credibility and good management.

Where there are agreed frameworks for action, whether at the local level or within the wider community for activities such as scaling up access to prevention and treatment, there is a need to ensure that these agreements are honoured.

Strategic plan

A strategic plan requires a disciplined effort to generate fundamental decisions and actions that will ultimately shape and guide the direction that the programme will take. There are many approaches to strategic planning and many excellent resource materials available, at commercial outlets as well as on the internet, to guide this process.⁴⁵

Common to most of these processes are the following key elements:

KEY ELEMENTS TO A STRATEGIC PLAN

1. Evaluate the current situation – a situation and response analysis – where are we now?
2. Define what would be the ideal situation – planning decisions: goal and objectives.
3. Identify what is the gap between the current and the ideal situation and how did it come about?
4. Identify what specific actions (activities) must be taken to close the gap between the current situation and the ideal state – implementation. How do we get there? (Methodology selection). Activities are selected on the basis of the desired outcomes.
5. What resources (inputs) are required to do this?
6. Document outputs (what is done and how many activities and participants involved?).
7. Outcomes: Show the actual impacts, changes or benefits noted and achieved as a consequence of the activities.
8. Monitoring and evaluation
How are we getting on? (Implementation / review / evaluation)
What changes (revisions) are to be made?
9. Indicators

Then back to 1, incorporating improvements or changes.

⁴⁵ Examples: <http://www.scn.org/cmp/modules/pm-pln.htm>

Strategic planning and the decision processes should end with objectives and a road map of ways to achieve these objectives. The overall goal should be to complement the national effort to curb the HIV epidemic and mitigate its impacts.

1. Evaluate the Current Situation

(a) Situation analysis – Where are we now?

A situation analysis involves both an external assessment and an internal assessment.

An internal assessment involves a critical look at the church or organization seeking to respond, to assess its weaknesses and strengths as well as its resources and capabilities. The resources refer to financial, structural, human, technical, time and other resources such as transport. Capabilities refer to the technical know-how and experiences of people involved in the church and the community served, and the capacity of the church to respond.

An external assessment identifies all relevant factors that could be contributing to, or impacting on, the situation in question. These may be economic, social, cultural, political and/or geographical. It involves:

- Realistically become informed of the HIV information available for the population being served.
- Seriously consider what major factors and which behaviours are driving the epidemic?
- Critically look at the socio-economic, political, cultural, legal and health factors that contribute to vulnerability to HIV infection, including such issues as:
 - Availability of HIV information and knowledge of services provided
 - Accessibility to, affordability and equity in health services
 - Educational opportunities, especially for girls
 - Gender issues, in particular inequalities and gender-based violence
 - Migration
 - Conflict zones
- Assess the present and projected impact of HIV on the community.

The outcome of a situation analysis is not merely a description of the status of the HIV and AIDS epidemic in the country or area in which the church is working. It should also provide insight into the specific context of HIV and AIDS in terms of:

- Who is the most vulnerable and why?

- What are the priority areas for effecting change?
- What are the major obstacles and how to overcome them?
- What are the opportunities and how to seize them?

A situation analysis is important both within the church/organization and outside of the church/organization. This helps to establish a realistic picture of what is known and observed about HIV within the church and broader community. It also involves looking at sound practices and helps to focus on the total need and to thus prioritize needs.

(b) A response and stakeholder analysis – who is doing what?

This process involves establishing what is currently going on, who is doing what, where it is being done and what should be done.

Each of the following needs to be investigated:

Current responses and services being provided:

- List the current quantity and quality of services provided by the church, and other organizations working in the same field, and their ability to supply the required services, e.g. home-based care.

Adequacy of response:

- Assess these efforts for adequacy, acceptability and relevance: what is working and why? What is not working and why not?

Gaps:

- Identify critical gaps and opportunities to initiate, improve on or strengthen responses.

Good practices:

- Look for 'best/sound practices' or good models of response.

Resources:

- Assess available and potential resources to enable realistic planning.
- Look for technical resources: who has the technical expertise and who will share the information? This will ensure efficient use of time and minimize the use of culturally inappropriate strategies.

- Identify partners, including people who are living with HIV.
- Critically look at the church/organization's response capacity: what is its ability to respond in terms of infrastructure, skills, funds (sources and donor support)?

Collaboration:

- Look for potential partners for synergy, to enable expanded outreach and for the opportunity of shared skills and expertise.

Decide and prioritize:

- Weigh the most important factors and set priorities for future actions. What do we want to achieve and who is our target group? This is a very important step as it is not possible to do everything all at once.

In addition, it is important not to overlook an assessment of who is going to benefit and who is going to lose if a certain objective is pursued. Benefits and losses are not restricted to material elements but also to social factors such as importance and influence in the church, village or other government institution. This information may give some understanding as to whether or not proposed activities might succeed or possibly be undermined.

The outcome of a situation and a response analysis should provide the necessary data and guidance for activities and strategies:

- What should continue?
- What could be expanded?
- What should be reoriented?
- What should be discontinued?
- What should be initiated?

All these are based on the core principles.

2. Planning Decisions: Goal and Objectives

There are several ways or processes in planning, implementation and evaluation.

The number of key questions to be considered depends on the complexity of the project or programme for which you are developing a strategic plan.

(a) Goal: Our desired achievement

“The project goal states the long-term intended change in the lives of beneficiaries toward which the project objectives and activities contribute. The project activities may or may not result in the full achievement of the goal, but they will help the target group move in that direction. The goal should be a direct response to the problems cited in the project’s problem statement and should anticipate the project objectives.”⁴⁶

This goal is generally stated in broad terms and captures the essence that the HIV programme needs to do. Goals often start with words like ‘to reduce...’ or ‘to increase...’ or ‘to provide...’.

For the church responding to HIV, it is likely that the goal would reflect a desire to have a HIV competent church within the next 5-15 years to eradicate stigma and discrimination and to provide the necessary leadership, guidance and appropriate support to communities to prevent the spread of HIV and to achieve a measurable improvement in the lives of all who are infected or affected, characterized by lives that are lived with dignity and hope.

A goal is the specification of what is hoped to be achieved by the end of the project – a specific, measurable and time-bound result.

See Annex 3: The Ecumenical HIV and AIDS Initiative in Africa (EHAIA)

(b) Objectives

Goals and Objectives, as terms, are often used interchangeably by different organizations, though they are not necessarily the same. An objective is more specific than a goal and describes what it is you want your project or programme to achieve. Generally, a set of objectives (if added together) should make up a goal.⁴⁷ Project objectives identify and quantify the conditions that will be created to overcome the cause of the problem. Objectives, then, are the expected outcomes of the project and point to the conditions that are necessary to achieve – or approach the achievement of – the project goal.

⁴⁶ Definitions for these terms are drawn from the Catholic Relief Services Project Text Format: CRS Overseas Operations Manual Section 7.7 as described in CRS AIDS Impact Indicators 97.

⁴⁷ HIV/AIDS planning process: A step by step guide to HIV/AIDS planning for the Anglican Communion, The Policy Project 2001

They express what will change, when, by how much, and for whom, as a result of the completion of the project activities.

Objectives must be **SMART**:

- **Specific** – in stating what will be done: where, when and how;
- **Measurable** – able to quantify the targets and benefits to allow monitoring and evaluation, to identify the success or not of the intervention;
- **Agreed upon** – in relation to the organization’s vision, mission and goal and the people who will be the implementers;
- **Realistic, relevant and achievable** – able to obtain the level of change reflected in the objective and in relation to the organization’s potential capacity and experience;
- **Time-bound** – stating the time period in which each objective will be accomplished.

3. The Gaps

Identify what is the gap between the current situation and what the ideal situation should be. Assess what might have been the reasons for the situation being like this.

4. Specific Actions. Implementation – Identification of activities – How do we get there?

In order to achieve and accomplish each stated goal or objective, major activities will need to be decided upon and undertaken, as well as ways to measure progress and impact. The activities selected should be based on the desired outcomes, be relevant to the proposed objective and should be logically and sequentially prioritized. All the activities should be quantified (how many?) and time-framed (when?). They should indicate *what* will be accomplished, in *what quantity* or magnitude, and *who* will carry them out.

These activities or processes could include trainings, teachings, counselling, feeding, clothing, developing and publishing guidelines or books, etc. – whatever is most appropriate to achieve the desired outcome in the process of accomplishing the stated objective.

There are, again, many resources to assist in development of action plans or work plans.⁴⁸

A very useful methodology is the use of the log frame presentation of a work plan, consisting of Objectives, Activities, Inputs, Outputs, Assumptions and Indicators.

⁴⁸ For example: Carter McNamara, *Basic guide to outcome-based evaluation for non-profit organisations with very limited resources*. NNI/LM National Network and Libraries of Medicine.

The benefit of such a framework is that the entire work plan is in tabular form, easy to read, and all aspects of a comprehensive work plan can be reflected on the same page.

5. Resources: Identification of Necessary Inputs

Activities require resources such as money, materials and skills, which are also known as **inputs**.

Resource mobilization is getting the resources that are needed to be able to do the work planned. It is more than fund-raising – it is about getting a range of resources, from a wide range of resource providers (or donors), through a number of different mechanisms.

Very often resource mobilization only takes place after the planning process and frequently is thought to refer only to financial resources. Resource mobilization is in fact an integral part of a truly strategic planning process and should refer to mobilizing:

- Financial resources
- People
- Communities
- Goods
- Services
- Technology

It involves making better use of the already available resources as well as securing additional ones. The church often feels that it is poor when it is in fact so blessed. In many instances it could look inwards for all or most of these resources.

(See Annex 2: Key Challenges in resource mobilization)

In order to access the bigger funds, there is an increased need for professionalism in the approach to resource partners or donors. Donors require tangible data to support proposals. They need to be convinced of the relevance of the anticipated response and have clear guidelines as to the process of accountability and monitoring and evaluation of the activity. There is a need also for increased collaboration with other key organizations to seek jointly for larger funding. At the same time, donors need to be challenged, and convinced, of the need to rethink the strategy of not providing core funding.

The next important step is to allocate responsibility to specific people for implementing the activities which have been decided on. These persons need to know what is to be done and to have the appropriate training in order to accomplish the activity.

Identify partners, (individuals, organizations, other key stake-holders) who can help with technical assistance, material and financial resources, or help create an enabling environment to assist in achieving the objectives as effectively as possible.

6. Outputs – Recording what is done and numbers involved

Measures, known as **outputs**, document the amount and quality of the service provided. They are the numerical record of units of service such as: numbers of people taught, counselled, sheltered, etc., or the number of books published etc.

7. Outcomes – The actual impacts, changes noted and activity achievements

Outputs help to track the progress but **outcomes** reveal the true changes or impacts that the programme has on its participants during and after the completion of the programme.

These changes are usually expressed in terms of:

- Knowledge and skills (usually a short term outcome)
- Behaviours (an intermediate or medium term impact)
- Conditions, values and status changes – impacts that are reflected socially, economically, civically, environmentally etc. (long term).

Outcomes help ensure that the church's programme is always kept focused.

Outcome targets represent the desired numbers and percentage of the population or participants for whom you wish to achieve an outcome. For example: 60 percent of all pregnant mothers attending the mission hospital antenatal clinic receive information about prevention of mother-to-child transmission of HIV and then go for voluntary counselling and testing and receive appropriate follow-up.

8. Monitoring and Evaluation

(a) How are we getting on? (Implementation / review / evaluation)

(b) What changes (revisions) are to be made?

Monitoring and evaluation is a means to observe whether or not we are on the right track. It is a tool to identify what impacts or changes are evident as a result of the programme, both during and after completion. It is a key management tool for assisting and guiding managers in adapting the strategies and activities to increase their effectiveness in a timely fashion. It also provides necessary information required by decision makers and resource partners.

Monitoring means keeping a track of what is being done and achieved. It is the continuous assessment of the project and its context with regard to the purpose, inputs, activities, outputs and risks. 'A Monitoring Plan' sets out what is going to be monitored, by whom and when. It is a reality check of the process of the project.

Evaluation means assessing whether the implementation of the project was successful in achieving its pre-determined objectives (what results did we achieve? Did we achieve what we set out to achieve?) and what were its strengths and weaknesses (how should we continue?). It is an evaluation of the effectiveness of the project.

Evaluating **outcomes** is looking for the short-term and more intermediate effects such as: attitude and behaviour change; increase of social support etc., whereas **impacts** are looking for more long-term effects such as changes in HIV trends; reduction in AIDS-related mortality; changes in the coping capacity of the community, etc. Both outcome and impact assessments almost always require quantitative measurements which will help identify how well the programme objectives were achieved. Outcome and impact evaluations can explain:

- What outcomes were observed?
- What do the outcomes mean?
- Does the programme make a difference?

Planning an intervention and designing an evaluation strategy are inseparable activities.⁴⁹

9. Indicators

Indicators represent ways to measure how successful something has been and should link well with the aim, objective and audience. They are observable and measurable 'milestones' towards an outcome target. They indicate or give a strong impression as to whether or not progress is being made towards the outcome target.⁵⁰

There are principally two types of measures: Quantitative and Qualitative.

- **Quantitative** is about numbers – e.g.: number of people trained; number of people in a support group, etc. They are exact, but measure only one narrow aspect which may or may not be indicative of reaching the overall objectives.

⁴⁹ FHI: HIV/AIDS Prevention and Care (IMPACT) project: 'Evaluating Program Effectiveness'.

⁵⁰ Carter McNamara, *Basic guide to outcome-based evaluation for non-profit organisations with very limited resources*. Authenticity Consulting, LLC.

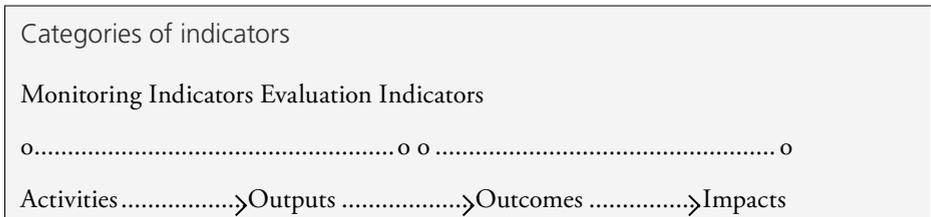
- **Qualitative** measurement refers to recording ‘descriptive’, ‘narrative’, ‘open questions’ (what has changed?) responses. They are difficult to summarize in progress reports but may also help to spot unexpected results and underlying reasons, whether positive or negative.

Indicators need to be reliable, valid, easy and inexpensive to collect. It is not worth the time and effort getting bogged down on incredible details with super-specific indicators. We are dealing with people and need to monitor and evaluate our programmes to make sure they are working as planned and that some change is evolving, but not to spend our time collecting information for indicators that are unattributable to our programmes and mean nothing to the programme staff,⁵¹ or the beneficiaries or, if applicable, the outside funding institutions.

When selecting indicators:

1. Ask: what could be seen, heard, read about the participants that means progress towards the outcome is being achieved?
2. Include numbers and percent regarding behaviour: e.g. 80 graduate students (50%) from the theological training institution will have received training on HIV and include HIV sensitive messages in sermons and prayers on Sundays after one year.
3. Decide what information is needed, who will collect it and how (questionnaires, interviews, surveys, documentary reviews, other?) and what to do with it afterwards.

Example:⁵²



51 Kari Egge, M&E Officer for CRS/Ethiopia: 'Feedback on Impact Indicators.' Aug. 5, 1997.

52 World Vision HIV/AIDS Response M&E Framework, December 2005.

Objective	Activity	Output	Outcome	Impact
Train children in values-based age-appropriate life skills to avoid HIV infection	# training sessions conducted # of trainers who conducted the meetings	# of children who received training	# of children who scored above 80% on a post-training test	Delay of age of first sexual encounter

Principles for effective implementation

Jesus frequently used parables that were rooted in the day-to-day life experiences of the people. These same parables are as applicable today as they were 2000 years ago.

The following section on principles in implementation is adapted from an agricultural programme designed to lift farmers from mere subsistence into abundance. The programme, called 'Farming God's Way',⁵³ has effectively identified four principles to be adhered to for successful results. These same principles can be applied to efforts in the fight against HIV and have been adapted accordingly below.

Competence Implementation Principles

1. Do it on time
2. Do it to a high standard
3. Do it with no wastage
4. Do it with joy, passion & thanksgiving

1. Do It on Time

This implies developing programmes appropriate to the stage of the epidemic in our communities. Be pro-active and read the signs of the times. Formulate programmes appropriate to the audience: e.g. prevention programmes initiated with and for the young involving life-skills training, self-worth and assertiveness, dealing with peer pressure, etc., before they face the challenge. In home-based care programmes, establish relationships with the children of the affected household before they become orphans. Ensure succes-

⁵³ Adapted from field trip presentation, 'Farming God's Way', Brian Oldrieve, May 2006 at 'River of Life', Harare, Zimbabwe.

sion planning is discussed to minimize disruption and uncertainty for the children when they finally lose their primary care-giver. Forward-plan in all activities and encounters with affected communities and be prepared for the eventuality of many circumstances so that the negative impact can be lessened.

Keep to the agreed deadlines, especially with reporting and accounting, of the resource providers who themselves have to account to their contributors.

2. Do It to a High Standard

Standards relate to the *way* something is done, not to the tools with which it is done. In all our work, we must aim for the highest possible standard “doing everything as unto the Lord”. It is our mandate and the people we serve deserve no less than the best that can be offered, whatever the resource setting. We must aim to be centres of excellence. To this end, it is important that all the implementers are properly trained, understand and know exactly how to perform their desired role. There should be no short-cuts – for example: a one-day counselling training does not make for an adequately trained counsellor.

It is incumbent upon us, if we say we are offering a service, that we become knowledgeable on what that service should represent and we aim for that standard. Though we may be operating in resource constrained settings, it is no excuse for not aiming for the best, advocating for the best, whilst at the same time giving of the best possible within the constraints of the environment in which one is operating or with the resources that are currently available.

3. Do It with no Wastage

Create the environment in which the message will be best received. Maximize the effective use of all resources that are already available and do not allow perceived deficiencies to be a deterrent to action. Too easily expensive technology and massive consumer resources become the pre-requisite to intervention. For example: do we have to have our workshops in hotels when we own church facilities? Lack of availability of anti-retroviral drugs has created a paralysis of action in many circles. Yet there are so many other preconditions to antiretroviral rollout that can be worked on in the interim such as: setting up counselling centres, treatment for opportunistic infections and education on treatment literacy. Doing the job without wastage also applies to our accountability of the resources available and allocated to us. Finally, we must hold governments and other implementers to account for the resources allocated to them to fulfill the responsibilities for which they are in office. Corruption and looting of resources are not acceptable and should be exposed wherever they are identified. This also applies to churches.

4. Do It with Joy, Passion and Thanksgiving

“Those that wait upon the Lord shall renew their strength.” Isaiah 40:31

“The joy of the Lord is your strength.” Nehemiah 8:10

As Christians, we are called to be Christ to each other. This implies loving our neighbour as ourselves and reaching out with selflessness and with compassion and love. This is not an option, though serving others can sometimes be a thankless task and working in the area of HIV can be enormously draining. At times, it can bring one to the brink of despair in the face of the enormity of the task, the extent of the suffering and the apparent low impact on halting the progression of HIV. The bottom line is to attempt seriously to respond to the needs of the community and to aim to see Christ in each person and to give each individual their due respect and dignity. It is about faces not just statistics. The quality and decency of our response will also reflect the high standards that are demanded of us as disciples of Jesus. A job well done, with sound planning, in response to identified needs, and in a professional and timely manner, is rewarding and a source of ongoing motivation and a source of inner joy. Doing a job joyfully is also a choice; it is an attitude which can have an enormous bearing on the quality of our work, and the inspiration to others to be there for the long haul. Thanksgiving is an inclusive process of gratefully acknowledging experiences encountered, both positive and negative. It also represents a way of giving something back. People who live with HIV do not wish to be mere recipients of other's assistance; they too want to feel a sense of contribution. This can be in the form of helping improve the lives of others similarly affected as well as helping to break the silence in order to protect others. An attitude of thankfulness can bring healing in itself, by changing perceptions that are focused on the negative to appreciating the positive.

“Pray without ceasing; give thanks in all circumstances.” Thess. 5:17-18

Prayers of thanksgiving can be and are deeply transformative.

3. SOCIAL RELEVANCE

The third component of outer competence is to ensure social relevance, inclusivity and to seek to build social cohesion.

Individual behaviour is profoundly influenced by broader contextual factors which include social norms, social cohesion, social equality, service accessibility and public policy. It is these many factors which must be acknowledged if the messages of HIV prevention, and

the mitigation of the impact of HIV and AIDS, are to be relevant in the context in which the majority find themselves.

Too often the debate concerning HIV transmission has stalemated on issues of morality, with great emphasis on the individual's sin. Yet there should be an even louder voice exposing and challenging the structural sins of society. "The admirable interventions so far made by faith-based communities are tremendous but it would seem morally irresponsible to advocate for higher quality care alone while neglecting to eradicate the dysfunctional root system that supports the spread of this deadly virus."⁵⁴ Structural sins are those social evils which constrain the choices that individuals are able to make and which render them so vulnerable to this epidemic. For example: there is much attention and blame for HIV transmission apportioned to the woman prostitute. Her 'sin' is widely condemned. Yet there is scant attention given to the structural sins of society which have left this woman poorly educated, discriminated against, stripped of assets and left with little else beyond her body to sell in order to feed and care for her children and herself. There are also injustices at the international level reflected in the levels of resource distribution and access. Over two decades into the epidemic and still less than 1 in 5 persons has access to basic HIV prevention services.

In our response, church members sometimes reflect a desire to do the least rather than the most to change situations of injustice. We are more comfortable giving handouts to the poor than addressing the systems and structures that keep the poor in their misery. We have failed to understand the mission of Jesus:

- "To bring sight to the blind", not just a guiding hand;
- "To bring freedom to the oppressed", *not just words of comfort and encouragement.*⁵⁵

HIV is an issue of justice and as such demands a response that is more than just charity. The Hebrew language does not have a word for charity: it is usually translated as 'tsedakah' which means righteousness or justice. This difference – the difference between charity and justice – is significant. Charity comes from the Latin, and means 'from the heart'. By contrast, 'tsedakah' is a right – and its implementation is our obligation. The Torah exhorts with extraordinary passion: "Tsedek, Tsedek Tirdof: Justice, Justice, you shall pursue" (Deut. 16:20). The most vulnerable of society, particularly widows and orphans are, in the Bible, frequently singled out for exceptional care and support.⁵⁶

⁵⁴ Fr Robert Igo: *Searching for God in the Context of HIV/AIDS*. Religious Life Review, Jan. 2005.

⁵⁵ *Churches in Manicaland: "The Truth Will Make You Free". A Compendium of Christian Social Teaching*, Sept. 2006.

⁵⁶ Lucy Steinitz: *Charity as Justice*. Presentation made at WCC Interfaith Consultation on HIV/AIDS. Nairobi, May 2003.

As HIV has been recognized as an issue of justice, it has now also become a human rights issue: right to knowledge, right to access to prevention strategies, right to confidentiality, right to access to treatment, care and support; right to equal opportunities in education, employment and advancement; a right to shelter; a right to social standing and all the associated benefits and opportunities accorded to HIV negative persons. Activists have championed this right and this activism has, in many countries, led to changes in government policy towards HIV issues. It has opened the space for organizations to operate more freely and to the provision of anti-retroviral treatment. Militant activism, at the same time, has induced an associated negative response from amongst many people because the heavy emphasis on the rights of the HIV positive person has at times seemed to ignore the rights of the HIV negative person too. The demand for the right to confidentiality has seemed to somehow cloud the responsibilities to also protect the HIV negative partner. HIV must be viewed through the lens of human rights but that alone is not enough. Rights need to be balanced with responsibilities, responsibilities of each to the other, for we are not islands and when one member of the body suffers, the whole body suffers.

Human rights need to be coupled to *shared rights* and *responsibilities*. In increasing numbers of countries, an HIV positive person now has many rights under law, providing them with the right to confidentiality, protection from discrimination and unfair practices in the workplace and the right to health-care and treatment. At the same time, an HIV positive person has both a duty and a responsibility to protect their non-infected partner from unprotected exposure to the virus and to inform decision-taking within relationships, where HIV has implications for them. Both human rights and responsibilities need to be acknowledged, promoted, and respected – for the good of all.

Orphans and vulnerable children represent one of the greatest challenges of the HIV epidemic. The sheer numbers of children affected are unprecedented in history and will continue to rise until a universally accessible cure for HIV is found. The complexity of their needs and the long term commitment required means that orphans and vulnerable children cannot be tagged onto some other programme such as ‘care’ or ‘counselling and psychosocial support’. Furthermore, the age range of children affected means that no one solution fits all. We cannot ignore these statistics, realizing they represent children – the vulnerable of society. There is no doubt that in human development and financial terms, the cost of care now will be less than the price society will ultimately pay for the neglect of these children left to a life on the streets, in the bush or in institutions.⁵⁷ They need their own stand-alone programme, which is fully comprehensive.

57 Sue Parry: ‘Farm Orphans: Who is Coping?’ Farm Orphan Support Trust 1997/98.

The ties that unite people – their organizations, institutions, key individuals, events, customs, and rituals – define them as a community, and the quality and strength of these ties determines the cohesiveness of the community.⁵⁸ Where there is social disintegration, there is a greater risk of HIV infection and thus greater prevalence of the virus. Social dislocation is common in our societies today, whether due to physical dislocation due to migration and displacement, or to psychological alienation from stigma, discrimination and rejection or to a host of other causes. Our churches can be centres where people can find an identity, a shared vision, shared challenges and be part of a caring, accepting community. The church can of itself rebuild lost social cohesion and play a vital role in reducing isolation and thus behavioural patterns which will increase the risk to HIV infection. Social cohesion, with social justice, respect, care, equality, solidarity and support, is a positive force against the negative tide of HIV challenges.

The spread of HIV is fuelled by many irregularities. Any response that is developed to mitigate HIV and its impact needs to be relevant, to recognize the many factors driving and fuelling the epidemic and the host of human rights issues that are abrogated or seriously challenged by the epidemic. As Christians however, we need to be aware of even more, if we are truly seeking to afford dignity, love and hope to each and every person.

Our choice of response(s) thus needs to pass through ‘the sieve’ of not just human rights, but of *shared* human rights and *shared* responsibilities, in the context of all the factors which are fuelling the spread of HIV.

For UNAIDS, the three pillars of a comprehensive and effective AIDS responses, as we move towards universal access, are HIV prevention, treatment and care and support.⁵⁹

Competently and compassionately, it is possible to focus on any one, or many, of these various areas of need: prevention, care, treatment, support, impact mitigation, advocacy, orphans and vulnerable children and/or research. Depending on the context, each of these responses has as much importance as the other and collectively makes for a truly comprehensive response.

Sharing best practices and learning from others helps to confirm the validity of our responses or provides the evidence to instigate changes in our activities and thus formulate more effective responses. This is the ultimate aim of all responses to HIV: effectively and sustainably to make a difference. For churches, however, there is an added dimension to

58 Decosas Josef: *The Social Ecology of AIDS in Africa. Draft paper for UNRISD Project HIV/AIDS and Development, March 2002.*

59 UNAIDS response to Potts et al, 2008, ‘Reassessing HIV prevention’ in *Science*.

all we do and seek to do. The ultimate aim of all our efforts is the restoration of hope and dignity to all who are infected and all who are affected by HIV.

Jesus declared that he was the fulfillment of the prophecy of Isaiah:

“The spirit of the Lord has been given to me,

For He has anointed me.

He has sent me to bring the good news to the poor,

To proclaim liberty to captives

And to the blind new sight,

To set the downtrodden free,

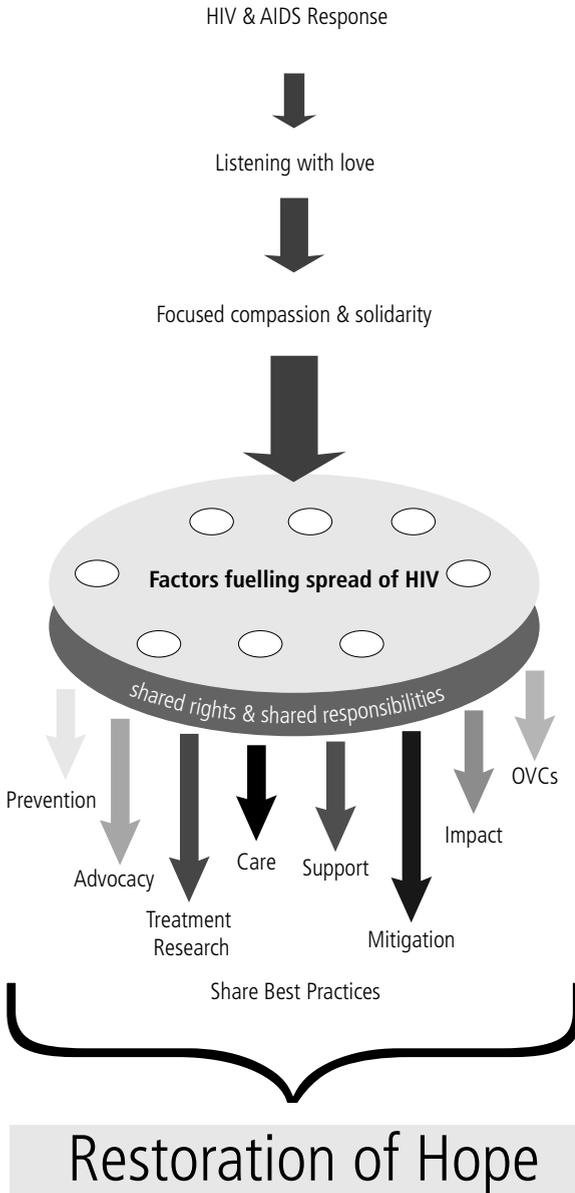
To proclaim the Lord’s year of favour.”

He also declared that God will judge us at the end on the criteria of social involvement (Matthew 25:31-46). As church, we do not stress enough this social dimension of the gospel.

“Whatever you do to the least of these my brothers, you do it unto me.” Matthew 25:40

COMPREHENSIVE RESPONSE

From a faith perspective



4. INCLUSIVENESS

Another key aspect of outer competence is the degree to which the church is inclusive.

What characterized the life of Jesus was his overwhelming capacity for compassion – no one was ever outside the realms of his compassion, no matter what their station in life or circumstance. He was inclusive in his relationships and his dealings with people. His compassion reached out, stood in solidarity, went the extra mile, stood up to the authority of the day, went against popular sentiments, rules and regulations, saw beyond the obvious and it was not without personal cost.

Our programmes too, need to be inclusive, non-judgmental and marked by compassion. Socially dislocated people, people isolated from families, familiar communities and usual regular support systems are possibly more vulnerable to resorting to a behaviour pattern that makes them more at risk to HIV. Churches can play an unrecognized preventative role by being a home, an anchor, a place where there is a reinforcement of positive value systems and loving, compassionate peer support. This is an area where churches are beacons of hope, providing a social network and a sense of inclusion. The church needs to be a safe space too, especially for those infected and affected by HIV and AIDS.

HIV is no respecter of persons and its impact is as devastating for the leader as it is for the servant. The difference lies in society's response of acceptance or rejection; solidarity or stigmatization and discrimination; equal access to services, care and treatment or qualified availability of resources to the well-connected and financially stable, with the exclusion of others.

People living with HIV need to be involved in all stages of our planning process. We need to acknowledge their capacities and aspirations and not just their vulnerabilities and fears. They have the greatest experience of the virus and knowledge of its impact on the individual and family. They can frequently best identify what increases stigma and what brings solace. Token inclusiveness of them in programmes is an insult.

Hearing the shared experience of a person living with HIV can have a transforming effect on pre-conceived attitudes and prejudices and can be a motivating force for change. It brings the situation of HIV from the theoretical into the practical reality.

Open and meaningful involvement of people living with HIV in programmes can also encourage others in similar situations, or suspecting that they might be, to break their silence and seek out testing, support and care. It can thus, in itself, be part of a prevention strategy.

“At every level, from community to national to international, the benefits of a greater involvement of people living with HIV have been shown. Stigma and discrimination towards people living with HIV has been reduced by their visibility and involvement in local, national and international organizations. Their participation in policy, programme design and implementation has been instrumental in reorienting priorities, ensuring relevance and effectiveness, and increasing accountability. As advocates for intensified prevention efforts, people living with HIV have been successful in bringing a human face and voice to the epidemic, challenging complacency and denial, strengthening the call for urgency in the response, and moving governments and their leaders to action.”⁶⁰

In association with GNP+, ANERELA+ and UNAIDS, the World Council of Churches has developed a ‘Framework for Engagement’ – for greater participation of all living with HIV in the life of the church. This includes a series of three documents which give a comprehensive overview of the situation and guidelines on the way forward, based on positive experiences worldwide.⁶¹

5. NETWORKING: SEEKING ALLIES AND COLLABORATION FOR INCREASED SCALE AND SUSTAINABILITY

Faith communities are not islands. If we are not personally infected, we certainly are affected by HIV. “If one part of the body suffers, we all suffer” 1 Cor.12:26. Greater collaboration is needed to maximize efforts, coverage and quality of service delivery and better utilization of resources, both human and financial. Networking implies collaboration with other key players in the response to HIV and AIDS. HIV is non-partisan in its impact. The need for increased coordination and collaboration has never been greater.

Networking can extend to partnerships of key social groups, government service providers, non-governmental organizations, activist groups, community-based groups and other religious organizations which should constitute a strong basis for successful strategies addressing HIV at the community level. Sharing of experiences, what works and what does not, exposure of gaps and challenges, is all essential, relevant and can help to formulate responses that are more strategic and thus more likely to have a better impact.

⁶⁰ UNAIDS: *Resource Guide for UN Theme Groups on HIV/AIDS*, March 2005.

⁶¹ The Framework for Engagement – for greater participation of living with HIV in the life of the church, <http://wcc-coe.org/wcc/what/mission/hiv-aids-e.html>

To facilitate a coordinated and comprehensive response, churches can better link their strong health infrastructure and services to non-health sector interventions effective against HIV, including primary and secondary education and income generation.

Churches can also lead by example. They have existing networks of quality schools. By expanding educational opportunities for girls, churches confront underlying gender inequality within communities and institutional structures and help promote successful strategies to reduce vulnerability of women and girls.⁶²

Some church leaders are cautious about entering into networks with other agencies which advocate HIV prevention techniques which may be considered to be contrary to the church's moral teaching. It should be possible to identify different ethical approaches and explore ways of complementing rather than confronting. There are plenty of success stories.⁶³

Churches can collaborate with organizations that provide technical support and thus better document and evaluate their work. This will enhance credibility and lessons learned and enable scaling up of successful strategies.

All collaboration and partnerships, particularly between the government sector, multi-lateral and bilateral agencies/donors and implementing agencies (civil society, NGOs and FBOs) require mutual respect and balance. Other, often more hidden, factors that limit networking involve issues such as problems with power sharing, guilt at having HIV as a reality within the church, and competition for funding from the same donors.

6. ADVOCACY

The church needs to reclaim its prophetic voice. To advocate is to "plead for another, to support, to recommend on behalf of another".⁶⁴ In the book *The truth will make you free. A compendium of Christian Social Teaching by the Churches in Manicaland, Zimbabwe 2006*, it is stated that: "The church that understands its role in society is a prophetic church. That is, a church that understands its social context and discerns its historical role. A prophetic church is one that teaches the value of human solidarity – the value that says that human beings must never lose sight of the humanity of others. A church, which teaches solidarity, should be able to teach social humility. A prophetic church is one which teaches and offers hope to the nation and to the world. To hope is to believe that human

⁶² *Faith in Action: Examining the role of faith-based organisations in addressing HIV/AIDS. CMMB and Global Health Council.*

⁶³ S. Parry: *Responses of the Faith-based Organisations to HIV/AIDS in Sub-Saharan Africa*, Nov. 2003.

⁶⁴ *Oxford Dictionary.*

beings can make a difference in their own lives. We have the capacity to do what is right and to bring good news to the world.”

Advocacy has been too muted given the scale of the problem and the injustices that exist. The church needs to be the voice for the voiceless and to hold governments accountable to their constitutions and the conventions to which they are signatories. There is a need to advocate for increased and meaningful political commitment and capacity. Advocacy is needed against discriminating laws, policies and practices, particularly those against marginalized groups of people. Orphans have a right to identification documents and a right to protection, education, shelter, food, health care and psychosocial support. Their property rights need safeguarding. Advocacy is particularly needed against those determinants that are driving the epidemic such as: gender disparities, sexual abuse, domestic and gender-based violence and negative cultural practices.

Church leaders also need to be held responsible for their commitments. Being signatory to statements and documents of commitment without follow-up action is totally wrong. If we do not keep our own house in order, few listen to us when we challenge them for their deficiencies.

Advocacy is a strategy as well as an activity, and not an end in itself, and needs to be rooted in what we believe.

Examples of issues requiring advocacy as suggested by the Executive Director of UNAIDS, Peter Piot, in 2007:

- Advocate for universal access. Pressure to set and achieve ambitious targets for prevention, treatment and care.
- Advocate for participation in HIV planning and governance structures. Participate in country annual and mid-term reviews.
- Speak out about HIV: confront stigma, denial and discrimination. Provide frank and open discussions about the sensitive/hidden issues that drive new infection and what must be done.
- Provide correct and consistent information: how and where to access services; how HIV is transmitted; how to prevent infections (evidence and value informed information).
- Mobilize/engage communities to prevent new HIV infections through: correct and consistent information and messaging; facilitate community conversations about responsible sexual behaviour; ensure access to sexual and reproductive health services.

A good example of an ecumenical organization that has taken up advocacy as its mandate, on a global level, is the Ecumenical Advocacy Alliance (EAA). It is made up of a wide range of churches and church-related organizations that seek to “speak with one voice against injustice, to confront structures of power, practice and attitudes which deprive human beings of dignity and to offer alternative visions based on the gospel.” It has developed numerous resources to assist churches and church leadership on issues of stigma, discussions on sexuality, prevention, treatment access and tools for advocacy, amongst many others.⁶⁵

Churches can use their power and influence to promote justice and social good. The constituencies of churches and indeed of faith-based organizations in general, offer an important vehicle for heightening attention among policy makers to issues that contribute to HIV impact, vulnerability and risk.⁶⁶

7. COMPASSION AND THE RESTORATION OF DIGNITY AND HOPE

Though we may achieve theological competence, technical competence, be socially relevant, inclusive in our approach and do everything to a high standard, we would still be missing an essential ingredient to a truly effective life-changing response. We need to be compassionate in what we do and to accompany, in solidarity, those amongst us who suffer from the effects of HIV. Compassion means “unlearning that hardness of heart which sits in judgment on other people, shedding the armour that holds others at bay, learning vulnerability to another’s pain and confusion, hearing their cry for help.”⁶⁷ Solidarity is a moral and social principle, a Christian virtue, and the soul of the social order. “Solidarity is not a feeling of *unfocused compassion* or just distress at the misfortunes of others. No, it is a firm determination to commit oneself to the common good; that is to say, to the good of all and of each individual, because we are really responsible for all.”⁶⁸

“Focussed compassion” is to commit ourselves to providing a more loving response to the reality of HIV, by doing our part to make sure that those amongst us with the disease, or who are affected by it, are served in the best way and by speaking the truth about all that concerns HIV. Those of us with HIV must not feel alone and abandoned. Much less should they be victims of stigma, discrimination and injustice. People living with or affected by HIV must enjoy the same respect and rights as others, and can rightly expect

⁶⁵ Ecumenical Advocacy Alliance Web site: www.e-alliance.ch

⁶⁶ *Faith in Action: Examining the role of faith-based organisations in addressing HIV/AIDS*. CMMB and Global Health Council.

⁶⁷ Fr Timothy Ratcliff: *To Praise, to Bless, to Preach*.

⁶⁸ Pope John Paul II.

the concern of their fellow believers. We, their brothers and sisters in the Lord, must walk in solidarity with them.”⁶⁹

Compassion is a gift from God, one of the most powerful of all God’s gifts to us.⁷⁰

One of the first casualties to accompany a positive diagnosis of HIV is hope. What we seek to do in our response, more than just bringing care, support, treatment and advocacy, is the restoration of that hope.

“Our task is to proclaim the hope of the gospel more frequently and preach to the limit of our vision even though we do not fully embody that vision. Jesus did not, after all, announce bad news. He announced good news. He was a prophet of hope. He was not a moralist who threatened punishment and created feelings of guilt. Rather he is the spiritual master who gives back hope to all who are burdened with sorrow and feelings of guilt.”⁷¹

“Love bears all things, believes all things, hopes all things, endures all things. Love never fails.” 1 Corinthians 13:7-8.

“And now I give you another commandment: love one another. As I have loved you, so you must love one another. If you have love one for another, then everyone will know that you are my disciples.” Jesus: John 13:34-35.

“What does Love look like?

It has hands to help others

It has feet to hasten to the poor and needy

It has eyes to see misery and want

It has ears to hear the sighs and sorrows of others

That’s what Love looks like.”

St Augustine, 354 A.D.

As a Benedictine monk said in his treatise on ‘The Meaning of Suffering’: “Medicines may give people a means to live, but faith gives people a reason to live.”⁷²

⁶⁹ Rev E. Adams, Apostolic Nuncio of Zimbabwe, speaking at the closing session on ‘Forward in Hope’, conference for Religious Superiors, Zimbabwe 2005.

⁷⁰ Nolan Albert: *Jesus Today. A Spirituality of Radical Freedom*, Orbis 2007.

⁷¹ Fr Damien Byrne OP.

⁷² Fr Robert Igo OSB: *The Meaning of Suffering*, 2004.

CONCLUSION: CHURCHES AS BEACONS OF HOPE

Churches have a unique role to play in responding to HIV and AIDS. No other organization or government has the reach into society, the continued presence nor the higher mandate to respond like the church. HIV is unlike any other challenge faced by the church because it strikes at the very core of relationships and its impact is chronically deadly. Responding appropriately, effectively, compassionately and to scale, requires so much more than was previously acknowledged. It challenges us as church to face reality as well as possibility. We need to look inwards, to look beyond the barriers, to dig deep to find the heart of the problem within ourselves, our churches, our communities and society as a whole, as well as to find the heart of the solution. It requires an active search for appropriate information, knowledge and understanding as well as an open engagement with those affected and with those involved in seeking to respond – whether from our own denominations or across the secular and denominational divide. At the same time, HIV provides the church with an unparalleled opportunity to reach out in solidarity, in practical care and support, in advocacy and in love and compassion.

This book has sought to show the process of developing both inner and outer competence and the bridge between the two. Inner competence is ‘bringing it home’ where the magnitude and reality of HIV is first owned. Outer competence is ‘taking it out’ in response. Both need to be firmly rooted in communities and in their social realities.

‘AIDS is to be combated by realistically facing its deeper causes and the sick are to be given the loving care they need. Social issues and the Gospel are inseparable. When we bring people only knowledge, ability, technical competence and tools, we bring them too little.’⁷³

Ultimately the response of the HIV competent church to the pandemic should be characterized, both in the life of the church and in the lives of those who serve in this field, by the fruits of the Spirit: love, joy, peace, patience, kindness, goodness, gentleness, faithfulness and self-control.

Churches can and should be agents of social cohesion, a vital and little recognized aspect in the fight for competence. HIV continues to devastate communities and it is at the community level that the outcome of the battle against HIV will be decided. Church communities can provide the sense of welcome and inclusiveness and values that so many

⁷³ Pope Benedict XVI homily at the Neue Messe Munich, Sunday, 10 September, 2006.
http://www.vatican.va/holy_father/benedict_xvi/homilies/2006/documents/hf_ben_xvi_hom_20060910_neue_messe_munich_ea.html.

people lack in their lives. By being safe places for all who are affected by HIV and its impact, there is opportunity for healing, reconciliation and the restoration of hope.

Jesus' life was characterized by seeing the individual, he heard what was not spoken and he responded not only to the expressed needs but to the deeper needs. He reached into the heart of the matter. Where this conflicted with the established teachings of the day, he stood firm and did not compromise, even when it put him at personal risk. At all times he demonstrated and reflected the overwhelming love and compassion of the Father.

He calls us to the same: if we, as the faith communities, do not respond effectively and competently to the challenge, drawing on all our extensive resources, experience and historical tradition of care and compassion, then we will surely have failed in our calling.

"When did we ever see you sick and visit you? When did we ever see you a stranger and welcome you into our homes?" Matthew 25:38-39.

Jesus stated: "I am the light of the world. He who follows me shall never walk in darkness." As his followers, we too are called to be lights in the world.

Reflecting on the challenges that HIV presents to the church today, the imagery of the lighthouse becomes relevant. For lighthouses are usually built in solitary strategic places, on rock, jutting out into the sea. Their function is to stand as secure reference points during the day and at night, to send out beams of repetitive sweeping light, illuminating dangers for vessels at sea and in coastal waters. They stand as beacons of hope to any in distress, and their very presence and function is to provide a means to expose dangers and to offer a light to help the seafarer avoid dangers.

The church too stands, and can stand, as *a living beacon of hope* in the era of HIV. In the context of this book, the lighthouse itself represents the structure of the church, the inner competence we seek. The lens that magnifies the light is the knowledge, leadership and resources. The sweeping beam represents the responses of the church, her outer competence and ultimately the love, compassion and hope we are called to give.

May we each, in our own way and in our own responses, be beacons of hope in a world full of darkness, fears, uncertainty and seemingly without direction.

"Therefore my beloved brethren, be ye steadfast, unmovable, always abounding in the work of the Lord, forasmuch as ye know that your labour is not in vain in the Lord." 1 Corinthians 15:58.

"May our Lord Jesus Christ Himself and God our Father, who loved us and by His grace gave us eternal encouragement and good hope, encourage your hearts and strengthen you in every good deed and word." 2 Thess. 2:16.

REFERENCES

- African Development Forum 2000: *AIDS: the Greatest Leadership Challenge: 'Scaling up the response to HIV/AIDS' Theme III.*
- African Religious Health Assets Program for the World Health Organisation: *Appreciating Assets: Mapping, Understanding, Translating and Engaging Religious Health Asset in Zambia and Lesotho 2006.*
- Byamugisha, G. & Williams G., *Positive Voices*, Strategies For Hope Series, Called To Care No.1, 2005.
- Cassidy, Sheila, *Sharing the Darkness*, DLT, 1988.
- Churches in Manicaland: "The Truth Will Make You Free." *A Compendium of Christian Social Teaching*, Sept. 2006.
- Clement Chan Kam, Gail Goodridge, Rob Moodie, *Strategic Planning, Program Design and Management: HIV/AIDS Prevention and Care in Resource-Constrained Settings*, FHI, 2002.
- Dube, Musa, *HIV/AIDS and the Curriculum, Methods of Integrating HIV/AIDS in Theological Programmes*, WCC Publications, Geneva, 2003.
- Dube, Musa & Kanyoro, Musimbi, eds, *Grant Me Justice: HIV/AIDS & Gender Readings of the Bible*, Cluster Publications, 2004.
- FHI/USAID: *Evaluating Program Effectiveness*, FHI HIV/AIDS Prevention and Care (IMPACT) Project.
- FHI/USAID: *HIV/AIDS Prevention and Care in Resource Constrained Settings*, 2004.
- FHI: HIV/AIDS Prevention and Care (IMPACT) project: 'Evaluating Program Effectiveness'.
- Gov. of Lesotho and the Expanded Theme Group partnership on HIV/AIDS: *Turning a Crisis into an Opportunity: Strategies for scaling up the National Response to the HIV/AIDS Pandemic in Lesotho*, Lesotho, 2004.
- Hunter, Susan, *Who Cares? AIDS in Africa*, 2003.
- Igo, Fr Robert, *Searching for God in the Context of HIV/AIDS*. Religious Life Review, Jan. 2005.
- Igo, Fr Robert OSB, *The Meaning of Suffering*, 2004.
- Kari, Egge, M&E Officer for CRS/Ethiopia, 'Feedback on Impact Indicators', Aug. 5, 1997.

- Lewis, Chris, 'Evidence-based Decision Making', developed in partnership with NCDVRS used as a job aid for RSA SRC Training Initiative 2004.
- Onipede, I. & Dorloech-Sulser, S., *Responding to HIV/AIDS – A Practitioner's Guide to Mainstreaming in Rural Development Projects*, Aachen, Germany: Misereor, 2005.
- L'Osservatore Romano: No.37, English Edition, 13 September 2006, p.7.
- Parry, Dr Sue, *Responses of the Faith-based Organisations to HIV/AIDS in Sub-Saharan Africa*, WCC, Nov. 2003.
- Phiri, Isabel & Haddad, B., eds, *African Women, HIV/AIDS and Faith Communities*, Cluster Publications, 2003.
- Rakoczy, Susan, *In Her Name: Women Doing Theology*, Cluster Publications, 2004.
- Rohr, Richard, *Job and the Mystery of Suffering*, Crossroads Publishing, 2001.
- Slattery, H. msc, *HIV/AIDS – A Call to Action: Responding as Christians*, Nairobi: Pauline Publications, 2002.
- Smith, Ann & McDonagh, Enda, *The Reality of HIV/AIDS*, Trocare/Veritas/Cafod, 2003.
- Steinitz, L.Y., *Making It Happen, A Guide to help your congregation do HIV/AIDS work*, Strategies for Hope series 'Called To Care' No.2, 2005.
- Steinitz, Lucy, Charity as Justice. Presentation made at WCC Interfaith Consultation on HIV/AIDS: Nairobi, May 2003.
- UK NGO AIDS Consortium: *Effective HIV/AIDS Activities: NGO work in developing countries. Report of collaborative study.*
- UNAIDS: *Report on the Global HIV/AIDS Epidemic*, 2002, Geneva, Switzerland.
- UNAIDS: *Report on the Global epidemic*, 2004.
- UNAIDS: Technical Note No.1: Local responses to HIV/AIDS. *A Strategic Approach Towards an AIDS-competent society.*
- UNAIDS: *Resource Guide for UN Theme Groups on HIV/AIDS*, March 2005.
- UNAIDS: *Report on the Global AIDS epidemic*, 2006.
- UNDP: *Conceptual Shifts for Sound Planning: Towards an Integrated Approach to HIV/AIDS and Poverty*, 2002.
- UNGASS on HIV/AIDS: 2003.

- Weinreich, Sonja & Benn, Christoph, *AIDS: Meeting the Challenge*, Geneva: WCC, 2004.
- West, Christopher, *Theology of the Body for Beginners*, Ascension Press, 2004.
- Williams G. & A., eds, *Journeys of Faith*, TALC 2002.
- World AIDS Campaign: *Leadership: The World AIDS Day Theme 2007 and 2008*.
- World Council of Churches: *Plan of Action: The Ecumenical Response to HIV/AIDS in Africa*, November 2001.
- WCC: *An HIV and AIDS Curriculum for Theological Institutions in Africa*, Geneva, Switzerland: WCC Publications.
- WCC Study Document: *Facing AIDS The Challenge, the Churches' Response*, Geneva 1997.
- 'Essential Principles' adapted from field trip presentation of Brian Oldrieve in May 2006 at 'River of Life', *Farming God's Way*, Harare, Zimbabwe.

WEB-SITES

Joint United Nations Programme on HIV & AIDS (UNAIDS): www.unaids.org

Declarations and policy statements on HIV/AIDS by churches and faith-based organizations from 2001 to 2005, (a compilation found in the WCC web-site): <http://wcc-coe.org/wcc/what/mission/hiv-aids-statements01-05.html>

The Framework for engagement – for greater participation of living with HIV in the life of the church – series of three documents, which consists of:

1. Towards a Policy on HIV/AIDS in the Workplace – Working Document:
<http://wcc-coe.org/wcc/what/mission/hiv-aids-workplace-e.html>
2. Guidelines on Partnerships between Churches and People Living with HIV/AIDS Organizations
3. Working with People Living with HIV/AIDS Organizations:
<http://wcc-coe.org/wcc/what/mission/hiv-aids-e.html>

Renewing Our Voice: Code of Good Practice for NGOs Responding to HIV/AIDS:
<http://www.ifrc.org/what/health/hivaids/code/>

The World Health Organization: www.who.int

The World Council of Churches: www.wcc-coe.org

World AIDS Statistics: <http://167.160.195.60/html/aidsstatworld.html>

HIV/AIDS policy formulation, advocacy, strategic planning, capacity development, networking, gender equality, human rights and community mobilization: the POLICY Project: <http://www.policyproject.com>

Example of Vision statement and strategic plan on HIV/AIDS: the Anglican Church:
<http://www.anglicancommunion.org/special/hivaids/index.htm>

Examples of Advocacy websites:

Ecumenical Advocacy Alliance: <http://www.e-alliance.ch>

Christian Aid's Stop AIDS Campaign: <http://www.christian-aid.org.uk/>

Examples of church's response to numerous HIV issues: Southern African Catholic Bishops' Conference: <http://www.sacbc.org.za>

ANNEX 1 AIDS COMPETENT CHURCH

(Definition developed by WCC team, working on HIV and AIDS Competence, at Bossey, Switzerland, July 2007)

A church that recognizes and accepts the imperatives of HIV to itself and communities; has the knowledge, willingness and experience to respond in an inclusive, effective and prophetic manner that reflects the fruits of a spirit-filled congregation. The response of the AIDS competent church to the pandemic is characterized by love, joy, peace, patience, kindness, goodness, gentleness, faithfulness and self-control. (Galatians 5:22-23).

Unconditional **Love**, as shown by the knowledgeable, compassionate and motivated Columban Sisters in the back alleys of Hong Kong as they literally accompany and serve sex workers, with deep respect for them, in a non-judgmental manner for the last 18 years. The sisters' work strives to help retain or regain dignity, liberation and welfare in the context of disease, poverty and exploitation; by providing protection against HIV, nutritional, psychological and family support; with assistance to keep in touch with families and communities of origin and with the possibility of career change and transformation.

Joy as seen in the Positive Women's Network of the Methodist Church in Dzivarasekwa, Zimbabwe, with 81 members. In spite of the suffering that the community experiences, they celebrate life and resilience, mutually supporting and encouraging, discerning the positive aspects of their life and mobilizing support from the wider community and contributing to it. Their attitude and approach to life overcomes self-stigma and the stigma and discrimination emanating from the society at large.

Peace as reflected by 'Justa Paz' a community-based organization in Maputo, Mozambique, which began by assisting to bring about peace and reconciliation in the nation during the liberation struggles and civil war (which stretched out for three decades). Now they work with the community in dealing with HIV as a source for conflict in and between individuals, families and communities, striving for solutions to deal with the disease as a source for ongoing peace, reconciliation and justice.

Kindness shown by the Salvation Army which works in Narva, Estonia, with intravenous drug users and people living with HIV since 1995. The care and prevention team, through their dedicated home visits, their thoughtful and consistent support, ensures the provision of holistic service that goes the extra mile, beyond the immediate needs of the people they serve, positively affecting the drug users, many of whom respond to the kindness by generating courage, action and hope.

Goodness as seen in the Pan African Institute for Public Health (IPASC), an ecumenical Christian institute in Eastern Democratic Republic of Congo, which has incorporated HIV in all their training programmes. It provides voluntary counselling and testing and treatment support for its students and the population they serve. The teachers, management and students have transparent, trustworthy and dependable systems which support, sustain, accompany and empower those students and members of the community who are HIV+ in a resource-poor and conflict-ridden environment.

Gentleness radiated by the “Shoulder to cry on”, a nationwide community-based programme in Swaziland, run by church women. The innovative movement is building up a wide peer support groups which provides members of the community with safe and supportive spaces for discussing issues related to sexuality and gives support and solutions support in cases of abuse and violence. The initiative works in an inter-disciplinary manner, to ensure that the most vulnerable members of the society receive a high quality of care in an environment of respect and dignity.

Faithfulness as embodied by St Theresa’s hospital in Zimbabwe where the community affected by HIV receives comprehensive support to face the pandemic. Be it receiving truthful forthright and scientific information regarding HIV; confidential and compassionate counselling and testing services; support and advice for balanced nutrition and anti-retroviral therapy and treatment for opportunistic infection. Mobilizing support to the community with a long term perspective, respecting and valuing the individual relationships and expecting mutual responsibility.

Self-control as promoted by the Marriage Enrichment Programme of the Anglican Community. The group training process for married couples strengthening mutual respect and responsibility, embodying values of relishing one’s relationship in the context of marriage and encouraging discipline in one’s sexual life.

ANNEX 2 KEY CHALLENGES IN RESOURCE MOBILIZATION

A consultation “Global Assessment and Strategy Session on Faith Communities Accessing Resources to Respond to HIV and AIDS”, in Geneva, Switzerland in January took a critical look at obstacles and opportunities for faith-based organizations to access financial and human resources in order to better respond to the HIV pandemic and identified the following:

- Capacity
- Issues and policies related to donors and among FBOs
- Networking and interactions
- Access to Information

CAPACITY

- The lack of expertise, and of human and financial resources, to prepare proposals.
- The difficulty in finding, training, and retaining qualified staff.
- Lack of awareness and skill in planning, monitoring and evaluation.
- Lack of accountability and governance structures recognized by development partners.

DONOR AND FBO POLICY ISSUES

- That FBOs are often not sufficiently involved in national networks but work parallel to national networks/national strategies.
- FBOs often are less involved in advocacy/public relations to make their work visible.
- FBOs do not fully mainstream HIV and AIDS and include their response throughout their structure, services and ministries.
- FBOs are not sufficiently engaged in areas that reflect priorities for the partners, such as treatment and gender inequality.
- Many FBOs still struggle with speaking about HIV and AIDS and how to respond to and include those affected in their ministries and communities.

Among development partners, it was perceived that:

- There is a lack of understanding among partners and some governments on the full spectrum of FBOs' involvement, strengths and resources in HIV and AIDS response.
- The preference of development partners to fund governments may deny or limit FBOs' access to funds.
- The lack of coordination among development partners leads to multiple requirements that must be filled by recipients.
- Many development partners only administer large grants which are out of the range of many FBOs.
- Complicated and bureaucratic application processes create obstacles, sometimes preventing organizations from applying in the first place.

Both partners and FBOs also recognized that:

- There is a lack of clarity in what we mean by FBO, religious organizations, development partners. We need to examine our terminology and be clearer about the levels we are referring to.
- There is a lack of clarity about what the needs are – and how they are perceived – between FBOs and development partners, e.g. programme content indicators, partners' offices in countries.
- Shifting priorities and resources by development partners threaten sustainability, especially of treatment projects.

Networking and interactions among FBOs, and among FBOs, NGOs, networks and governments

- The consultation noted that many successful applications for funding are assisted because FBOs are part of larger networks and develop relationships with other NGOs, networks, government structures and development partners.
- There remain many cases of FBOs not forming or linking to other networks locally or nationally.
- Relations with national funding structures are sometimes extremely problematic.

Access to information

- Many FBOs reported that they lack information ranging from awareness of funding possibilities to addresses of development partners and submission procedures.
- Case studies highlighted repeated instances of no feedback, no response from partners, or feedback which was unhelpful and demonstrated misunderstandings from the proposal.

The consultation was organized by the World Council of Churches, Caritas Internationalis, Norwegian Church Aid (NCA), German Institute for Medical Mission (DIFAEM), and the Ecumenical Advocacy Alliance. The full report is available at:

http://www.e-alliance.ch/hiv_accessingresources.jsp

ANNEX 3 THE ECUMENICAL HIV/AIDS INITIATIVE IN AFRICA (EHAIA)

PLAN OF ACTION

In November 2001, church leaders of Africa, International and African ecumenical organizations developed a coordinated Plan of Action to respond to the AIDS epidemic in Africa, at a World Council of Churches (WCC) “Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa” in Nairobi, Kenya. The meeting was a follow-up to a series of consultations that had taken place throughout Africa during the preceding year. These consultations had involved African church leaders, ecumenical bodies, national councils of churches and related non-governmental organizations. In Nairobi, the results of those discussions were shared with international ecumenical partner agencies from Europe and North America and a joint plan of action was developed. The Vision statement captured the essence of what was to follow:

“With this Plan of Action, the ecumenical family envisions a transformed and life-giving church, embodying and thus proclaiming the abundant life to which we are called, and capable of meeting the many challenges presented by the epidemic. For the Churches, the most powerful contribution we can make to combating HIV transmission is the eradication of stigma and discrimination: a key that will, we believe, open the door for all those who dream of a viable and achievable way of living with HIV/AIDS and preventing the spread of the virus.”

The Plan of Action outlines a series of 13 commitments, which churches can own and undertake responsibility to implement. The Plan does not call for uniformity, as what works in one place may not work in another. What it does attempt to achieve is a new and realistic initiative which will make it possible for church leaders and their congregations to speak honestly about HIV and AIDS, and to act practically in response to it.⁷⁴

⁷⁴ World Council of Churches: *Plan of Action: The Ecumenical Response to HIV/AIDS in Africa*. November 2001.

ECUMENICAL HIV & AIDS INITIATIVE IN AFRICA PLAN OF ACTION



The last few pages of the document were added after the Nairobi consultation. They include a section ‘The Plan of Action and you’. It aims at giving readers a start towards ownership and implementation.⁷⁵

⁷⁵ World Council of Churches: <http://www.wcc-coe.org>

ANNEX 4 BENCH MARKS AND SELF ASSESSMENT TOOLS

It is important to develop self-assessment and peer evaluation methodologies in our institutions and churches so that we can chart our progress or lack of it.

As people of faith we have an obligation and a responsibility to work to the highest possible standard. To this end, it is necessary to seek out and/or to develop quality standards against which our work can be bench-marked.

When we talk about ‘having a home-based care programme’ in our church, does it imply a fortnightly visit to pray with an ill person or does it mean a comprehensive package of medical care, psychosocial and spiritual support, succession planning, care training to family members, community sensitization and outreach to the orphans within the family? What do we mean when we talk about ‘having a home-based care programme’? What *should* we mean?

Similarly: when we refer to ‘our orphan programme’ – are we referring to a soup-kitchen once a week for street children? Or do we refer to a comprehensive programme ensuring protection, identification and registration, health and education access, psychosocial support, skills training, amongst many other issues? What standards of care and support are to be found in each of these activities? What constitutes ‘minimum standards of care’ against which we can measure our activities and discover if we are on target or if we are way off the mark?

The following is an example of a peer assessment tool which was developed by the team that met at the World Council of Churches Ecumenical Institute in Bossey, Geneva, Switzerland in July 2007.

HIV COMPETENT CHURCH BENCH MARKS AND SELF-ASSESSMENT TOOL

An HIV competent church is one that recognizes and accepts the imperatives of HIV to itself and communities; has the knowledge, willingness and experience to respond in an inclusive, effective and prophetic manner that reflects the fruits of a Spirit filled congregation. The response of the HIV competent church to the pandemic is characterized by love, joy, peace, patience, kindness, goodness, gentleness, faithfulness and self-control (*Galatians 5:22-23*).

We can ask ourselves – Is my church HIV Competent? Do you want to find out?

Good intentions, policies and plans are crucial but are incomplete without sustained action that follows consistently to ensure societal transformation and life-enhancing responses. A good tree is recognized by its good fruits (*Matthew 7:20*).

Our response as individuals and as a congregation to the crisis the world faces in the form of HIV contributes to how we are defined as communities and recognized as followers of our Lord Jesus Christ.

“A new command I give you: love one another. As I have loved you, so you must love one another. By this all men will know that you are my disciples, if you love one another.” (John 13:34-35)

In the context of HIV, we as people of faith, have the responsibility to work to the highest possible standard. To this end, there is a tremendous need for us to assess truthfully the quantum and the quality of our responses. This will not only help us to identify our contributions, but will help us to identify our weaknesses and strengths, and to monitor our effectiveness as an HIV Competent church. The self assessment tool that is given below has been developed by church workers and theologians who have been deeply involved in the churches’ work to overcome HIV.

It is hoped that this assessment tool will be used by groups, as a community activity for self assessment and peer review.

If we do not have policies in place, let us create them in a participatory manner.

If we have policies, let us ensure that we implement them as a church or church-related organization.

Let us periodically assess ourselves to ensure that our efforts are relevant, effective and sustained.

A. Pastoral Care

Care in the context of our own faith that is edifying and supportive

Does my church have:

1. Systems that ensure home visits when people are sick, including possibility of individual counselling for those among us who are HIV+? (*0 for none, 1 indicating basic functioning system, 2 indicating a good system, 3 indicating excellent*)

2. Systems such as area fellowships and accompaniment programmes that provide support for affected families? (0 for none, 1 indicating basic functioning system, 2 indicating a good system, 3 indicating excellent)
3. Marriage enhancement programmes? (0 for no, 2 indicating yes)
4. Pre- and Post-Marriage Counselling? (0 for no, 2 indicating yes)
5. Do we minister to the needs of widows, widowers and single parents (0 for no, 2 indicating yes)
6. Safe spaces / forums for addressing diverse issues such as domestic violence and incest (0 for none, 1 indicating basic functioning system, 2 indicating a good system, 3 indicating excellent)

B. Homilies / Preaching

The spoken word and the writing we commit on paper in the place of worship and in the context of worship, as leaders, clergy and laity

1. How often do we hear HIV being addressed in sermons? (0 for none, 1 indicating one event, 2 indicating 2, 3 indicating 3, 5 more than 3)
2. What is the quality of the message? (-2 for stigmatizing, 0 for poor, 2 indicating good, 4 for inspiring/thought provoking)
3. Are our leaders knowledgeable and trained on the issue? (0 for no, 1 indicating adequate, 2 indicating good level)
4. Have there been specific publications/periodicals/newsletters addressing HIV? (0 for none, 2 indicating one, 4 indicating 2, 6 indicating more than 3)
5. Is the issue addressed in other publications/periodicals/newsletters (0 for none, 1 indicating one, 2 indicating 2, 3 indicating more than 3 and 4 indicating 4 or more)

C. Liturgy

Worship which includes silence, contemplation, words, songs, dances and practices that are used to communicate with God in fellowship and in solitude

1. Do we have HIV-specific liturgies for funerals, marriages, confirmation? (0 for no, 2 indicating yes)
2. Have our routine liturgies incorporated and addressed HIV? (0 for no, 2 indicating yes)
3. Do we celebrate healing services/liturgies? (0 for no, 2 indicating yes)

- Do we say special prayers for those of us who are living with HIV and affected by it? (0 for no, 2 indicating yes)

D. Faith Formation and Moral Education

Formation that that helps us to incorporate the Christian values into our daily lives

Have we incorporated HIV (in the form of change in curriculum, addition of workshops and seminars) in our:

1. Sunday schools (0 for no, 2 indicating yes)
2. Youth groups (0 for no, 2 indicating yes)
3. Women's fellowship (0 for no, 2 indicating yes)
4. Men's fellowship (0 for no, 2 indicating yes)
5. For the whole congregation (0 for no, 2 indicating yes)

E. Ecumenism and Inter-Faith Cooperation

Meaningful and respectful cooperation with other Christian denominations and with other faiths

Has HIV been addressed in:

1. Ecumenical church services (0 for none, 2 indicating one event, 4 indicating 2, 6 indicating more than 2)
2. Collaborative action (both inter-denominational and inter-religious) (0 for none, 2 indicating one event, 4 indicating 2, 6 indicating more than 2)
3. Do we have venues to listen to each other's experiences? (0 for no, 2 indicating one event, 4 indicating 2, 6 indicating more than 2)

F. Meaningful Participation of Those Among Us Who Are Hiv+

1. How many of us are openly positive in our church? (0 for none, 2 indicating one member, 4 indicating 2, 6 indicating more than 2)
2. How many of our leaders are openly positive? (0 for none, 2 indicating one leader, 4 indicating 2, 6 indicating more than 2)
3. Do we have a work place policy that is conducive to those among us who are HIV+? (0 for none, 1 for one being developed, 3 for adopted)

4. Are those among us who are HIV+ part of committees in our church (*0 none, 3 for membership in one committee, 6 for more than one committee*)
5. Do those among us who are positive feel welcomed and embraced in the congregation? (*-2 for feeling stigmatized, 0 for mixed, 1 marginally good, 2 good, 3 very good*)
6. Do we have retreats or capacity-building programmes for those among us who are positive (*0 for none, 2 indicating one or more programmes*)

G. Prevention

Addressing prevention of HIV in a holistic manner and making us less vulnerable

1. Is human sexuality addressed in a sound, forthright and scientific manner and addressed to different age groups? (*0 for no, 1 marginally good, 2 good, 3 very good*)
2. Do we discuss the social factors that can make us vulnerable to HIV? (*0 for no, 1 for marginally good discussions, 2 for good, 3 very good discussions*)
3. Do we deal with cultural practices within our own society that enhance our vulnerability or protect us? (*0 for no, 1 marginally dealing with cultural practices, 2 good, 3 very good*)
4. Do we reach out to those among us who are vulnerable in our communities or do we behave as if such a population does not exist (*0 for no, 1 marginally affirming, 2 affirming and reaching out, 4 strongly affirming and reaching out*)
5. In our education and activities on prevention, do we complete our information with scientifically proved and evidence based methods such as use of condoms, clean needles and syringes? (*0 for no, 3 for yes*)

H. Care

Caring for those of us in our congregation and in our community who are hurting with HIV

1. Do we have home-based care programmes? (*0 for no, 2 for first level care – occasional – once in two weeks or less frequent visits and material support, 4 for second level care – regular visits more than fortnightly visit and material support, 6 for comprehensive care programme which includes care, prevention and treatment and holistic support*)
2. Do we provide nutritional aid? (*0 for no, 2 for yes*)
3. Do we provide legal aid to those among us who are positive or marginalized? (*0 for no, 2 for yes*)
4. Do we see prevention as part of care? (*0 for no, 2 for yes*)

I. Vulnerable Children

Let the little children come to me, and do not hinder them, for the kingdom of heaven belongs to such as these. (Matthew 19: 13,14)

Don't steal the land of defenceless orphans by moving the ancient boundary markers. (Proverbs 23:10)

He gives justice to orphans and widows. He shows love to the foreigners living among you and gives them food and clothing. (Deuteronomy 10:18)

1. Do we have special programmes addressing the needs of vulnerable children?
2. Provision of shelter (0 for no, 2 for yes)
3. Protection against exploitation and sexual abuse (0 for no, 2 for yes)
4. Support in documentation/identity papers and legal assistance (0 for no, 2 for yes)
5. Educational support (0 for no, 2 for yes)
6. Nutritional support (0 for no, 2 for yes)
7. Psycho-social support (0 for no, 2 for yes)
8. Work for the empowerment and long term future (0 for no, 2 for yes)

J. Treatment

1. *The congregation facilitating and sustaining the access to life giving treatment*
2. We as a community take steps to promote treatment literacy – like giving information, conducting seminars/workshops and training of congregation members *(0 for no, 1 for satisfactory action, 2 for good actions)*
3. Do we know where we can refer pregnant women and their spouses to be screened and to benefit from the prevention of parent to child transmission of HIV and would we advise them to utilize the service? *(0 for no, 2 for yes)*
4. Involved in dispensing of medicines, facilitates/buddy programme {individuals who are trained and committed to accompany a person in need} *(0 for no, 1 for satisfactory action, 2 for good actions)*
5. Provides treatment of opportunistic infections and ART *(0 for no, 1 for satisfactory programmes, 2 for good programmes)*

K. Counselling and Testing

1. *Opportunities within our community's own sacred space to test for HIV in a supported, confidential and secure manner*
2. Do our leaders and members know where testing is being done? *(0 for no, 1 for yes)*
3. Is the congregation connected to and can refer members to testing facilities? *(0 for no, 1 for yes)*
4. Do we have facilities within our own structures for testing? *(0 for no, 1 for yes)*
5. Do we maintain confidentiality? *(0 for no, 1 for yes)*
6. Can discordant couples who are among us {when one partner is HIV + and the other is negative} get sound advice and support from our congregation? *(0 for no, 1 for yes)*

L. Stewardship of Finances and Resources

The congregation being aware of and mobilizing the resources that are available within the community, attempting to mobilize additional resources needed to serve better and being accountable to all concerned

1. Is there a person mandated to follow through the issue of HIV within the congregation? *(0 for no, 1 for person is held responsible, 2 for person is held responsible and has a clear cut programme)*
2. Do we utilize available structures of our church for our HIV-related work {structures could mean schools, church, clinics and hospital} *(0 for no, 1 for satisfactory use of facilities, 2 for good use of facilities)*
3. Is there a budget line devoted to HIV in the finances of the congregation? *(0 for no, 1 for yes)*
4. Do we mobilize financial resources for HIV from within the congregation? *(0 for no, 1 for yes)*
5. Do we receive external funding for our programmes? *(0 for no, 1 for yes)*
6. Do we document what we do and communicate to all concerned? *(0 for no, 1 for yes)*
7. Are there mechanisms which ensure that we are accountable to each other and to the people we serve and receive resources from {boards, committees, audited and publicized financial reports}? *(0 for no, 3 for yes)*

