

World Council of Churches

Partnerships between Churches

and

People Living with HIV/AIDS Organizations

The Lord God is the creator of heaven and earth; the creator of all life forms in the earth community. He created all life and everything good. In this HIV/AIDS era, he sees the misery of his people, who are infected and affected by this disease; He has heard their cry on the account of this epidemic. He knows their sufferings and he has come down to deliver them from HIV/AIDS. So he calls to send us to the infected and affected, to bring his people, his creation, out of the HIV/AIDS epidemic.

All Africa Conference of Churches (AACC), The Covenant Document on HIV/AIDS, All Africa Conference of Churches 8th General Assembly, Yaoundé, Cameroon, 22–27 November 2003.

Guidelines

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Index

Chapter 1 Introduction

Box 1: Breaking the Silence – Declarations by Churches on HIV/AIDS

Chapter 2 The response of churches to date

Chapter 3 Partnerships

3.1 What is building partnerships?

Box 2: The United Church of Canada – Beads of Hope Campaign

Box 3: International Orthodox Christian Charities and Ethiopian Orthodox Church expand anti-AIDS Campaign

Box 4: United Methodist Global AIDS Fund

3.2 With whom can partnerships be built with?

Box 5: Where are all the big church projects?

Box 6: Churches Health Association of Zambia (CHAZ)

Box 7: Caritas Internationalis

Box 8: Programmatic track record, technical expertise and political savvy: World Vision International's formula for proposal success

3.3. Why Partner with people living with HIV and AIDS organizations?

Box 9: No Preaching before a person living with HIV speaks

Box 10: Religious leaders and communities need to make a realistic analysis of the context and situation

Box 11: 'Umrah' for Muslims living with HIV/AIDS

Box 12: ANERELA+ and GNP+

Box 13: World Young Women's Christian Association (YWCA) and the International Community of Women Living with HIV and AIDS (ICW) Partnering.

3.4 The imperative to work with people living with HIV and AIDS organizations

3.5 The challenges of partnering with people living with HIV and AIDS

3.6 What benefits can partnerships bring for churches?

3.7 How do partnerships relate to programme work?

3.8 What HIV and AIDS issues affect partnerships?

3.9 Appreciating different perspectives

3.10 What church issues affect partnerships?

3.11 What does building partnerships mean in practice?

Box 14: Partnerships in practice in all the endeavours of churches

Box 15: Providing hope amidst despair – the example of BOCAIP

Box16: Norwegian Church Aid

Chapter 4 Troubleshooting in Partnerships

4.1 Thinking about the reasons for and against a partnership

4.2 Monitoring a partnership: understanding the ups and downs

4.3 Using language

4.4. Getting the message across

4.5 Responding to crises

Annex 1 List of Declarations and Policy Statements by Churches and Faith-based Organizations from 2001 to 2004

Annex 2 The Covenant Document on HIV/AIDS

Annex 3 Sensitive language use vis-à-vis HIV and AIDS

Annex 4 Glossary

Annex 5 People living with HIV and AIDS networks contact details

Bibliography

Chapter 1

Introduction

In keeping with World Council of Churches (WCC) commitments to take an active role in the response to HIV and AIDS, these guidelines have been developed by the WCC in conjunction with the African Network of Religious Leaders Living with or personally affected by HIV/AIDS (ANERELA+) and the Global Network of People living with HIV/AIDS (GNP+). While some of the information provided is general, there is an emphasis on forming, nurturing and sustaining partnerships with people living with HIV and AIDS (PLWHA) networks, organizations and self-help groups.

HIV-related stigma is seen to be at the heart of many failed efforts over the years – both church and secular – to respond to HIV, particularly to break the silence and denial surrounding the existence of HIV in communities.¹ Many interventions, whether for HIV prevention, care, support or treatment, have also been less than effective due to HIV-related stigma. These guidelines are intended to assist churches in a transformation process that in some cases has already begun and in others is yet to begin, and to steer that process. They are targeted at all levels of the church, whether church leaders, parish priest or ministers, people working in faith based organizations etc. – anyone within a church working on HIV should be able to benefit from partnering with PLWHA.

¹ HIV-related stigma can be defined in the following terms:

HIV/AIDS-related stigma can be described as a ‘process of devaluation’ of PLWHA or people associated with HIV/AIDS. This stigma often stems from the underlying stigmatisation of sex and intravenous drug use – two of the primary routes of HIV infection. HIV/AIDS-related stigma builds upon, and reinforces, existing prejudices. It also plays into, and strengthens, existing social inequalities - especially those of gender, sexuality and race. Prejudiced and stigmatizing thoughts frequently lead people to do, or not do, something that denies services or entitlements to another person. For example, they may prevent health services being used by a PLWHA, or terminate their employment on the grounds of their HIV status. This is discrimination.

HIV/AIDS-related stigma and discrimination play a key role in producing and reproducing relations of power and control. They cause some groups to be devalued and others to feel that they are superior. Ultimately, stigma creates and is reinforced by social inequality.

Stigma and discrimination can lead to depression, lack of self-worth and despair for PLWHA. But PLWHA are not the only ones at risk from this fear and prejudice. Negative attitudes about HIV also create a climate in which people become more afraid of the stigma and discrimination associated with HIV than of HIV itself. When fear and discrimination prevail, people may choose to ignore the possibility that they may already be, or could become, HIV-positive – even if they know they have taken risks – and not seek testing and treatment, if available. And people may decide not to take actions to protect themselves for fear that in doing so they are associating themselves with HIV and having been ‘at risk’. All of this helps to create an environment in which HIV transmission can more easily take place.

UNAIDS. Fact Sheet: Stigma and Discrimination. 2003. www.unaids.org. Also see UNAIDS. *A Conceptual Framework and Basis for Action: HIV/AIDS Stigma and Discrimination*. Geneva, Switzerland, 2002. at 12. <http://www.unaids.org>

Partnerships are an essential part of the process of change. These guidelines aim to foster partnerships so that both the churches and partnering organizations can nurture and sustain their collaboration. The focus is on the challenges and ways forward in creating partnerships between churches and PLWHA organizations, while giving a broader perspective on partnerships generally. These guidelines are to help churches to reach out to others skilfully and in a planned way, highlighting the reasons for forming partnerships, some of the challenges and suggest some ways forward, including by providing examples of existing partnerships and initiatives. They should be read in conjunction with World Council of Churches. *Working with People Living with HIV/AIDS Organizations, Guidelines* (2005), which provides practical information on forming and maintaining partnerships with PLWHA networks, organizations and self-help groups.

Within the text boxes are used to highlight specific issues or to provide examples of projects or programmes or partnerships that have been successful. The Annexes contain sections on a list of declarations by churches on HIV, the Covenant Document on HIV/AIDS, best practice use of HIV- and AIDS-related language, a glossary of common HIV- and AIDS-related terms, and contact details for PLWHA networks and organizations. Please note the full texts of the declarations by churches on HIV listed in Annex 1 are available on the World Council of Churches – health work related web-site at www.contactforhealth.org If you do not have access to internet; you can obtain copies from:

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Much of the material herein is adapted from the International HIV/AIDS Alliance Toolkit, *Pathways to Partnerships* (1998) and it is intended that churches adapt the materials to suit their local needs².

Successful partnerships are built on entities understanding why they are entering into a relationship, and a clear understanding of the rights and responsibilities of each partner. The power of communication should never be underestimated in keeping partnerships inclusive, honest and transparent – the hallmarks of a good relationship and, it is to be hoped, successful programming. *Building partnerships is about working with others to achieve what we cannot achieve on our own.* A partnership is a special kind of relationship, in which people or organizations combine their resources to carry out a specific set of activities. Partners work together for a common purpose, coherence and for mutual benefit. The advantage of partnerships is that different people and organizations have a wide range of resources to offer each other.

² <http://www.aidsalliance.org/eng/>

In the past twenty-three years, any organization working on any aspect of HIV and AIDS has encountered the frustration caused by HIV-related stigma, which can limit the effectiveness of prevention, care, support and treatment interventions. Any effective intervention, therefore, requires mainstreaming stigma eradication strategies into all interventions – something that cannot be achieved without forming partnerships with PLWHA organizations. As stressed above, “building partnerships is about working with others to achieve what we cannot achieve on our own,” and the pervasiveness of HIV-related stigma underlines the fact that all organizations responding to the epidemic need to be in partnership with PLWHA organizations.

For the churches, partnership with PLWHA and their organizations is a gospel imperative, the very centre of their mission and ministry. It is not an option, it is a must³. As Matthew 25:31–46 indicates, Christ underlines that the measure of Christian faith shall be judged according to the believers’ capacity to show compassion for the poor, the hungry, strangers, the sick, the imprisoned and to undertake efforts to meet their needs by changing their oppressive situations. In this passage, Christ presents himself as identical to the suffering and oppressed – regardless of their faith – thus underlining that one cannot be a Christian, a Christ lover or follower, without caring for the suffering and doing something to change their oppressive situation. As He says:

When the Son of Man comes in glory with all the angels, then he will sit on his throne in heavenly glory. All the nations will be gathered before him, and he will say to those on his right: Come, you who are blessed by my Father; take your inheritance, the kingdom prepared for you since the creation of the world.

*For I was hungry and you gave me something to eat
I was thirsty and you gave me something to drink
I was a stranger and you invited me in,
I needed clothes and you clothed me
I was sick and you looked after me
I was in prison and you came to visit me*

*Then the righteous will answer him:
Lord when was it that we saw you hungry and gave you food
Or thirsty and gave you something to drink/
And when was it that we saw you a stranger and welcomed you
Or naked and gave you clothing?
And when was it that we saw you sick or in prison and visited you?*

*And the kind will answer them truly I tell you, just as you did it to one
Of the least of these, who are members of my family, **you did it to me**⁴*

³ Dube, Musa W. "Towards an HIV/AIDS Christology: Christ the Compassionate Healer and Liberator in the New Testament," (2b edited--delete) in Dube, Musa W. *The HIV&AIDS Bible: Selected Essays*, (Forthcoming in Scanton: Scranton University Press, 2005).

⁴ Emphasis added.

Churches in many countries with high HIV prevalence, particularly those in Africa, are already suffering from the onslaught of the HIV pandemic. Members of churches have similar rates of HIV infection as the community in which they live. Churches, as living organizations, have much to learn and to give to their members who are living with HIV and AIDS. Churches must go through a transformation process, become AIDS competent and be a better home for those directly affected by the pandemic. Churches, as living organizations, are inseparable from their members. The worldwide church is one body of Christ. Therefore, for churches, whose theology holds that, “For in one Spirit we were all baptized into one body...If one member suffers, all suffer together with it; if one member is honoured, all rejoice together with it,” (1 Corinthians 12:13 and 26), the church is inseparable from the PLWHA. This holds true for churches many members who are living with HIV and AIDS and for their sister churches, which may have few members living with HIV as they are all part of the one body of Christ.

There is no “us” (the uninfected) and “them” (PLHWA) within the worshipping community of the church. In being followers of Christ, who identify themselves with the suffering (Matthew 25:31–46), and recognising that some members of the church are HIV-positive, the whole body of Christ, the church, is HIV-positive.

Partnership with PLWHA organizations is therefore central to the mission, ministry and identity of the church as the body of Christ. As an expression of its ministry and commitment to identifying with PLWHA and to breaking stigma and discrimination⁵, the church needs to make part of its confessional liturgy, wherever Christians are gathered for fellowship, that “*the church is HIV-positive*”⁶.

As the Symposium of Episcopal Conferences of Africa and Madagascar said, “As heads of our Christian communities, **we commit ourselves to making available our Church’s resources be they** our educational and healthcare institutions or social services. We will work closely with all funders who are disposed to support and work with Christian and faith-based organizations. We are open to partnerships with them and others who are **happy to put their resources to work in the struggle, and do so knowing well that we work according to our Gospel convictions**. For “man does not live by bread alone, but by every word that issues from the mouth of God” (Matthew 4: 4)”⁷.

⁵ UNAIDS, *A Report of Theological Workshop Focusing on HIV and AIDS Related Stigma*, Windhoek, Namibia, 8-11 Dec 2003, is an excellent resource to employ for churches to eliminate a discriminative theology. Developed by the UNAIDS in conjunction with church theologians worldwide to counteract stigma. Forthcoming www.unaids.org keyword search “Religion” under select a topic.

⁶ For churches that are interested in adopting HIV & AIDS sensitive sermons and liturgy, see Dube, Musa W. ed. *Africa Praying: A Handbook on HIV/AIDS Sensitive Sermon Guidelines and Liturgy*. Geneva: WCC, 2003. <http://www.wcc-coe.org/wcc/what/mission/ehaia-documents-e.html>

⁷ Symposium of Episcopal Conferences of Africa and Madagascar, *The Church in Africa in face of HIV/AIDS Pandemic, Message issued by Symposium of Episcopal Conferences of Africa and Madagascar (SECAM)*, Dakar, Senegal, 7 October 2003. Emphasis added.

Chapter 2

The response of churches to date

This chapter outlines the response to date of churches and faith-based organizations in breaking the silence surrounding HIV and AIDS and challenging HIV-related stigma within churches and faith-based organizations as well as in the wider community. It begins with the early days of the epidemic, which were characterized by silence, except in the few examples provided, and goes on to document the tremendous commitments and moves in the last years by churches to break the silence surrounding HIV and AIDS.

The response of churches and from members within churches to HIV has been variable. The following paragraph summarizes both the ignorance and fear of some, and the humanity of others in responding to HIV in their midst:

Despite the fact that the rejection and scapegoating of people affected by HIV and AIDS finds no basis in theological scholarship, such incidents continue to occur. While visiting many different countries to facilitate HIV and AIDS workshops for pastoral personnel, I have heard the “horror stories” of pastors refusing to anoint HIV-infected people or forcing them to publicly confess the “sins” that caused them to be infected. I believe that members of the hierarchy, clergy, and laity alike have responsibilities to stop such poor pastoral practices as soon as they occur. I received much personal inspiration from an archbishop in a Caribbean country who, upon hearing that his priests were unwilling to visit a woman of supposed “ill repute” and suffering with AIDS-related illnesses went himself to visit her in the hospital and continued to do so on a daily basis, until the woman died. Then he celebrated her funeral Mass in his cathedral.⁸

The World Council of Churches (WCC) has been deeply committed and involved in responding to HIV and AIDS since 1986. It has assisted member churches in:

- sharing lessons learnt;
- developing policy guidelines;
- initiating and sustaining theological discussions on HIV and AIDS;
- developing and applying strategies, methodologies and tools for education;
- mobilizing churches to action both internationally and regionally;
- mobilizing resources for churches for HIV- and AIDS-related work;
- advocating on HIV and AIDS issue in the international arena; and
- mapping and monitoring the churches involvement around HIV and AIDS.
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⁸ Vitillo, Rev. Robert J., *Pastoral and Theological Challenges of HIV and AIDS*. National Seminar for Priests in Ghana, The Centre for Human Development, Accra, Ghana, 16–17 June 2004.

During 1986 the WCC gave serious attention to the escalation of the AIDS epidemic and its implications for the churches. In June 1986 three WCC sub-units (Church and Society, Family Education and the Christian Medical Commission) called a joint consultation at which the General Secretary, Dr Emilio Castro, in an opening address, challenged the view that disease is a punishment from God:

*Aids is a disease and should be treated as such... God, who loves all human beings, cares for the well-being and health of every one of his children, and does not inflict disease as a punishment*⁹.

The final statement of the June consultation, called for the Church to be the Healing Community, expressing its solidarity with those affected by AIDS through pastoral care, education for prevention and social ministry:

"In the mysteries of life and death we encounter God; this encounter calls forth trust, hope and awe rather than paralysis and immobilisation. Those we cannot cure we can support and sustain in solidarity: 'I was hungry ... thirsty... a strange ... naked... sick... imprisoned, and you fed... clothed... took care... visited' "(Matthew 25).

*"The Aids crisis challenges us profoundly to be the Church in deed and in truth: to be the Church as a healing community. Aids is heartbreaking and challenges the churches to break their own hearts, to repent of inactivity and of rigid moralisms. Since Aids cuts across race, class, gender, age, sexual orientation and sexual expression, it challenges our fears and exclusions. The healing community itself will need to be healed by the forgiveness of Christ"*¹⁰.

In January 1987 the sub-unit on Church and Society organized a Hearing on the subject for the WCC Central Committee, which recommended:

*The Central Committee of the WCC urges all churches to make known the seriousness of the problem of Aids and to take every opportunity to cooperate with one another and with medical, social and educational agencies and the mass media in appropriate educational programmes*¹¹.

Churches were largely silent in the first years of the AIDS epidemic, but there were some notable exceptions. The World YWCA, World Council passed Resolutions on AIDS (1987)¹² and Women and HIV/AIDS (1991)¹³. At its General Assembly in

⁹ World Council of Churches. *AIDS and the Church Hearing on AIDS*. Central Committee, Geneva, Switzerland, January 1987. (March 1987 No. 1).

¹⁰ World Council of Churches. *AIDS and the Church Hearing on AIDS*. Central Committee, Geneva, Switzerland, January 1987. (March 1987 No. 1).

¹¹ World Council of Churches. *AIDS and the Church Hearing on AIDS*. Central Committee, Geneva, Switzerland, January 1987. (March 1987 No. 1).

¹² World YWCA. *World Council Resolutions on AIDS*. Phoenix, Arizona, United States, 1987.

1987, Caritas Internationalis, the Vatican-based, global confederation of Catholic social service and development organizations operating (at that time) in more than 260 countries of the world, designated HIV and AIDS as one of its priority areas of reflection and action¹⁴. This commitment has continued to the present. Since that time, Caritas Internationalis has attempted to mobilize a non-judgmental and compassionate education-focused and service-oriented response to the challenges posed by this pandemic.

Pope John Paul II has made frequent and emotional appeals to avoid discriminatory treatment of people living with HIV and AIDS. In his visit to PLWHA in a Californian hospital in the United States in September 1987, he held out the unconditional love of God himself as the guideline to be followed:

God loves you all, without distinction, without limit ... He loves those of you who are sick, those suffering from AIDS. He loves the friends and relatives of the sick and those who care for them. He loves all with an unconditional and everlasting love¹⁵.

The bishops of the United States were among the first to appeal to all the faithful to respond to those affected by the pandemic with compassion and without fear or prejudice¹⁶. In *The Many Faces of AIDS: A Gospel Response*, 1987, the Administrative Board of the U.S. Catholic Bishops Conference mentioned the new services which should be considered by parishes and institutions sponsored by the Catholic Church and offered a litmus test for responding to the HIV pandemic:

Current programs and services need to be expanded to assist the families of those with AIDS while they are alive and also to support them in their

¹³ World YWCA. *World Council Resolutions on Women and HIV/AIDS*. Stavanger, Norway, 1991

¹⁴ Caritas Internationalis, General Assembly, 1987. <http://www.caritas.org/>

¹⁵ Pope John Paul II, Address given at Mission Dolores, 1987.

Also see: Pope John Paul II in Tanzania, September 1990

Pope John Paul II, Burundi, September 1990

In *The Church responds to HIV/AIDS, A Caritas Internationalis dossier*, 1996. Edited by Duncan MacLaren, Head of International Relations, Caritas Internationalis.

http://www.cafod.org.uk/resources/worship/church_statements/hivaids_statements/ci_aids_dossier

¹⁶ See: New Zealand Catholic Bishops, *Care, Not Judgment for AIDS*, May 1987.

Cardinal Paulo Evaristo Arns, Archdiocese of Sao Paulo, Brazil, 1988.

Bishops of Uganda, *AIDS: A Challenge to Church and Society*, 1989.

Pastoral Statement on AIDS, Bishops of Uganda, 1989.

Canadian Conference of Catholic Bishops, *Beyond Fear: Compassion, Clear-Sightedness, Solidarity*, 1989.

Bishops of Southern Africa, *AIDS: A Christian Response*, June 1990.

Bishops of New Mexico, United States, June 1990

Ghana Bishops' Conference, October 1990.

Components of Parish AIDS Outreach, Seattle Archdiocese AIDS Ministry, June 1993

Bishops' Conference of the Philippines, 1993.

In *The Church responds to HIV/AIDS, A Caritas Internationalis dossier*, 1996. Edited by Duncan MacLaren, Head of International Relations, Caritas Internationalis.

http://www.cafod.org.uk/resources/worship/church_statements/hivaids_statements/ci_aids_dossier

Also see: Australian Bishops Conference, *Concerning A.I.D.S.*, 1987.

Australian Bishops Conference, *The A.I.D.S. Crisis*, 1987.

Australian Bishops Conference, *A.I.D.S.: (Pastoral Statement on) A Challenge to Love*, 1988.

bereavement. In addition, new programs, services, and support systems need to be developed to deal with unmet and poorly met needs.

Our response to the needs of persons with AIDS will be judged to be truly effective when we discover God in them and when they, through their encounter with us, are able to say, in my pain, fear, and alienation, I have felt your presence, a God of strength, love, and solidarity¹⁷.

In a subsequent pastoral letter issued by all the bishops of the United States, Catholics were reminded of the Gospel-based responsibility to affirm the dignity of those living with HIV and AIDS and to care for them without hesitation:

Persons with AIDS are not distant, unfamiliar people, the objects of our mingled pity and aversion. We must keep them present to our consciousness, as individuals and as community, and embrace them with unconditional love. The Gospel demands reverence for life in all circumstances. Compassion - love - toward persons infected with HIV is the only authentic Gospel response¹⁸.

Pope John Paul II said at the Vatican AIDS Conference, November 1989, said:

AIDS has by far many more profound repercussions of a moral, social, economic, juridical and structural nature, not only on individual families and in neighbourhood communities, but also on nations and on the entire community of peoples....

Those who suffer from AIDS, even in their unique pathology, are entitled to receive adequate health care, respectful comprehension and complete solidarity, just like every other ailing person.

The Church, imitating her divine Founder and Teacher, has always deemed as fundamental to her mission assistance to those who are suffering. She now feels that she is called upon as protagonist in this new area of human suffering, aware as she is that suffering man is a "special way" of teaching and her ministry....

Brothers in Christ, who know the bitter harshness of the way of the cross do not feel that you are alone. The church is with you as sacrament of salvation to sustain you in your difficult path. She receives much when you live your suffering with faith; she is beside you with the comfort of active solidarity in her members so that you never lose hope. Remember

¹⁷United States Catholic Conference Administrative Board, *The Many Faces of AIDS: A Gospel Response*, in *Origins*, XVII, 28 (December 24, 1987), p. 136.

¹⁸National Conference of Catholic Bishops. *Called to Compassion and Responsibility: A Response to the HIV/AIDS Crisis*, as appeared in *Origins*, November 30, 1989, vol. 19, no. 26.

how Jesus invites you "Come to me all of you who are weary and tired, and I will give you complete rest" (Matthew. 11:28)¹⁹.

In Africa, the Bishops of Southern Africa proposed in June 1990:

Perhaps the AIDS crisis is God's way of challenging us to care for one another, to support the dying and to appreciate the gift of life. AIDS need not be merely a crisis: it could also be a God-given opportunity for moral and spiritual growth, a time to review our assumptions about sin and morality. The modern epidemic of AIDS calls for a pastoral response²⁰.

And the Catholic Bishops in Ghana were also among the first voices to be raised in appeal for an unconditional and accepting response among Christians to the brokenness in human relationships that both precedes and results from HIV infection:

AIDS often involves alienation and separation between the person with the disease and every surrounding system. We are challenged to be reconcilers, helping to restore a sense of wholeness to broken relationships between the patient and those near to him or her. We must build a sense of trust and caring. This requires education, and a change of heart...

If the yardstick of our faith is unconditional love, particularly love of those whom society regards as outcasts, then our response to people suffering from AIDS will be a measure of our faith²¹.

The Lutheran World Federation, in a report *Pastoral Work in Relation to AIDS*, in 1988, stated:

The church should open its doors to all, unconditionally, just as Christ opened the door to all, irrespective of who they were or what they had done. Salvation is given to all by grace, through faith, not because of deeds or behaviour. By accepting everybody Christ gave access to his forgiveness and to a new life. Today in his church, we receive this new life through the Word and the sacraments. By excluding somebody from these sources of life, the church becomes guilty of the gravest form of discrimination that exists.

The spread of AIDS is dependent on cultural, social and economic realities. The church should question seriously its own role in developments facilitating the spread of the disease, and challenge its own members and the society to take steps to remove discriminatory attitudes and actions prevailing in society²².

¹⁹ Vatican AIDS Conference - Fourth International Conference organised by the Pontifical Council for Pastoral Assistance to Health Care Workers, Vatican City, November 1989.

²⁰ Bishops of Southern Africa, *AIDS: A Christian Response*, June 1990.

²¹ Ghana Bishops' Conference. *Pastoral Statement on AIDS*, October 1990.

²² The Lutheran World Federation, *Report from a Consultation: Pastoral Work in Relation to AIDS*. Kaiserswerth, Federal Republic of Germany, 21-25 March 1988

The Lutheran World Federation members of Argentina, Uruguay, Paraguay, Chile, Brazil, Peru and El Salvador in the *Declaration of Buenos Aires*, in 1998, stated:

We are called to commit ourselves to such pastoral action. This call arises out of the recognition that a medical diagnosis has often been confused with a moral judgment affecting the dignity of many brothers and sisters. We are moved by the suffering of those persons exiled from family and social solidarity networks, and we are called to be facilitators of the reconstruction of these networks.

We take seriously the profound meaning of the word "epidemic" (epi = over, demos = people) which reveals to us that it is a crisis installed in the midst of the entire society and in all churches...

Christ continues calling us to conversion today, by means of the excluded: the Samaritan shows us solidarity (Luke 10:25-37); the widow, generosity (Luke 21:1-4); the Canaanite woman, the certainty of faith when faced with the prejudices of belonging (Matthew 15:21-28); and persons in situations of prostitution and tax collectors show us the way of the reign of God (Luke 18:14).

This pastoral ministry desires to contribute to the reintegration of those who have been exiled, due to our judgements, to the space which belongs to them by virtue of the Gospel: "Come to me" (Matthew 11:28).

We know that the cost of this identification with those stigmatized by our society and by our churches is always very high, but that in faithfulness to the Gospel we cannot avoid it. This price should be paid by all the faithful, and not only by those who are directly involved. We desire that this pastoral ministry be previsionary, while we wait for the entire Christian community to assume it in the near future²³.

The Seventh Day Adventist Church stated in 1990:

AIDS challenges the ministry of Seventh-day Adventist pastors and chaplains. They already have people with HIV infection in their congregations, communities and hospitals. The numbers will increase. They should not fear casual physical contact including shaking hands and baptizing. Pastors should continue to call on the sick at their homes or in the hospital. HIV infections should not change patterns of visitation or in any way limit ministry.

The fear of AIDS should not compromise our compassion or our witness. Those who test positive for HIV and who may be sick with the disease should find acceptance and fellowship in the local congregation. They should be comfortable in our church services and be welcomed to

²³ The Lutheran World Federation: Argentina, Uruguay, Paraguay, Chile, Brazil, Peru and El Salvador. "AIDS Calls Us To Be Community". *Declaration of Buenos Aires*, Buenos Aires, Argentina, 15 April 1998.

participate in all activities of the church: baptism, foot washing and the communion supper. The local church can find many ways to minister to those with AIDS. Church members can join or form a support group and become individually involved in a supportive role to meet the needs of persons and families impacted by AIDS²⁴.

In September 1996, the WCC Central Committee on the basis of the WCC Consultative Group on AIDS Study Process adopted a statement on HIV and AIDS outlining the epidemic, the theological basis for a response and possible responses by churches, including:

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

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

²⁴ AIDS Committee of the General Conference of Seventh Day Adventists. *AIDS A Seventh-day Adventist Response*, Health and Temperance Department at the General Conference Session. Indianapolis, Indiana, United States, 1990.
http://www.adventist.org/beliefs/other_documents/other_doc1.html

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

1. We ask the churches to recognize the linkage between AIDS and poverty, and to advocate measures to promote just and sustainable development.
2. We urge that special attention be focussed on situations that increase the vulnerability to AIDS such as migrant labour, mass refugee movements and commercial sex activity.
3. In particular, we ask the churches to work with women as they seek to attain the full measure of their dignity and express the full range of their gifts.
4. We ask the churches to educate and involve youth and men in order to prevent the spread of HIV/AIDS.
5. We ask the churches to seek to understand more fully the gift of human sexuality in the contexts of personal responsibility, relationships, family and Christian faith.
6. We ask the churches to address the pandemic of drug use and the role this plays in the spread of HIV/AIDS and to develop locally relevant responses in terms of care, de-addiction, rehabilitation and prevention.²⁵

In this period, most churches (especially in Africa) were still either silent, or on denial, or on condemnation, with only a few examples of positive response to HIV and AIDS. Since then there has been a massive change both at the individual and denominational level and at the ecumenical level. From 2000 to the present, the work of the Anglican Communion, Lutheran Communion, Roman Catholic Church (to name a few), the work of United Evangelical Mission (UEM), United Church of Christ (UCC), the Ecumenical HIV/AIDS Initiative in Africa (EHAIA), All Africa Conference of Churches (AACC), World Young Women's Christian Association (YWCA), World Alliance of Reformed Churches (WARC) and several National Christian Councils have made a great exodus from Egypt, crossing the Red Sea into the wilderness, where many have made a covenant with God to respond to the AIDS crisis. Of course, some members of churches are crying "we were better in Egypt" and some still are building up idol calves. However, sadly, some churches are still in Egypt denying the reality of HIV, and the need for their church to change and respond.

While churches have not entered the Promised Land in so far as the struggle against HIV and AIDS is concerned; "the church has crossed the Red Sea" and is in the wilderness, struggling and working out their relationship with God. This analogy is very much dependent on which church and continent is being discussed. While many flaws remain, while the full potential and commitment of churches is yet to be unleashed, a great move has occurred. The greater church, especially in the developing world, has heard God's voice saying, "I have seen the suffering of my

²⁵ World Council of Churches. *The Impact of HIV/AIDS and the Churches' Response. A statement adopted by the WCC Central Committee on the basis of the WCC Consultative Group on AIDS Study Process.* Geneva, Switzerland 12-20 September 1996. Document No. 6.2B.

people, I have heard... I know... come let me send you to deliver my salvation to them.”

In 2001, church leaders of Africa, and international and African ecumenical organizations developed a coordinated Plan of Action to respond to the AIDS epidemic in Africa, at a WCC “Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa”, Nairobi, Kenya. The Plan of Action stated, “The Plan is part of the response, by these groups of partners, to the urgent challenge presented by the epidemic of HIV/AIDS: a challenge to which all religious organizations have been struggling to respond, which is depopulating Africa faster than any calamity since the slave trade”²⁶. It is notable that at this gathering, the vision of the Plan of Action and the first commitment adopted by the churches centred on breaking the stigma and discrimination surrounding HIV and AIDS:

Vision

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.

Commitments

1. The teaching and practice of churches indicate clearly that “stigma and discrimination against PLWHA is sin and against the will of God”²⁷.

²⁶ The Ecumenical Response to HIV/AIDS in Africa (EHAIA), *Plan of Action, Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa*, Nairobi, Kenya, 25-28 November 2001. <http://www.wcc-coe.org/wcc/what/mission/ehaia-e.html>

EHAIA describes the AIDS competent church through five main objectives:

- The teaching and practice of churches indicate clearly that “stigma and discrimination against PLWHA is sin and against the will of God”.
- Churches and ecumenical partners have a full understanding of the severity of the HIV/AIDS pandemic in Africa.
- Churches in Africa reach out and respond to collaborative efforts in the field of HIV/AIDS.
- Churches find their role in prevention of HIV/AIDS taking into consideration pastoral, cultural and gender issues.
- Churches use their resources and structures to provide care, counseling and support for those affected.
- EHAIA is present in Africa through four regional co-ordinators and a theology consultant. Their addresses can be found on the last page.

²⁷ The Ecumenical Response to HIV/AIDS in Africa, *Plan of Action, Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa*, Nairobi, Kenya, 25-28 November 2001. <http://www.wcc-coe.org/wcc/what/mission/ehaia-e.html>

Since 2001, a number of churches and faith based organizations have stated their commitment to break the silence around HIV and AIDS and challenge the stigma and discrimination faced by PLWHA. Box 1 “Breaking the Silence – Declarations by Churches on HIV/AIDS” provides examples from different religions and from around the world.

Box 1: Breaking the Silence - Declarations by Churches on HIV/AIDS

The Bishops’ Conference, Church of Norway, in April 2001, stated that “in our own country, too, there is a lack of openness about the disease and HIV victims are also suffering from condemnation and exclusion. As fellow human beings in the church and in the community, each one of us is being challenged to examine our own attitudes. For the church, it is important to keep to the principle that Christian charity commits us to support, not condemn, those who are suffering. We must help people who are infected with HIV to live openly in the community”²⁸.

The bishops of the Southern Africa Catholic Bishops’ Conference, in July 2001, left no room for any possibility of stigmatization or marginalization based on the false premise that God has “willed” AIDS for sinful individuals. “AIDS must never be considered as a punishment from God. He wants us to be healthy and not to die from AIDS. It is for us a sign of the times challenging all people to inner transformation and to the following of Christ in his ministry of healing, mercy and love”²⁹.

The Christian Conference of Asia, in November 2001, stated that “the church at all levels, international, regional, national and local, has an important role to play in:

- challenging the negative, judgmental attitudes that still exist towards people with HIV/AIDS
- decreasing fear and misconceptions about HIV/AIDS
- providing accurate information about HIV/AIDS, including prevention information, and information about HIV services that may assist PLWHA”³⁰.

In April 2002, the Primates of the Anglican Communion stated: “We raise our voices to call for an end to silence about this disease - the silence of stigma, the silence of denial, the silence of fear. We confess that the Church herself has been complicit in this silence. When we have raised our voices in the past, it has been too often a voice of condemnation. We now wish to make it clear that HIV/AIDS is not a punishment from God. Our Christian faith compels us to accept that all persons, including those who are living with HIV/AIDS, are made in the image of God and are children of God”³¹.

The Pan-African Lutheran Church Leadership, in May 2002, stated:

²⁸ Church of Norway, *Statement from the Bishops’ Conference*. April 2001

²⁹ Southern African Bishops Conference. *A Message of Hope to the People of God from the Catholic Bishops of South Africa, Botswana, and Swaziland*. Pretoria, South Africa, 30 July 2001.

³⁰ Christian Conference of Asia, *Consultation on HIV/AIDS: A challenge for religious response: Statement*. Chiang Mai, Thailand, 25-30 November 2001.

³¹ Anglican Primates, *Report of the Meeting of Primates of the Anglican Communion: Appendix III Statement of Anglican Primates on HIV/AIDS*, Canterbury, United Kingdom, 17 April 2002.

We commit ourselves to breaking the silence.

We recognize the many willing people who are currently engaged in and outside our churches in giving care and support. We will, however, publicly confess and acknowledge that we have too often contributed to stigmatization and discrimination and that our churches have not always been safe or welcome places for people living with or affected by

HIV/AIDS. In some cases Holy Communion has been refused to people living with HIV/AIDS, funerals of people having died from AIDS have been denied and comfort to the bereaved has not been given. We repent of these sins.

We therefore commit ourselves to a faithful and courageous response in breaking the silence, speaking openly and truthfully about human sexuality and HIV/AIDS.

³² Pan-African Lutheran Church Leadership, *Breaking the Silence, Commitments of the Pan-African Lutheran Church Leadership Consultation in response to the HIV/AIDS pandemic*. Nairobi, Kenya, 2–6 May 2002.

³³ World Council of Churches (WCC) and Christian Conference of Asia (CCA). *Report of the WCC-CCA Consultation on 'An Ecumenical Agenda to combat HIV/AIDS in South Asia'*. Colombo, Sri Lanka, 24 - 26 July 2002.

³⁴ Council of Anglican Provinces in Africa (CAPA). *Statement from CAPA AIDS Board Meeting*. Nairobi, Kenya, 19-22 August 2002.

³⁵ Council for World Mission. *Assembly Statement*. Ayr, Scotland, 15 - 25 June 2003.

³⁶ Symposium of Episcopal Conferences of Africa and Madagascar, *The Church in Africa in face of HIV/AIDS Pandemic: Message issued by Symposium of Episcopal Conferences of Africa and Madagascar (SECAM)*, Dakar, Senegal, 7 October 2003.

³⁷ Church of Nigeria (Anglican Communion). *Communiqué, National HIV/AIDS Strategic planning and policy development workshop*. Abuja, Nigeria, 10 - 14 November 2003.

³⁸ Catholic Bishops of Myanmar. *Pastoral Letter on HIV/AIDS and the Response of the Church*. December 2003.

³⁹ Indian Catholic Bishops. *Pastoral Letter from Indian Bishops for World AIDS Day 2003: The challenge to be his Light today*. 1 December 2003.

⁴⁰ Lutheran World Federation and the United Evangelical Mission. *"Covenant of life" Statement of Commitment of the Asian Church Leadership Consultation on HIV/AIDS*. Batam Island, Indonesia, 1-4 December 2003.

⁴¹ *Memorandum of Intention, Strategy consultation on Churches and HIV/AIDS in central and eastern Europe*. St. Petersburg, Russia, 15–18 December 2003.

⁴² Romanian Orthodox Church. His Beatitude Teoctist, Patriarch of the Romanian Orthodox Church. *A message, urging to love and tolerance for those suffering from AIDS/HIV*. Romania, 27 January 2004.

⁴³ Regional Meeting facilitated by the Latin American Council of Churches (CLAI) and supported by the World Council of Churches (WCC), *The Church and HIV/AIDS in Latin America and the Caribbean*, Panama City, Panama, 27 January – 1 February 2004.

⁴⁴ World YMCA. *YMCA Global Capacity Building Forum on HIV/AIDS: YMCA Movement Statement on HIV/AIDS*. Durban, South Africa. March 2004.

⁴⁵ World Council of Churches' Pacific Member Churches, *The Nadi Declaration: A statement of the world council of churches' Pacific Member Churches on HIV/AIDS*. Nadi, Fiji, 29 March – 1 April 2004.

⁴⁶ Pontifical Council for Health Pastoral Care, *Message for the World Aids Day*, 1 December 2004.

⁴⁷ *The Cairo Declaration of Religious Leaders in the Arab States in Response to the HIV/AIDS Epidemic*. Cairo, Egypt, 11–13 December 2004.

We recognize that it is especially important for the bishops, presidents and other church leaders to publicly speak and provide leadership in breaking the silence³².

The WCC-CCA Consultation on An Ecumenical Agenda to combat HIV/AIDS in South Asia, in July 2002, said that “Churches are challenged to be more inclusive, changing the mindset that demarcates “us” and “them” and opening the way for mutuality in a spiritual journey we all travel together. Churches need to overcome being judgmental, recognizing that we ourselves stand in need of forgiveness for our attitudes, apathy, and inaction in the face of HIV/AIDS. With the active participation of people living with HIV/AIDS in our program planning and implementation, churches are challenged to confront stigma and discrimination. Churches are also challenged to include HIV/AIDS in theological training and to undertake practical measures such as promoting gender justice in the church and communities, advocating for access to treatment and drugs for PLWHA, and strategies to decrease people’s vulnerability to HIV/AIDS”³³.

The Council of Anglican Provinces in Africa (CAPA) stated, in August 2002, that: Stigma is a sin! Stigma is the silent killer decimating our continent and is spreading disease. We call for an end to stigma and discrimination against those who are HIV+ and their families. Our sisters and brothers living with AIDS experience silence and rejection. Silence feeds denial and shame. This, too, is stigma. We know the Church has been complicit in silence.

That silence is ended! Our Church has declared stigma as a sin before God and Human kind. We will uphold the dignity and worth of all people as Children of God, especially those living with AIDS. Therefore each Province is being asked to implement a Pastoral Plan for eradicating stigma as soon as possible³⁴.

The Council for World Mission, in June 2003, stated: “We recognize the need to become more caring, welcoming and healing communities that no longer stigmatize, exclude and discriminate against our brothers and sisters living with HIV/AIDS. We acknowledge the value of personal encounters with people infected and living with HIV/AIDS to enrich our understanding, and strengthen our ability to be professionally competent, spiritually sound and socially relevant in dealing with the human dimensions of the pandemic”³⁵.

The Symposium of Episcopal Conferences of Africa and Madagascar, in October 2003, stated that “facing the serious threat of AIDS, with you we are committed to work tirelessly to eradicate stigma and discrimination and to challenge any social, religious, cultural and political norms and practices which perpetuate such stigma and discrimination” and “finally, as Pastors of the Church Family of God in Africa in a time of AIDS, we want to welcome people living with HIV and AIDS in a warm, non-judgemental and compassionate manner in our churches and ensure them a “place at the table of the Lord”³⁶.

In November 2003, the Church of Nigeria (Anglican Communion) stated “it shall be HIV/AIDS friendly and shall ensure greater involvement of people living with HIV/AIDS in all aspects of church ministry”³⁷.

In December 2003, Catholic Bishops of Myanmar released a Pastoral Letter stating, “Bishops and priests are public figures in the communities they serve; they can lead by example in what they say and in what they do, for example:

- Every Sunday, priests and bishops have an opportunity to speak out. They can use their sermons to condemn any form of discrimination against people affected by HIV, to educate their communities about HIV and AIDS, and to address some of the root causes of infection in Myanmar.
- Bishops and priests can make sure that they and their parishioners are not judgemental in their words or actions, and that people living with HIV and their families are always welcome in the liturgies and wider activities of their Church communities.
- Bishops and priests can enable and encourage the HIV-related work of sisters and lay catechists. There are many examples where clergy say, “our people don’t need to know about HIV/AIDS”, or “our people would be scandalised if we talked about sex”. In other instances, priests or bishops have stopped lay people from raising awareness about HIV, telling them they are not qualified to discuss these moral questions and even preventing them from giving scientifically proven sexual health information about HIV prevention. Such negative attitudes need to change if the Church is to offer any meaningful response to HIV/AIDS”³⁸.

The Indian Catholic Bishops released a Pastoral Letter on World AIDS Day 2003, stating:

7. Proper awareness on HIV/AIDS should help us to overcome our prejudices and fears. Those who contract HIV/AIDS, whether by accident or by consequences of their own actions, carry with them a heavy burden of social stigma, ostracism and condemnation. The infected and affected persons deserve all the compassion and care offered by Jesus. Those who feel morally superior to those living with HIV/AIDS may remember that self-righteousness is condemned more than any other sin by Jesus in the pages of the Gospel...

8. Let us help those people living with HIV to come out of the shadow of despair, gloom and guilt and enter into a joyful hope and acceptance. Those among us who are living with HIV/AIDS must not feel that they are alone and abandoned. We, who are their sisters and brothers, must walk in solidarity with them on their journey. In the words of Pope John Paul II, “Solidarity is not a feeling of vague compassion or shallow distress at the misfortunes of so many people. On the contrary, it is a firm and persevering 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.” As the body of Christ, the Church needs to take care of those infected and help them to ‘live positively’ with HIV/AIDS³⁹.

The Lutheran World Federation and the United Evangelical Mission in the “*Covenant of*

life”, in December 2003, stated: “We commit ourselves as part of the body of Christ to make HIV/AIDS a priority in our mission and diakonia through formulation and implementation of a policy that empowers local congregations and communities to:

- Combat and defuse stigma and discrimination against people living with HIV/AIDS by first and foremost breaking the socio-cultural barrier of shame or “losing face” by openly talking about HIV/AIDS, human sexuality and drug addiction”⁴⁰.

The strategy consultation on Churches and HIV/AIDS in central and eastern Europe, in December 2003, organized by Christian Aid, Christian Interchurch Diaconal Council of St. Petersburg, Norwegian Church Aid and the World Council of Churches stated that “persons living with HIV/AIDS are often severely stigmatized and subject to various forms of discrimination. As Christians, we believe all human beings are created in the image of God and therefore have intrinsic value and dignity. Any form of stigmatization or discrimination perpetrated against human beings violates this divine image and is therefore a sin. We believe as Christians that all people are called to resist this offence against God-given human dignity anywhere it occurs”⁴¹.

The Romanian Orthodox Church has joined the national campaign of fighting HIV-related intolerance, which is being run by USAID, in cooperation with the Romanian Government and some Romanian and international NGOs active in Romania. On 27 January 2004, His Beatitude Teoctist, Patriarch of the Romanian Orthodox Church, addressed a message to all Romanians, urging to love and tolerance for those suffering from AIDS/HIV, specifically stating:

It is a duty of every Christian to look for the good of the neighbour, thus following the great and holy law given to us by Christ: “Love your neighbour as you love yourself!” (Luke 10: 27)...

We have, therefore, the duty to accept them among us and to help all those suffering. In this sense, our Church offers everyone an example of self-sacrificing service for the good of one’s neighbour, through the pastoral and spiritual activity of the devout priests unfolded in social establishments and hospitals, especially in the wards for AIDS treatment. Following the example of the Saviour Jesus Christ, day by day, they watch over the sick, giving them comfort and encouraging them to face the disease. This is, many times, the only help, but the greatest proof of the love we can offer them. Even so, from different unsustainable reasons, some of us avoid them. That is why we believe that the example of these servants of the holy altars is an urge to be followed by all those among whom people suffering from AIDS live.

Christ identifies Himself with these brothers and sisters of ours, when He says: “I was sick, and you visited me” (Matthew 25:36), or “I tell you, whenever you did this for one of the least of these my brethren, you did it for me” (Matthew 25:40). We are all Christ’s friends. He loves us all, in the same degree. If we banish them, we banish Him! If we do not care about them, we do not care about Christ! If we do not love them, it is Christ we do not love! We should never forget that they are our neighbours and they need love and understanding⁴².

The Regional Meeting facilitated by the Latin American Council of Churches (CLAI) and supported by the WCC, in January–February 2004, stated:

8. With profound concern, we recognise that the HIV/AIDS situation reveals the different faces of the church. On the one hand, it reveals the face of indifference, where the church has met and heard the clamour of those who live and are affected by HIV/AIDS in its path, but has nevertheless passed by, like the priest in the parable of the Good Samaritan (Luke 10:27–35). We are also concerned at the Pharisaic face that, from its position of authority, thoughtlessly points an accusing finger and condemns those living in these circumstances as impure and reprehensible sinners. However, it is with gladness that we celebrate meeting the face of the church of love, solidarity and commitment. A face of the church which has encountered many difficulties in the first steps of this ministry to raise awareness, get to know, prevent, care for, accompany and involve oneself once again in this reality. In many cases this simply means to participate in the Easter message of resurrection, dying to rise up another day⁴³.

In March 2004, the World YWCA stated, “Therefore, the YMCA around the world hereby commits itself to work to eliminate stigma and discrimination in its communities, promoting the use of friendly language in every day communication and interaction”⁴⁴.

The World Council of Churches’ Pacific Member Churches on HIV/AIDS, in March–April 2004, stated that “we, the churches are encouraged to seek forgiveness from God and from Positive People, for not doing what we ought to have done, and for contributing to their pain and suffering. This will provide us with opportunities to heal our communities and liberate us to be a healing and reconciling community. It will also reaffirm our role as channels of the God given strength, to bring hope, succour and peace in the society”⁴⁵.

The Pontifical Council for Health Pastoral Care, on World AIDS Day 2004, stated “we must banish the stigma that so often makes society harsh in relation to the AIDS victim. In order to dissipate the prejudices of those who fear the proximity of AIDS victims because they want to avoid contagion, we should remember that AIDS is only transmitted through the three routes of blood, the link between a mother and her unborn child, and sexual contact. All these routes of transmission must be combated effectively and thereby eliminated”⁴⁶.

Religious Leaders in the Arab States, in December 2004, vowed to “break the silence around HIV/AIDS: We emphasize the need to break the silence, doing so from the pulpits of our mosques, churches, educational institutions, and all the venues in which we may be called to speak. We need to address the ways to deal with the HIV/AIDS epidemic based upon our genuine spiritual principles and our creativity, and armed with scientific knowledge, aiming at the innovation of new approaches to deal with this dangerous challenge. We reject and emphasize the necessity to abolish all forms of discrimination, isolation, marginalization, and stigmatization of people living with HIV/AIDS we insist on defending their basic freedoms and human rights”⁴⁷.

Breaking the silence around HIV and AIDS also involves respecting the rights of marginalized groups. For example, members of the World Alliance of Reformed Churches (WARC) have different views on homosexuality but Christians can agree that it is wrong to violate human rights because of sexual orientation, WARC General Secretary, Setri Nyomi, told delegates at the WARC's General Council Meeting in Accra, Ghana. WARC's Executive Committee has engaged in a study of where member churches stood. "While it is clear they have a variety of views on gays and lesbians, the executive committee came to the conclusion that we can together as Christians at least agree on the fact that it is wrong to violate the human rights of anybody for any reason - including sexual orientation," Nyomi said⁴⁸.

In addition to such statements, actions have been taken by churches to break the silence around HIV and AIDS within churches and to tackle HIV-related stigma. Some examples of churches responses include:

- At the All Africa Council of Churches (AACC) 8th General Assembly, Yaoundé, Cameroon, November 22–27 2003, free, voluntary on-site testing for HIV was offered. More people than expected came for testing. Of the 800 participants at the Assembly's, 105 were tested with demand initially surpassing the availability of testing kits. "As far as we are concerned, this is war," said Mvume Dandala, General Secretary of the AACC. "We declare unequivocally that HIV/AIDS is not the will of God for Africa; we will try with all we have to resist it"⁴⁹.
- In November 2004, the Anglican Church in Tanzania, Dodoma Diocese, announced that 12 of its priests are HIV-positive. Three of those priests have declared their status to the public, while the remaining nine are to do so at an "appropriate" time⁵⁰.
- Twelve years ago Canon Gideon Byamugisha, an Anglican priest from Uganda, stunned his fellow clerics and parishioners when he revealed his HIV-positive status. He was supported by his local Bishop and made a canon in 2001. Now he travels the world and is serving as a global role model and urging churches in Africa to help develop the right attitudes, skills, services and supportive environment to roll back the pandemic. Canon Gideon is believed to have been the first religious leader in Africa to make public his HIV-positive status when in 1992 he announced he had the virus, at a time when churches were consumed by denial about the phenomenon⁵¹.
- Twenty-seven Zimbabwean pastors from various Christian denominations underwent a voluntary HIV test in a move aimed at removing stigma in the

⁴⁸ *Sexual orientation no reason to violate rights, WARC delegates told.* Ecumenical News International 04-0496, Accra, Ghana, 2 August 2004.

⁴⁹ Carol Fouke with Dave Wanless, AACC. The United Methodist Newscope, Volume 31, No. 49/December 5, 2003.

⁵⁰ Okema, Michael. *So Far From God, So Close to Temptation*, The East African (Kenya), 1 November 2004.

⁵¹ AIDS calls for holistic response, says HIV-positive cleric 1 December 2004 Nairobi/Bangkok, Ecumenical News International, <http://www.eni.ch/> [657 words, ENI-04-0784]

For more information on Rev Gideon, see box 20 "Canon Gideon Byamugisha – the Anglican Church stands behind its pastors" in 4.3 Confidentiality of World Council of Churches, *Working with People Living with HIV/AIDS Organizations: Guidelines*, 2005.

church against people living with HIV/AIDS. The pastors from churches in the townships of Tafara and Mabvuku in Harare became the biggest group of church leaders ever to take an HIV test in Zimbabwe⁵².

In 2001, at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), the WCC facilitated a statement on behalf of faith based organizations, which outlined the successes and challenges of faith-based responses as follows:

Faith-based organizations are joining many other actors in the global fight against this devastating pandemic and can offer our specific resources and strengths. At the same time we acknowledge that we have not always responded appropriately to the challenges posed by HIV/AIDS. We deeply regret instances where FBOs have contributed to stigma, fear and misinformation.

However, it is also fair to say that FBOs have often played a positive role in the global fight against HIV/AIDS. Countries such as Senegal, Uganda, and Thailand which have involved religious leaders early on in the planning and implementation of national AIDS strategies have seen dramatic changes in the course of the epidemic. For example, religious communities in Uganda, working hand in hand with AIDS service organizations and the government, have championed peer education, counselling and home care programmes. A church leader has led the National AIDS Commission in Uganda since 1995. In Uganda, Zambia and Tanzania, prevention efforts have resulted in changed sexual behaviour including delayed sexual activity among adolescents, and a reduction in the number of sexual partners. These modifications of behaviour have been part of the message of many FBOs. In Thailand, Buddhist and Christian groups have introduced home based care services and greatly contributed to the destigmatization of the disease⁵³.

The follow up report to the UNGASS Declaration, appraised faith-based organizations responses in the intervening period, stating:

18. The importance of faith-based organizations in the response to HIV/AIDS was well recognized, given their long history of service in communities, their moral authority and financial and organizational resources that they command. In addition, these organizations boast a reach that cannot be matched and are often present in even the most remote areas. Representatives of faith-based organizations were frank in admitting that they had, in general, been slow to react to the epidemic, usually because of the stigma and moral overtones associated with being

⁵² Zimbabwe pastors take HIV tests in stand against prejudice 2 December 2004 Geneva Ecumenical News International, <http://www.eni.ch/> [388 words, ENI-04-0787]

⁵³ Statement by Faith-based Organizations facilitated by the World Council of Churches. *Increased Partnership between Faith-based Organisations, Governments, and Inter-Governmental Organizations*. UN General Assembly Special Session on HIV/AIDS, New York, United States, 25 - 27 June 2001.

http://www.unaids.org/en/events/un+special+session+on+hiv_aids.asp

HIV-positive. However, as more believers fall victim to the disease, the position of many religious leaders has evolved.

19. Today most faiths have taken up the challenge of HIV/AIDS, providing spiritual comfort and support to people living with HIV/AIDS and their families, challenging stigma and discrimination and incorporating education and prevention messages into worship services. Dialogue with international religious partners and ecumenical agencies such as the World Council of Churches was credited with having played an important role in encouraging change.

20. It was noted however that faith-based programmes operate within the framework of religious values that emphasized abstinence, fidelity and compassion towards the ill. For religious leaders present at these meetings, this has meant that certain prevention methods, including condom use outside of marriage or needle exchange programmes, could not be supported. In some regions, faith-based organizations are important providers of health services and this includes the treatment of individuals with AIDS. Few are currently able to offer treatment with antiretroviral drugs, a situation that is only likely to be corrected through the provision of considerable and sustained external assistance. In other regions, faith-based organizations considered health service provision to be beyond their limited resources and capacity and therefore something best left to others⁵⁴.

The Ecumenical HIV/AIDS Initiative in Africa (EHAIA established in 2002 as a joint undertaking of African churches, northern churches and agencies, and the WCC⁵⁵. This initiative has been strengthened by the involvement of PLWHA organizations and networks in governance and planning. Canon Gideon Byamugisha, a PLWHA, is part of International Reference Group – the Board of EHAIA – which guide the initiative both internationally and sub-regionally in Africa. UNAIDS - with whom WCC has worked closely – is also part of the governance with the Partnership Unit giving critical input and guidance in the processes. The four Regional Reference Groups of EHAIA also have PLWHA representation: Central Africa: Marianne Djamba, Kinshasa, Democratic Republic of Congo (DRC); Eastern Africa: Rose Njeri, Nairobi, Kenya; Southern Africa: Lynde Francis, Harare, Zimbabwe and Japé Heath, Johannesburg, South Africa; and West Africa: Samuel Williams, Freetown, Sierra Leone. All are members or part of the leadership of a PLWHA networks.

⁵⁴ United Nations General Assembly. Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS. *Implementing the Declaration of Commitment on HIV/AIDS: building partnerships and expanding national responses to HIV/AIDS*. Fifty-eighth session A/58/150. Item 48 of the provisional agenda, 2003. UN General Assembly Special Session on HIV/AIDS, New York, United States, 25–27 June 2001.

http://www.unaids.org/en/events/un+special+session+on+hiv_aids.asp

⁵⁵ The Ecumenical Response to HIV/AIDS in Africa, *Plan of Action, Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa*, Nairobi, Kenya, 25-28 November 2001. <http://www.wcc-coe.org/wcc/what/mission/ehaia-e.html>

The experience of the WCC in being a partner in the Communities Responding to the HIV/AIDS Epidemic (CORE) Initiative⁵⁶ has also broadened the scope of faith-based organizations involvement in working in partnerships with PLWHA organizations. More recently, the WCC has been part of a wider coalition in the drafting and promotion of a Code of Good Practice for Nongovernmental Organizations (NGOs)

⁵⁶ The Communities Responding to the HIV/AIDS Epidemic (CORE) Initiative <http://www.coreinitiative.org/> is a USAID-funded global program, whose mission is to support an inspired, effective and inclusive response to the causes and consequences of HIV/AIDS by strengthening the capacity of community and faith-based groups worldwide. The main approach of the CORE Initiative is to leverage existing efforts, while catalyzing and encouraging new efforts through diverse and innovative partnerships in the areas of community-based prevention, stigma reduction, and care and support to PLWHA and their families. Leading this initiative is CARE International in partnership with the World Council of Churches (WCC), the International Center for Research on Women (ICRW), the International HIV/AIDS Alliance, and the John Hopkins Bloomberg School of Public Health, Center for Communication Programs (CCP). With a global network of partners, the CORE Initiative provides state-of-the-art technical support and organizational development to community and faith-based organizations and other USAID partners to design, implement, and evaluate comprehensive community HIV/AIDS programming. Through the following principles, the CORE initiative strives to ensure that innovations are tested, best practices transferred and scaled up, and lessons learned documented.

- Applied innovation: encouraging and rewarding innovation among CBOs and FBOs.
- Learning and excellence: supporting and expanding excellence in HIV/AIDS programming defined by commitment, sustainability and impact.
- Partnering and collaboration: working with and through the full range of community, national, and regional implementers and donors.
- Responding to community need: creating mechanisms for engaging community actors in all aspects of HIV/AIDS programming.
- Taking a multi-sectoral approach: strengthening community capacity to address HIV/AIDS in the context of livelihood security, human rights, economic development, food security, education, health, and gender equity.

The CORE Initiative brings together key stakeholders, including PLWHA, CBOs and FBOs, non-governmental organizations (NGOs), private voluntary organizations, and donors to enable holistic programming and excellence in HIV/AIDS prevention, care and support at the community level. The CORE Initiative engages these stakeholders through eight strategic, interrelated program elements that provide funding, technical assistance, and information.

1. Close partnerships with various local, regional, international and U.S-based groups, including people living with HIV/AIDS - this will include consultations with CBOs and FBOs and associations of PLHA to identify needs and mechanisms for partnership.
2. Small Grants to provide seed money and technical support to build capacity and expand programmes.
3. Demonstration projects to scale-up and/or transfer successful innovations.
4. Knowledge management and learning.
5. Capacity-building support to CBOs and FBOs and their regional and international coordinating bodies.
6. Technical support to USAID Missions in how to effectively and appropriately support a multi-sectoral response of CBOs and FBOs to the HIV/AIDS epidemic.
7. Donor and implementer coordination.
8. Monitoring and evaluation mechanisms at all levels that effectively and accurately capture the strengths and weaknesses of community and faith-based. Working with partners to insure the Greater Involvement of People Living with HIV/AIDS (GIPA) Guidelines are applied will be significant to the response.

Over 50 resource organizations, including the International Community of Women Living with HIV/AIDS, Islamic Medical Association of Uganda, Salvation Army, World Conference on Religion and Peace, and YMCA have pledged their support to this effort. The CORE Initiative will be implemented in a spirit of mutual learning, sharing, and partnership, involving PLWHA and their support organizations in the hope of preventing and mitigating the impact of HIV/AIDS epidemic.

responding to HIV and AIDS (the Code).⁵⁷ The drafting process has again raised the need to bring about specific changes in the life of churches and faith based organizations in order to promote and uphold the Greater Involvement of People Living with HIV and AIDS (GIPA) Principle (*see* 1.4 The Imperative to Work with PLWHA Organizations).

The WCC, and some 30 related networks and member organizations signed the Code at the end of October 2004. Their signature makes these faith-based organizations accountable to the norms contained in the Code. A focus on assisting member churches to work more closely with PLWHA in a measurable manner is an essential follow-up process after signature. This will ensure that the gains made by the churches in the realm of HIV prevention, HIV and AIDS care as well as HIV/AIDS advocacy will be owned by the whole community and will be rooted in the life of churches.

The lessons learned for partnerships from the above initiatives have been:

- PLWHA need to be part of both the planning and governance of initiatives in HIV/AIDS.
- Faith-based organizations have to be accountable not only to their own constituencies but also to governments, NGOs and international bodies. This means faith-based organizations need to be transparent in their workings and open guidance from a broader of stakeholders.
- Specific measurable mechanisms, including for monitoring and evaluations, have to be in place to ensure that organizations are held accountable to the stated principles.

⁵⁷ Renewing Our Voice: Code of Good Practice for NGOs Responding to HIV/AIDS
<http://www.ifrc.org/what/health/hivaids/code/>

Chapter 3

Partnerships

This chapter explores partnerships in general including those between churches that have existed for many years. In relation to forming partnerships between churches and PLWHA organizations issues such as why form such partnerships, covering gospel imperatives and the benefits to both parties; sources of funding; and some of the difficulties faced by both churches and PLWHA and their organizations in forming partnerships, are covered. Other issues such as the relationship between partnerships and programmatic work as well HIV- and church-related issues which may impact upon a church/PLWHA organization partnership are also covered. The chapter concludes with a section outlining concretely what partnerships between churches and PLWHA organizations look like at various levels i.e. church leadership, theological training, parish priest or minister, women's groups etc.

3.1 What is building partnerships?

Building partnerships is about working with others to achieve what we cannot achieve on our own. A partnership is a special kind of relationship, in which people or organizations combine their resources to carry out a specific set of activities. Partners work together for a common purpose, coherence and for mutual benefit. The advantage of working in partnerships is that different people and organizations have a wide range of resources to offer each other.

NGOs use different words to refer to building partnerships. For example, some talk about “external relations” or “strategic alliances”. It is important that churches define for themselves the meaning of key words such as “collaboration”, “strategic alliances”, “partnerships” etc. that they commonly use.

Building partnerships is about relationships that are in-depth, involve a few carefully selected targets, and have specific, practical goals. It is different from “public relations” or “networking” – where activities are likely to be less in-depth, involve many more targets and have the general purposes of information sharing and solidarity. Although building partnerships and “public relations” are different, they can both help a church and its HIV/AIDS work in communities. Partnerships can be time limited or task driven.

In building partnership, it will be helpful for the churches to recapture the creation theology of Genesis 1-2. That is, God is the creator of everything and of all life; that *God created all things good* (Genesis 1:4,10,12,18,31). Further, that God gave human beings stewardship – to maintain the earth's goodness (Genesis 1:28). HIV and AIDS destroy God's created life and its goodness. By working with all stakeholders in the HIV/AIDS struggle and particularly with PLWHA organizations, churches can see themselves as being *co-creators with God* in fighting to maintain life and its goodness in the face of HIV/AIDS plunder.

Almost all churches already have experience in building partnerships – many have decade long partnerships with sister churches. Many of these partnerships have been between churches in the North and those in the South. However, the relationship between partners has often been unbalanced with power over finances and direction residing in northern churches. Partnerships between churches on HIV/AIDS offer an opportunity to redress this imbalance, to create an equitable relationship. The greatest needs are in developing countries, and responses should reflect the lived need and experience of PLWHA and their churches.

Interesting initiatives of North–South church and faith based organization co-operation and partnership are described in boxes two to four below. They highlight the efforts being brought to bear by churches and faith-based organizations to increase funding so as to be able to scale up their programmes and projects.

Box 2: The United Church of Canada – Beads of Hope Campaign⁵⁸

The United Church of Canada, Canada's largest Protestant denomination instituted the two year (December 2002 – December 2004) Beads of Hope Campaign designed for HIV awareness raising, advocacy, and fundraising campaign, hoping to:

- take action to improve policies which impact the lives of people living with or affected by HIV/AIDS;
- increase awareness and engagement in HIV/AIDS related issues in the church at all levels; and
- raise one million Canadian dollars to support global partner responses to the HIV/AIDS crisis.

Congregations were invited to make use of the Beads of Hope materials to raise awareness about the HIV/AIDS pandemic in their own congregations. The Beads of Hope Campaign was [inspired by the beaded pins](#) made by women's groups in South Africa, and Zambian men and women who are living with HIV/AIDS, and have become a sign of support for the millions of people with HIV/AIDS. Just before World AIDS Day, the UCC reported that the campaign had netted two million dollars, double its original objective⁵⁹.

The Beads of Hope Campaign supports global partner work in a number of areas:

- raising awareness about how HIV/AIDS is spread;
- advocacy to improve policies that impact HIV/AIDS and people living with AIDS;
- providing accessible HIV/AIDS testing and counselling;
- supporting people with HIV/AIDS and affected families (including HIV/AIDS orphans);
- training leaders to help communities better respond to the virus; and
- increasing the capacity of organizations to better engage in the fight against HIV/AIDS.

⁵⁸ See <http://www.united-church.ca>

⁵⁹ *Canadian church's AIDS campaign doubles fundraising objective.* Ecumenical International News, Ottawa, Canada, 30 November 2004.

The UCC is in partnership with councils of churches, denominations, and non-governmental agencies in more than 40 countries in Africa, Asia, and the Caribbean and Latin America. Partners have developed programs, expertise, and become prominent national actors in the fight against the spread of HIV/AIDS. As partners,

they receive ongoing support through the UCC's Mission and Service Fund (M&S), but the need is beyond the support that is possible through M&S. Hence the campaign.

Box 3: International Orthodox Christian Charities and Ethiopian Orthodox Church expand anti-AIDS Campaign⁶⁰

In Ethiopia, a country of 70 million inhabitants with some 50% of people said to be Orthodox Christians, and the third largest number PLWHA in the world (2.2 million PLWHA and 1.2 million orphans orphaned by AIDS), the customary greeting from an Orthodox priest to his parishioners has become, "May God save you and your family from AIDS." The AIDS epidemic has affected Ethiopia like few other countries in Africa, prompting an increasingly vigorous effort by the Ethiopian Orthodox Church to educate the nation about the disease and to care for the afflicted.

Patriarch Paulos has become an outspoken leader on the challenge of HIV in Ethiopia, holding large "Save the People" rallies each year. The Church also regularly promotes its anti-AIDS message in worship services, Bible studies and Sunday school classes. Because of its size, the Ethiopian Orthodox Church is uniquely equipped to deliver this message to a large segment of the population. With 35 000 churches and monasteries, and 500 000 clergy, including priests, deacons and monks, the Church has access to the most remote parts of Ethiopia.

Now, that campaign is getting a boost from International Orthodox Christian Charities (IOCC), the humanitarian aid agency of Orthodox Christians. The new IOCC program will strengthen the anti-AIDS efforts of the Ethiopian Orthodox Church and its humanitarian arm, the Development and Inter-Church Aid Commission (DICAC). "This battle requires the cooperation of everyone within Ethiopia, and from outside, who has the resources and expertise to help," said His Holiness Abune Paulos, Patriarch of the Ethiopian Orthodox Church. "Saving life is the Church's fundamental obligation and its sacred duty and responsibility."

The three-year, US\$ 6 million project, supported by the U.S. Agency for International Development (USAID), aims to:

- Build the Church's capacity to care for AIDS orphans and to give palliative and hospice care to PLWHA. By 2006, the project plans to extend faith-based community care to nearly 9000 orphans and vulnerable children, providing them with adult supervision and access to education, health care, food, shelter

⁶⁰ IOCC, *Ethiopian Orthodox Church expand anti-AIDS Campaign - new \$6 million agreement with USAID will strengthen efforts*, 5 February 2004. www.iocc.org

and other forms of assistance.

- Reduce the incidence of HIV infections in Ethiopia through an educational campaign that promotes the importance of abstinence and/or faithfulness to one partner, especially among young people ages 15 to 24.
- Training of counselors who will spread the message of AIDS prevention beyond the life of the program, and who will train others. With this model of "trained trainers," thousands of counselors will be available to support the anti-AIDS campaign by 2006.
- Expand the Church's network of "Hope Centers" for AIDS orphans - increasing the number of centers from the current 13 to 200.
- Expand hospice care for people living with HIV/AIDS – increasing the number of community-based programs to 250 by the year 2006.

Box 4: United Methodist Global AIDS Fund

In response to the global HIV/AIDS pandemic, The United States United Methodist Church adopted a resolution at the 2004 General Conference to establish a Global AIDS Fund, stating:

Whereas, to date, the response of Christians, including United Methodists, has been minimal, particularly in comparison to our resources and other commitments.

Therefore, be it resolved that the 2004 General Conference, therefore, commits itself to establishing the United Methodist Global AIDS Fund (UMGAF). During the 2005-2008 quadrennium, United Methodists will raise US\$ 8 million through Advance Specials.

Be it further resolved, of the total money raised in each annual conference for UMGAF, 25 percent shall be retained by the annual conference that raised it, to be used in programs combating HIV/AIDS in their region and in other global connectional projects. Each annual conference shall designate an appropriate agency for the promotion and distribution of these funds.

The United Methodist Global AIDS Fund will:

- Assist local congregations and conferences in identifying and creating global partnerships for mutual HIV/AIDS ministry.
- Provide support for projects sponsored by local congregations or organizations related to the United Methodist Church, partner autonomous Methodist churches and the ecumenical church.
- Encourage partnerships between congregations and conferences in the United States and Methodist congregations and ecumenical organizations globally that are engaged in the struggle against HIV/AIDS.
- Advocate for social justice, particularly related to increasing governmental and non-governmental funding and issues regarding the role of pharmaceutical companies.
- Develop appropriate promotional materials and funding guidelines.
- Engage the leadership of a person with appropriate skills for a special global

Reflection

Then I heard the voice of the Lord saying: “Whom shall I send, and who will go for us? And I said, “Here am I; send me” (Isaiah. 6:8).

Identify the key words that are used when talking about building partnerships outside the church world, and make a statement or a drawing that expresses the meaning of each word by linking it with some of the biblical ideas in the above mentioned verse.

3.2 With whom can partnerships be built?

Partnerships can extend to representatives of civil society, to NGOs, to associations of PLWHA, to the United Nations, to women’s groups, to the private sector, to government and, of course, to other faith-based organizations.

Health-care professionals are key partners for religious leaders as they can fill in important gaps in knowledge, expertise and experience, and provide information about services, symptoms, treatments and psychological needs.

The media are also critical partners. Churches need to take the initiative to build relationships with journalists, encouraging them to better understand the church’s perspective and to focus more on solutions and less on sensationalism. An example of this is the media workshops held as part of the Ambassadors of Hope Programme undertaken by Churches United against HIV/AIDS in southern and Eastern Africa (CUAHA)⁶¹ in conjunction with African Network of Religious Leaders Living with or

⁶¹ CUAHA <http://www.cuaha.info/web/> is an ecumenical network of churches and faith-based organizations involved in capacity building of its partners working with people affected by HIV/AIDS. The overall objective of the project is to reduce the number of new HIV infections and improve care through integrating HIV/AIDS work as a part of the work by churches, church related organisations and faith based organizations. The aim is to reduce high-risk behaviour and, at the same time, fight against social exclusion and stigmatisation that PLWHA deal with.

The project’s goal is to strengthen the capacities of its partners through providing conditions where the partners can share their materials, best-practices, innovations and know-how to create common strategies and methods, as well as to create common projects and campaigns in their HIV/AIDS programmes. These include preventive, supportive and caring work as well as tolerance-building. Emphasised are actions and projects crossing borders between countries, cultures or denominations.

CUAHA consists of members from 24 Catholic, Lutheran, Anglican, Pentecostal and Orthodox churches and organizations in twelve African countries: Angola, Botswana, Ethiopia, Kenya, Malawi, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda and Zimbabwe as well as partners from Finland. Started in 2002, CUAHA responded to requests from churches, church-related NGOs and faith-based organizations in Eastern and Southern Africa to their Finnish partners to join efforts and resources in the fight against the HIV/AIDS pandemic. The project is supported by the development cooperation funding for non-governmental organizations, provided by the Ministry of Foreign Affairs of Finland. Funding is also provided by several Finnish church-related organisations. The network

personally affected by HIV and AIDS (ANERELA+). In the media workshops time is spent sharing with journalists and clergy the important role that they can play in overcoming stigma and giving accurate information. Journalists and clergy are also challenged with regard to stigmatizing language.

Many churches already have long-term partnerships with sister churches some of whom provide financial support. For example, the Ethiopian Orthodox Church is to receive US\$ 6 million from International Orthodox Christian Charities (IOCC), the United States-based Orthodox Christian aid agency, to boost the church's struggle against HIV/AIDS⁶².

Churches need to recognize their own weakness in organizational structures and the need for technical support from UN agencies and NGOs in developing materials and capacity. Many churches need financial support but must also acknowledge their own responsibility to contribute their own resources. Donor organizations, in turn, need to recognize that churches can, and do, contribute resources including personnel and meeting facilities. Box five below “Where are all the big church projects?” raises

builds on already functioning Finnish – African cooperation contacts and existing networks, both South-South and South-North.

CUAHA has defined six thematic components in which they are concentrating their efforts:

- Advocacy: 'Ambassadors of Hope' where CUAHA supports a group of infected or affected volunteers who will advocate publicly for positive living in hope, and support local groups in their work. The first CUAHA video, “Ambassadors of Hope”, was launched in Dar es Salaam, on November 30, 2003. The video is available now in both English and Swahili. For the video, contact Maria Owen info@cuaha.info Contact Euni Motsa, Lutheran Development Service, P.O. Box 388, Mbabane, Swaziland H100. Tel: +268-404-2562 lds@realnet.co.sz
- Information, Communication and Networking, the purpose of which is to achieve strengthened an improved information sharing and communication capacity and well-functioning communications within CUAHA in collaboration with other co-existing networks. One of the activities has been media sensitisation seminars. Contact through CUAHA regional office, Maria Owen info@cuaha.info For further information about media sensitisation workshops: Mari Teinila, Mari.Teinila@kotimaa.fi
- Diaconia (Caring Ministry), social services and pastoral care. The purpose is to strengthen the churches to carry their social responsibility and empower them as healing communities. Contact through CUAHA Regional Office: Maria Owen, Regional Network Coordinator. P.O. Box 105647, Dar es Salaam, Tanzania. Tel/Fax: +255-22-2667657 info@cuaha.info or maria@cuaha.info
- Theology and Ethics with the purpose to agree upon and work on a common agenda on theological understanding and ethics in issues regarding HIV and AIDS. Contact Dr. Veikko Munyika, CUAHA Co-Chairperson, Evangelical Lutheran Church in Namibia, P/Bag 2018, Ondangwa, Namibia. Tel: +264-65-240241 gen.sec@mweb.com.na
- Education and Training, with the purpose to achieve capacity building by improved skills and knowledge of the clergy and professional church workers, including volunteers to deal with issues related to HIV and AIDS. Contact Rev. Simon Mureithi, Full Gospel Churches of Kenya, P.O. Box 28272, Nairobi, Kenya. Tel: +254-20-785273 smmureithi@yahoo.co.uk
- Arts and Culture with the purpose to use arts and culture as an integrated element in CUAHA activities. Contact Olli Pitkanen, Fida International, P.O. Box 50, 00421 Helsinki, Finland. olli.pitkanen@fida.info

CUAHA Helsinki Team: Birgitta Rantakari, CUAHA Chairperson, Helsinki Deaconess Institute, Alppikatu 2, 00530 Helsinki, Finland. Tel: +358-9-7750-4730
birgitta.rantakari@helsingindiakonissalaitos.fi

⁶² Ethiopian church to receive million-dollar boost for anti-AIDS work, Nairobi, Kenya. ENI-04-0066, 9 February 2004.

questions about the lack of proposals being submitted by churches and faith-based organizations to donors.

While sometimes certain churches may feel shy or incompetent to work in partnership with UN agencies, NGOs and governments or to tap their skills and resources, it is time for churches to remember that, “the earth is the Lord’s and all that is in it, the world and all those who live in it,” (Psalms 24:1). These other stakeholders must be seen as God’s people, using God’s gifts and equally labouring to maintain the goodness of the earth. Partnership should therefore be sought and developed.

Box 5: Where are all the big church projects?⁶³

A personal comment from Christoph E. Mann, Project Manager, World Council of Churches, cma@wcc-coe.org

Nobody in the church denies that HIV/AIDS is in the church, and that even if it were not, churches must respond to the suffering of the world. But very few quality projects that match the challenge are submitted to big donors by churches. Why?

Because nobody is giving money for this?

Not at all – there are billions of US\$ available for HIV/AIDS prevention and care, and to deal with the consequences of the epidemic. Some of the real big sources are The Global Fund, the MAP facility of the World Bank, and USAID. Numerous medium-size donors are there as well, such as foundations, governments and NGOs – these are still big in comparison with traditional church donors. For example, the Global Fund just approved its third round of projects amounting to approximately US\$ 600 million. At least the same amount will be approved later this year. How many churches are preparing requests?

Because these donors do not want to give money to churches?

The opposite is true – they seek the cooperation of faith-based organizations because they know that in many areas, they have unique opportunities to reach the people in the suburbs and in the bush. In my opinion, it is not just coincidence that a Protestant theologian and medical doctor were recently made the Global Fund’s director for External Relations.

Because churches feel they do not have the capacity to run huge projects?

Maybe, but some of the medium-size and small donors even offer training to build up capacity for planning and managing. In a very decentralized way, churches handle quite a lot of people and money already, especially in the field of health care and charity. A few examples show that church organizations can indeed scale up to be meaningful and professional national players. For example, the Christian Health Association of Zambia (CHAZ) has become a principal recipient of Global Fund money in the country, which means that it receives sizeable amounts for its own use and to pass on to other members of the national country coordinating mechanism. And not only that, CHAZ was visited and praised by international authorities during the

⁶³ EHAIA News No. 4, <http://www.wcc-coe.org/wcc/what/mission/ehaia-news-e.html>

last World AIDS Day for its superior quality work.

So why aren't there hundreds of country-wide denominational or ecumenical or inter-faith projects to combat HIV, for which churches are particularly suitable?

- Because churches are afraid of HIV-positive people?
- Because churches are morally stigmatizing them?
- Because churches shy away from talking sex – this life-creating gift of God?
- Because churches can not face the truth for which the Gospel has set them free?
- Because it would mean too much loss of power for church leaders if a professional project director handled (and earned) more money than the bishop?

Have I got it all wrong?

But then, where are all the big projects to help the ailing church hospitals, the orientation-seeking youth, the isolated and stigmatized women who care for the sick, the orphans and impoverished children resulting from HIV? I can see only a few; they give hope, but are only drops in the ocean of the epidemic.

No partnership is more critical than with communities themselves – where families and children live and die. Care needs to be bolstered with community level strategies, mechanisms and structures that are best equipped to identify the needs of families, mobilize support and deliver services.

Churches must also face the challenge of entering new arenas of activity - arenas that they have previously generally ignored or felt lay outside their responsibility, including the political arena. Access to treatment must be high on churches' agenda. Churches have a legitimate, even essential role in advocating for policies, laws and programmes that prevent HIV infection and provide care for PLWHA. This means using a full range of advocacy efforts for being involved in policy discussions right through to direct action on the street. For example, on World AIDS Day 2003, in Washington, D.C., interfaith leaders held a vigil at the United States Treasury building and a press conference to send a call to President George W. Bush and Treasury Secretary John Snow for greater leadership on global AIDS and debt. In letters addressed to both Snow and Bush, the religious leaders called for an increase in funding to at least US\$ 5.4 billion for global AIDS, tuberculosis, and malaria relief in the President's 2005 budget request, along with full debt cancellation for impoverished nations in order to free up resources to fight the HIV/AIDS pandemic.⁶⁴

Entering the political arena will open the church to new partners working on HIV and AIDS, and ultimately draw churches into the Global Fund for AIDS, TB and Malaria's (Global Fund)⁶⁵ funding process. Some church-related networks such as Churches Health Association of Zambia as well as international church-related organizations such as Caritas Internationalis and World Vision have already

⁶⁴ Newscope, A Newsletter for United Methodist Leaders, Vol. 31, No. 49/December 5, 2003.

<http://www.umph.org/resources/publications/newscope/viewIssue.asp?id=211>

⁶⁵ For more information: <http://www.theglobalfund.org/en/>

succeeded to a great extent in this area. Boxes six to eight, which follow, provide details of the processes undertaken by three different faith-based organizations in relation to the Global Fund.

Box 6: Churches Health Association of Zambia (CHAZ)⁶⁶

Established in 1970, CHAZ, an umbrella organization of church health institutions and community based organizations, is one of the largest health care providers in Zambia, accounting for approximately 50% of rural area coverage. Due to its extensive infrastructure and local experience, the Zambia Country Coordinating Mechanism (CCM) chose CHAZ as the principal recipient to disburse funds to faith-based organization for an integrated HIV/AIDS, tuberculosis and malaria grant from the Global Fund on AIDS, TB, and malaria.

The Global Fund and CHAZ signed grants totalling nearly US\$ 10 million for HIV and TB in March, and Malaria in September 2003. CHAZ oversees the implementation of these programmes, which aim to make significant inroads into the disease burden in Zambia. Through comprehensive treatment and prevention efforts, the HIV and AIDS programme plans to reduce HIV prevalence in youth aged 15–19 by 4 % and decrease the number of mothers passing the infection to their children by over 20%. The malaria programme plans to decrease morbidity and mortality by distributing over 1.5 million insecticide treated bed-nets and scaling up distribution of Artemisinin Combination therapy – the most effective malaria treatment, particularly in areas with drug resistance. The TB programme is increasing the number of health centers providing Directly Observed Treatment Short-course (DOTS), the agreed international standard for TB control in order to increase the cure rate of new cases to 57%.

⁶⁶ Communication with Dr.Simon Mphuka, Churches Health Association of Zambia (CHAZ), mphuka@zamnet.zm

Box 7: Caritas Internationalis⁶⁷

The network of Caritas Internationalis and other Catholic organizations engaged in the response to HIV and AIDS have convened two working groups of experts from both North and South to develop guidelines for Catholic agencies engaged in anti/retroviral (ARV) programmes, including involvement with the Global Fund. The first such consultation was convened in Wurzburg, Germany, during August 2001, before the creation of the Global Fund. The second was convened in Paris, France, during April 2004 and took into account Caritas' interest in and promotion of the Global Fund as well as WHO's "3 by 5" Initiative.

Some Catholic agencies have received funding through the Global Fund. In Madagascar, Catholic Relief Services serves as the conduit for Global Fund monies in the absence of a Country Coordinating Mechanism (CCM); while in Rwanda, the national Caritas organization serves on the CCM. In some other countries, however, the Catholic agencies report many difficulties with the application process for Global Fund monies, including a lack of understanding of non-governmental organizations by the CCM and more pointed discrimination against faith-based organizations.

Box 8: Programmatic track record, technical expertise and political savvy: World Vision International's formula for proposal success⁶⁸

World Vision International (WVI) is a faith-based global NGO that has offices in 100 countries, a mix of developed and developing countries. Long before policy gets translated into calls for proposals, WVI was involved in the processes, which led to the establishment of the Global Fund.

A public-health physician, Dr. Milton Amayun, was designated the WVI focal point, participated in the consultations that led up to the Global Fund's establishment, and primed the network of WVI offices on this new, potential funding source. He developed a strategy of engagement and maintained relationships with various organizations with interest in HIV/AIDS. Finally, he presented WVI's work in different forums on HIV/AIDS.

In early 2002, information about the Global Fund was gradually spreading. WVI's national offices were encouraged to be ready with their programmes and staff, who could participate in the proposal writing process. In a meeting of African staff on HIV/AIDS in Johannesburg, presentations on the Global Fund and training in HIV/AIDS programme development was undertaken.

⁶⁷ Communication with Fr. Robert J. Vitillo, Special Adviser for HIV and AIDS, Caritas Internationalis. Bobvitillo@cs.com

⁶⁸ Communication with Milton B. Amayun, MD, MPH, Senior Technical Advisor, The Hope Initiative, World Vision International, iamilton@aol.com

When the Global Fund's first call for proposals was issued, many WV staff around the globe had known about it for several weeks. Due to their ongoing relationships with Ministries of Health, a number of national directors were invited to sit on Country Coordinating Mechanisms (CCM) or to write parts of the country proposal.

WVI's policy has been to help CCMs write quality proposals, offering WVI's resources in whatever way possible. Local staff in Armenia, Cambodia, Dominican Republic, Democratic Republic of Congo, East Timor, Lesotho, Philippines, Tanzania, Thailand, Uganda and Zambia were actively involved in developing country proposals. In Sierra Leone, WVI co-sponsored the proposal writing team. In the Democratic Republic Congo, WVI supplied a TB expert from Canada. Dr. Amayun assisted in writing proposals for Lesotho, Mali, Mozambique and Sierra Leone - "countries that could not afford technical assistance for their proposals."

The experience of WVI's country programmes assisted in this process as many country offices already ran substantial HIV/AIDS and health programmes with extensive staff expertise in programme design.

Over the last three years, WVI's approved Global Fund portfolio has grown to around US\$ 100 million. This sum includes acting as the Principal Recipient for HIV/AIDS in Armenia (US\$ 7 million) and Guatemala (US\$ 40 million), and for TB in Somalia (US\$ 13 million).

The resources are budgeted for a variety of interventions, including HIV prevention, orphan care, purchase of pharmaceuticals, and support for grassroots initiatives. For TB, community-based treatment is the main intervention; for malaria, prophylaxis and treatment, bed nets and laboratory support are the principal interventions.

Collaborative responses between denominations and ecumenical bodies are occurring in different forms throughout Africa. The following examples are taken from *Responses of the Faith-Based Organizations to HIV/AIDS in Sub Saharan Africa*.⁶⁹

Mozambique is a country which suffered 16 years of civil war, cyclic floods and a severe drought. An estimated 13% of the population is living with HIV and AIDS. Some 40% of the population has no access to health services, the illiteracy rate is 60% and there are 300 000 orphans. In the midst of this poverty, the HIV/AIDS Christian Network has taken the bold stand of "Faith as an Instrument of Change" with a declaration, approved by the Council of Churches for Mozambique and the Evangelical Association, October 2002 that encapsulates a deep commitment to respond to HIV/AIDS.

In another Mozambiquan initiative, 74 different churches are jointly collaborating in a project called 'Kubatsirana.' Its mission is to work ecumenically through church structures at grass roots by training pastors and volunteers to provide HIV and AIDS

⁶⁹ Parry, Dr Sue. *Responses of the Faith-Based Organizations to HIV/AIDS in Sub Saharan Africa*, Southern Africa Regional Co-ordinator: World Council of Churches, Ecumenical HIV/AIDS Initiative in Africa (EHAIA), 2003. <http://www.wcc-coe.org/wcc/what/mission/ehaia-documents-e.html>

awareness, hands-on programmes of care, support, training and follow-up. They are building capacity within the church and the local community to develop and maintain their own programmes.

In Namibia, Catholic AIDS Action can be seen as a unique but highly replicable model of a national HIV/AIDS programme built within church structures. With the support of the Namibian Catholic Bishops Conference, Catholic AIDS Action has fourteen offices nationwide and utilizes the existing structures of the 90 parishes, 300 Christian communities, hospitals, clinics, schools and hostels as a basis for spreading the message of prevention and care. Home based family care, voluntary counseling and testing services, community mobilization, support for orphans and vulnerable children and support for PLWHA are all based on the Christian values of human dignity and provide spiritual, emotional, social and physical care and support. In collaboration with Catholic Health Services and the Namibian Ministry of Health, Catholic AIDS Action volunteers provide support and encouragement for individuals receiving antiretroviral therapy. This model served as an inspiration for the Lutheran communities who also took up the challenge, within their own spheres of influence, and collaborated significantly with the Catholics⁷⁰.

In South Africa, the Treatment Action Campaign <http://www.tac.org.za/> is courageous, widely supported by the FBOs, as it keeps the international spotlight on the need for ARVs for the country.

Muslims have networks that are replicable models for other countries and regions for example: The Islamic Medical Association is a network which deals with HIV/AIDS health issues. The Islamic Leadership Association, South Africa, a network for HIV-positive Muslims <http://positivemuslims.org.za/> has a telephone hot-line to support community members in their hour of need. The collaboration between Muslims, State and other faiths in Senegal has become recognized as UNAIDS 'Best Practices'⁷¹.

In Botswana, with the government providing for most needs, it took a long time for churches to take up the challenge of HIV and AIDS. However, when they did, they formed Botswana Christian AIDS Intervention Programme (BOCAIP), a collaborative effort between denominations to fill the gaps, to supplement and complement government efforts, and established a counselling service and network that is second to none and has now become a regional initiative stretching to Liberia. See box 14 "Providing hope amidst despair – the example of BOCAIP" in section 3.11 What does building partnerships mean in practice?

Ethiopia has formed 'The Organization for Social Service for AIDS in Ethiopia' bringing in religious organizations and HIV/AIDS focused NGOs to support the Ministry of Health. Its training of religious leaders, formation of anti-AIDS clubs, and other services is having considerable impact.

⁷⁰ For further information, contact Richard W. Bauer, MM, LCSW, Chief Executive Officer, Catholic AIDS Action, P.O. Box 11525, Windhoek, Namibia. Tel: +264 61 276350; email: Rick@caa.org.na, www.caa.org.na

⁷¹ UNAIDS, *Acting early to prevent AIDS: The case of Senegal*, (1999) at 12 <http://www.unaids.org/NetTools/Misc/DocInfo.aspx?href=http%3A%2F%2Fgva%2Ddoc%2Dowl%2FWEBcontent%2FDocuments%2Fpub%2FPublications%2FIRC%2Dpub04%2Funa99%2D34%5Fen%2Epdf>

Kenya hosts numerous faith-based associations, councils, organizations, secretariats, consortia and networks that are not only national but also regional and international. Because they are umbrella organizations, or have chapters in many countries, they represent a huge constituency of some millions of believers and as such have the potential for enormous influence.

Early in the epidemic, the Government of Uganda exhibited a high level of political commitment to addressing the emerging problem. The external help that Uganda received may have had an impact but this was not the only determinant in turning the tide of HIV. The government and the people themselves recognized, from the beginning, that the response to HIV lay in their own hands and could only be truly effective if they united and took responsibility. Churches in Uganda, to their credit, stood side-by-side with the government and put their full weight behind the campaigns. Whilst the secular response was 'condom promotion' and responsible behaviour, the message from churches was 'abstinence and fidelity'. Alongside the government's educational campaign entitled "Love Carefully," churches developed their own "Love Faithfully" campaign. These two leading focuses of influence and authority agreed not to undermine the efforts of each other nor contradict the messages, but to do what each could do best within their own spheres of influence. In Africa, this was a unique response.

In practice, building partnerships is different for every church and faith-based organization – depending on their needs, priorities and projects. However, it may include working with:

<ul style="list-style-type: none"> • Local Government Departments • National AIDS Programmes • Community radio stations • Lawyers • Farmer's representatives • Midwives groups • Traditional leaders • Newspapers • Rotary clubs • Human Rights groups • Factory owners • Foundations • Other Priests, Mullahs or Monks • Women's clubs • Local philanthropists • Business leaders • Advocacy NGOs 	<ul style="list-style-type: none"> • Civil servants • United Nations bodies • International donors • Presidents • People living with HIV and AIDS organizations • Influential individuals • Social workers • Arts groups • Youth groups • Health professionals • Local councillors • Academics • Police • Churches, mosques or temples • Traditional healers • Politicians
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Reflection

Then he said to them, “Is it lawful to do good or to do harm on the Sabbath, to save life or to kill? (Mark 3:1–6)

In the light of the above scripture, consider all of the potential partners who are responding to HIV in your local area. Of these who could your church establish partnerships with?

3.3. Why Partner with PLWHA Organizations?⁷²

There are many reasons why involving PLWHA is important in the response to the HIV epidemic and to the life of churches. At the social level, publicly acknowledged involvement helps reduce stigma and discrimination, and sends a signal to society regarding acceptance and recognition of PLWHA.

In addressing stigma, PLWHA are the churches’ most precious resource. They have been described as the ‘wounded healers’ of our time. Their full inclusion in all aspects of the church’s life is the best possible strategy for changing attitudes and removing fear. The experience of living with HIV or AIDS raises profound questions about the meaning of suffering and the nature of God and in sharing these insights, the spirituality of the whole worshipping community may be enriched. PLWHA have commented that the liturgies and rituals of the Church have been a great source of strength, particularly when they are combined with the support of the worshipping community⁷³.

Within churches, involvement can be a powerful tool for breaking down barriers, whether subjective or objective. For example, since 1996 the JL Zwane Memorial Church, named after the founder Rev. Jeremiah Lafangaye Zwane, *see* box nine below, a constituent member of the Uniting Presbyterian Church in Southern Africa, in Guguletu, Cape Town, South Africa, has adopted a policy of “No Preaching before a PLWHA speaks” and the impact has been evident in reducing HIV-related stigma through creating a supportive environment.

⁷² This and the following section are adapted from UNAIDS. From Principle to Practice: Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA), 1999.

⁷³ Vitillo, Rev. Robert J. HIV and AIDS: The Challenge and the Context. Why Should Churches Respond to Issues of Stigma and Discrimination in Reaction to HIV and AIDS? In UNAIDS, *A Report of Theological Workshop Focusing on HIV and AIDS Related Stigma*, Windhoek, Namibia, 8-11 Dec 2003. www.unaids.org

Box 9: No Preaching before a PLWHA speaks⁷⁴

In the JL Zwane Memorial Church, has allowed and requested PLWHA or those affected to speak in church every Sunday just before the sermon and share their experiences. Sometimes there has not been a single dry eye in church. The congregation has learnt to respond to those who share their experiences by giving much needed support. This way the whole congregation is challenged to reflect theologically on the implications of this epidemic. For example, last Sunday a woman whose husband left her on finding out her HIV status was speaking with her mother-in-law. She told the congregation how afraid she was to disclose her status and how well and lovingly she was received by her mother-in-law. She has three children, a twelve year old who is HIV negative and twin girls who are HIV positive. Her husband left them and they are happy with their mother-in-law who is taking good care of her son's family. They both pleaded with mothers in law not to quickly put the blame on daughters in law but learn to be more accepting.

Stigmatization of and discrimination against PLWHA is widespread, though it is often subtle or hidden, and is not even always consciously recognized as such by those who stigmatize or discriminate. Working with HIV-positive individuals on a daily basis, and having a name and face to associate with the concept of “people living with HIV or AIDS” – where previously the association was with a virus or terrible disease – helps people overcome their fears and prejudices, and change their perception of PLWHA. By providing a basis for partnership, mutual respect and understanding, involvement breaks down simplistic concepts of “service giver” (that is, the person who is not HIV-positive) and “service receiver” (the person who is).

As well as reducing stigma and discrimination, partnerships can expose a church or faith-based projects and programmes to the unique perspectives of PLWHA – bringing the lived experience of PLWHA to churches and faith-based organizations. Such exposure can increase general morale and team-building, or it can lead to substantive improvements in the way a church, project or programme functions. For instance, PLWHA can perform a valuable support function in a church that has hired or designated “AIDS workers” such as peer educators, or home and community care workers. Whereas workers often receive little emotional or practical support for their HIV prevention and education activities, PLWHA can give them the benefit of their knowledge, help boost their confidence, and reassure them of the value of their contribution.

PLWHA can also instruct churches in the language of AIDS and in creating a response which reflects the local realities of the epidemic. Box 10 highlights one example of this:

⁷⁴ Communication with Rev Dr Spiwo Xapile, JL Zwane Memorial Church, Uniting Presbyterian Church in Southern Africa, South Africa, spiwo@sun.ac.za
www.jlzwane.sun.ac.za

Box 10: Religious leaders and communities need to make a realistic analysis of the context and situation, and often, they need assistance to do this.⁷⁵

In the experience of Norwegian Church Aid (NCA), this is a reoccurring challenge. Many religious leaders and faith-based communities tend to limit themselves to dealing with the “easy issues” i.e. those with little controversy within their faith tradition such as care, especially for orphans etc. Not to say that this is not important – obviously it is – but sometimes, the contextual analysis done by faith communities is rather poor, resulting in a lot of resources being spent on activities that do not necessarily meet the real and acute needs.

To illustrate with an example from NCA’s experience. NCA arranged a consultation to map the different HIV-related activities in the region covered by NCA and facilitate relation building across sectors. The workshop began with mapping the epidemiological situation in the area, which clearly showed that the bulk of PLWHA and those affected were located in urban areas among men who have sex with men (MSM), and male and female commercial sex workers.

When mapping the churches’ involvement, no church was addressing the needs of any of these groups. Churches were focusing on either orphans, who in terms of numbers were a marginal problem, or care projects among rural poor where prevalence rates was barely detectable. NCA saw a clear difference in the response of the secular partner organizations, which were without exception working with the hardest-hit populations and were addressing prevention and care as well as advocacy against stigma and discrimination.

Further examination of the churches’ project portfolio showed that the grassroots workers were actually aware of this apparent misfit between needs and action. As one of the Catholic sisters said:

I know that you all think that we don’t work with MSM because our tradition disapproves with their way of life, and that we don’t work with prevention because we can’t promote condoms. But our main problem is that most of us don’t have the language to talk about sexuality. Since we don’t have the language, we very rarely talk about sexuality in our church. On the rare occasions we do talk about it, we are in a way forced to stick to the limited knowledge and language we have and that is really not suitable for the context and situation right now. Somebody needs to teach us how to talk about sexuality in a real manner, without necessarily condemning us for the views we have on, for example, condoms.

In my church, we actually tried to contact a local AIDS foundation to see if they could help us, but they cut us off before we got around to asking, saying that our views on condoms were destructive and that they had no time for “people like us.” So we have been waiting for our religious leaders to teach us, but I guess that they are just as confused and insecure

⁷⁵ Communication with Anne-Marie Helland, Special Advisor, Department for Advocacy and International Development Policy, Norwegian Church Aid. anne-marie.helland@nca.no

as we are...

In this situation, a strong network of PLWHA can be invaluable. NCA asked the Catholic Diocese to set up a team to look at these issues, and linked them with the national branch of GNP+, which in turn was able to set up a team among their members, consisting of amongst others a Catholic theologian, a male former commercial sex worker and a teenage girl, who was active in her local church. Together, they started on a journey to explore how they could help each other out.

Reflection

Read the story of the Good Samaritan (Luke 10:29–37). Samaritan people were despised due to their ethnic identity, but they are re-valued by Jesus, far beyond religious leaders and other outstanding ethnic groups, due to their capacity to be moved by compassion and to care for the sick. Similarly, the church, which tends, sometimes, to be sidelined by the NGO world, agencies and some governments can prove its worth by its commitment to the well being of PLWHA.

Partnerships also have important benefits for PLWHA as individuals. Experience indicates that this kind of involvement – especially if it comes after a period of feeling hopeless and depressed – builds up a person’s motivation. PLWHA (like everyone else) need to feel valued for what they can offer. Involvement gives HIV-positive people support and can empower them in ways that increases the value of their contribution to a church. Furthermore, churches through partnering and being open to PLWHA can minister to their spiritual needs. Assisting PLWHA in their faith can take many forms, including praying, giving sacraments and even pilgrimages. Box 11 'Umrah' for Muslims living with HIV/AIDS” highlights one example of fulfilling a basic tenant of a faith and a wish expressed by some PLWHA.

Box 11: 'Umrah' for Muslims living with HIV/AIDS⁷⁶

The Muslim Youth Movement of Malaysia (ABIM), the Pelangi Community Foundation with the cooperation of Positive Muslim (PCF), Prokim and Positive Living (PTF) are assisting to fulfil the wish of PLWHA clients to make the pilgrimage as Mecca and Medina while they are healthy enough to do so

All humans PLWHA need physical, mental and spiritual strength. After living for years as outcast of society, the Umrah would be the place where they will be reunited with Allah, receive his blessings and return to Islam as a way of life.

This would be the first time that HIV-positive Muslims are going as a group for

⁷⁶ Rainer Rotthoff, rainersg@yahoo.com [AIDS_ASIA] 'Umrah' for Muslims living with HIV/AIDS, 03 January, 2005.

Umrah (a visit to Holy Places to seek guidance and mercy from Allah). A fund raising campaign has been developed under the theme “Oh ye God, we are thirsty of your guidance and your mercifulness” to make the wish a reality.

Pelangi's mission is to ensure that all homeless PLWHA have access to basic medical care and treatment for:

- opportunistic infections; and
- ensure that all homeless PLWHA will be able to live and die with pride and dignity.

70% of Pelangi's expenses are covered by the Missionszentrale der Franziskaner in Bonn, Germany. See <http://www.pelangifoundation.org>

Boxes 12 and 13 describe how international PLWHA networks are partnering with faith-based organizations.

Box 12: ANERELA+ and GNP+

African Network of Religious Leaders living with or personally affected by HIV and AIDS (ANERELA+)

The forerunner to ANERELA+ was isolated church leaders speaking out about HIV and AIDS. ANERELA+ is interfaith, pan-African network, open to religious leaders, people living with or personally affected by HIV and friends of ANERELA+. ANERELA+ held its first meeting in 2002 and aims to:

- support without judgement;
- live positively, healthily and openly; and
- fight stigma, denial, discrimination and inaction around HIV and AIDS

ANERELA+ conducts retreats which aim to build the capacity of participants to become advocates of hope and change in their own congregations, communities and countries. This rapidly-growing network uses its members' massive potential to challenge and overcome the stigma, discrimination, denial and inaction frequently associated with HIV and AIDS.

UNAIDS and the World Council of Churches (WCC) are assisting ANERELA+ in identifying potential members in other African countries. As a result, in addition to members in Kenya, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zimbabwe and Zambia, ANERELA+ has members in Angola, Democratic Republic Congo (DRC), Ethiopia, Namibia, Nigeria, Rwanda and Togo. ANERELA+ currently has a membership of over 500 in the countries within which it is operating, and has been challenged by various groups to expand to become a truly international organization.

Within ANERELA+, a new model of responding to HIV has been developed, called **SAVE** (Safer practices, Available medications, Voluntary counselling and testing, and Empowerment through education). HIV and AIDS prevention will never be effective without a care component and the SAVE model combines both prevention and care

components as well as providing messages to counter stigmatization.

For a more comprehensive explanation of SAVE, see box 10 “HIV Prevention and Care: An Alternative Model” in 3.1 HIV Prevention – Sexual Transmission in World Council of Churches, *Working with People Living with HIV/AIDS Organizations: Guidelines*, 2005.

In the life of churches, ANERELA+ works towards breaking the silence surrounding HIV and AIDS, including bringing the realization to churches that they have AIDS, demonstrates positive living by example, assists in developing, modify and implementing existing church policies, declarations and workplace policies, and runs support groups.

The Global Network of People Living with HIV/AIDS (GNP+)

GNP+ <http://www.gnpplus.net/> is a global network operated by and for people living with HIV and AIDS, which has been at the forefront of the development of the global civil society response to the HIV/AIDS epidemic. The mission of the Global Network of People Living with HIV is “to improve the quality of life of people living with HIV/AIDS”. The methods for pursuing these goals are three-fold:

- lobbying: for the development of sound policies that protect and care for HIV+ people;
- linking: through international conferences to showcase the strengths and needs of people with HIV, and to working with the scientific, medical, government, and media sectors as well as with fellow civil society; and
- sharing: capacity-building to strengthen organizations of HIV+ people at the local, national and regional levels to serve the interests of HIV+ people effectively.

GNP+ has been organizing International Conferences for People Living with HIV/AIDS since 1987. The Global Advocacy Agenda, drawn up by PLWHA at the 9th International Conference in Warsaw, August 1999, consists of:

- developing policy advocacy on access to care and treatment,
- ending HIV-related stigma and discrimination, and
- promoting the greater and more meaningful involvement of people living with HIV/AIDS.

GNP+ has been active in the formation of the Global Fund to Fight AIDS, Tuberculosis and Malaria, advocating for effective PLWHA participation in the Country Coordinating Mechanisms and is also responsible for the Global Fund Board delegation of Communities living with the three diseases.

GNP+ formed a partnership with the International Federation of the Red Cross and Red Crescent Societies in 2001. During the 11th International Conference for People Living with HIV/AIDS in Kampala, Uganda, in October 2003, ANERELA+ was officially launched. ANERELA+ sees itself as a bridge between what are falsely perceived as two different worlds – churches and PLWHA organizations. With members belonging to both constituencies it hopes to bridge gaps in the relations between churches and PLWHA.

While this partnership is in its infancy, the WCC is using the expertise of both organizations to assist it in developing and promoting the Framework of Engagement: HIV/AIDS workplace policy, fostering partnerships between churches and PLWHA organizations, and advocating for a declaration on HIV and AIDS at the World Council of Churches' General Assembly in Porto Alegre, Brazil, 14–23 February 2006.

GNP+ and ANERELA+ are also working closely in the preparation of the 12th International Conference for People Living with HIV/AIDS, Lima, Peru, 9–14 October, 2005 under the banner *Living with HIV Partnership*, and will in the coming months sign a Memorandum of Understanding (MoU).

Box 13: World Young Women's Christian Association (YWCA) and the International Community of Women Living with HIV and AIDS (ICW) Partnering⁷⁷

In the response to HIV/AIDS, the World YWCA strongly believes that partnerships with other organizations working on the issue are critical. One of these organizations is the International Community of Women Living with HIV and AIDS (ICW). The World YWCA and ICW are sharing information, undertaking joint advocacy work, exchanging and training personnel, developing resource materials, sharing space for meetings and jointly applying for funding.

Since 2001, the World YWCA and ICW have shared information and resources that speak to women. In the context of the UNAIDS Global Coalition of Women and AIDS, the two organizations are together developing key advocacy messages on women's leadership in the area of HIV and AIDS. Training materials and resources designed for women relating to stigma and discrimination are also being developed. The World YWCA consults with ICW to ensure that the messages are sensitive and non-discriminatory.

The World YWCA and ICW co-operate on workplace issues. In this regard, ICW shared with the World YWCA workplace policies that include PLWHA and will be training World YWCA staff on workplace behaviour towards staff and colleagues living with HIV. In addition, a former YWCA intern from Zimbabwe is currently a staff member of ICW and the two organizations plan to continue identifying young women for staff exchange and volunteer roles as well as providing training opportunities through ICW and World YWCA programmes.

ICW http://www.icw.org/tiki-view_articles.php

World YWCA <http://www.worldywca.org/>

3.4 The imperative to work with PLWHA organizations

The concept of the greater participation of PLWHA derives, in part, from the Paris AIDS Summit held on 1 December 1994.⁷⁸ The acronym "GIPA" was first coined during its preparatory meetings and stands for the Greater Involvement of People Living with HIV/AIDS, found in Article 4, the Paris AIDS Summit Declaration, which states:

We, the heads of government or representatives of the 42 states assembled in Paris on 1 December 1994 are resolved to step up the international co-operation through the following measures. We shall do so by providing

⁷⁷ Communication with Marie-Claude Julsaint, Programme Director for the Americas and the Caribbean, World YWCA m-cl.julsaint@worldywca.org

⁷⁸ See "2.2. Looking Inside the PLWHA Movement" in World Council of Churches, *Working with People Living with HIV/AIDS Organizations: Guidelines*, 2005, for a more detailed history of the GIPA Principle.

our commitment and support to the development of the joint and co-sponsored United Nations programme on HIV/AIDS, as the appropriate framework to reinforce partnerships between all involved and give guidance and world-wide leadership in the fight against HIV/AIDS. The scope of each initiative should be further defined and developed in the context of the joint and co-sponsored programme and other appropriate fora:

1. support a greater involvement of people living with HIV/AIDS through an initiative to strengthen the capacity and co-ordination of networks of people living with HIV/AIDS and community-based organizations. By ensuring their full involvement in our common response to the pandemic at all -national, regional and global- levels, this initiative will, in particular stimulate the creation of supportive political, legal and social environments⁷⁹.

As the WCC executive committee noted in 1987, "through their silence, many churches share responsibility for the fear that has swept our world more quickly than the virus itself"⁸⁰. Sometimes churches have hampered the spread of accurate information or created barriers to open discussion and understanding. Further, churches may reinforce racist attitudes if they neglect issues around HIV and AIDS because HIV infection occurs predominantly among certain ethnic or racial groups. These groups may be unjustly stigmatized as the most likely carriers of the infection.⁸¹

In an assessment of churches responses to the HIV epidemic in 1997, it was stated:

From the beginning of the pandemic Christians, churches and church-related institutions have been active in education and prevention programmes and in caring for people living with HIV/AIDS. The consultative group was privileged to have worked with several of these during the study. The group observes, however, that by and large the response of the churches has been inadequate and has, in some cases, even made the problem worse⁸².

In some churches a 'them and us' paradigm still prevails. *We* the churches provide the service; *they*, the PLWHA, receive them. However, the fact is that "they" are our brothers and sisters in our parishes and congregations, our choirs and on our pulpits, in our offices and youth clubs. Over the past two decades, churches have provided a

⁷⁹ See UNAIDS, *From principle to practice: greater involvement of people living with or affected by HIV/AIDS (GIPA), Report* (1999), for full text. www.unaids.org

⁸⁰ World Council of Churches, Quoted in the Minutes of the 38th meeting of the WCC central committee, Geneva, Switzerland, 1987. Appendix VI, "AIDS and the Church as a Healing Community", p.135. <http://www.wcc-coe.org>

⁸¹ World Council of Churches Central Committee, Geneva, Switzerland 12-20 September 1996. Document No. 6.2B. The Impact of HIV/AIDS and the Churches' Response. A statement adopted by the WCC Central Committee on the basis of the WCC Consultative Group on AIDS Study Process, September 1996. <http://www.wcc-coe.org>

⁸² World Council of Churches, *Facing AIDS, The Challenge the Churches' Response*, A WCC Study document, WCC Publications, Geneva, Switzerland, 1997, p. 4. <http://www.wcc-coe.org>

significant proportion of the care and support for PLWHA⁸³. And as illustrated throughout this document and in the accompanying document, World Council of Churches, *Working with People Living with HIV/AIDS Organizations: Guidelines*, 2005, churches have begun a process of transformation. As the Declarations in box 1 “Breaking the Silence - Declarations by Churches on HIV/AIDS” in chapter two “The response of churches to date” show many churches have broken their silence on HIV and are beginning a process of reconciliation. This is a first step in churches transforming themselves into HIV/AIDS competent ones⁸⁴ becoming welcoming and inclusive communities for PLWHA. Churches are also becoming involved in HIV prevention efforts and continuing or scaling up their work on care.

Nevertheless, the situation is not perfect. Translating words into actions such as involving PLWHA in the life of churches and faith-based organizations, decision-making processes including programming is variable and, when present, can be tokenistic. Yet the first steps have been taken. See “4.4 Tokenism” in World Council of Churches, *Working with People Living with HIV/AIDS Organizations: Guidelines*, 2005, which outlines steps to prevent tokenism and the commitments made by churches to involve PLWHA.

3.5 The challenges of partnering with PLWHA

As well as promising a range of potential benefits, partnerships between churches and PLWHA organizations face a number of challenges, particularly at the higher levels of organizations. Some churches and faith-based organizations are facing these challenges; while others are still in Egypt. The challenges include:

Lack of supportive environments and policies for involving HIV-positive people within some churches and faith-based organizations

Up to now, some churches may not have a policy for the employment or involvement of PLWHA. They may also lack the sort of environment and facilities that are necessary or helpful to HIV-positive people such as healthcare facilities, medical insurance and psychosocial support. A workplace policy including medical benefits is a prerequisite for creating a supportive environment in which PLWHA can work.

⁸³ For example, at the present time, 26.7% of the centres dedicated to treating HIV/AIDS in the world are Catholic centres. Pontifical Council for Health Pastoral Care, *Message for the World Aids Day*, 1 December 2004.

⁸⁴ Ecumenical HIV/AIDS Initiative in Africa (EHAIA) works to help churches in Africa become "AIDS-competent churches". <http://www.wcc-coe.org/wcc/what/mission/ehaia-e.html> An AIDS-competent church is one:

- whose teaching and practice indicate clearly that stigma and discrimination against PLWHAs is sin and against the will of God;
- which, along with its ecumenical partners, has a full understanding of the severity of the HIV/AIDS pandemic in Africa;
- which reaches out and responds to collaborative efforts in the field of HIV/AIDS;
- which find its role in prevention of HIV/AIDS, taking into consideration pastoral, cultural and gender issues; and
- which use its resources and structures to provide care, counselling and support for those affected.

The WCC has drafted a working document which provides suggested text and clauses for the development by churches of HIV workplace policies⁸⁵. Box 18 “The Church of Scotland – implementing a HIV workplace policy” in section 4.3 Confidentiality in World Council of Churches, *Working with People Living with HIV/AIDS Organizations: Guidelines*, 2005, provides an example of the difficulties that can be encountered in trying to draft and implement a HIV workplace policy.

Also, the United Evangelical Mission (UEM) in its Anti HIV/Aids Programme Policy outlines its responsibilities regarding personnel, scholarship holders, volunteers and visitors in the following areas:⁸⁶

- HIV/Aids information, education and counselling for staff and exchange – co-workers;
- testing;
- post Exposure Prophylaxis (PEP); and
- care for UEM staff and exchange co-workers infected with and affected by HIV/Aids.

Needless to say, churches commitments to break the silence on HIV and AIDS, and efforts to challenge stigma and discrimination both within the church and in society have and will assist in creating a supportive environment for PLWHA involvement in the life of churches.

Lack of awareness of and taking into account the diversity of PLWHA

PLWHA have different needs and experiences depending on different factors such as class (rich, middle or poor), gender (man or woman), age (child, young person, adult or grandparent), sexual orientation (heterosexual, bisexual, men who have sex with men (MSM), lesbian and transgender), race (black, brown, red, white or yellow), ethnicity. HIV infection is an additional factor to such social categorization and/or identification meaning that PLWHA have a plethora of different lived experiences and needs. Churches and faith-based organizations need to be aware of these differences and factor them into their responses, interventions and pastoral care to ensure that some groups of PLWHA are not further marginalized, ignored or discriminated against, and that all groups of PLWHA are involved in the response to HIV.

Failure to mainstream gender

The AIDS epidemic is closely related to social relationships; it has not responded to interventions that have failed to make gender considerations central to their activities. Since most prevention activities have focused (and continue to focus) on some version of ABC, the failure to mainstream gender has rendered most of these projects less than effective. Churches and faith-based organizations need to listen to PLWHA tell

⁸⁵ World Council of Churches, *Towards a Policy on HIV/AIDS in the Workplace, Working Document*, 2005.

⁸⁶ World Council of Churches, *Working with People Living with HIV/AIDS Organizations: Guidelines*, 2005. See specifically “5. UEM as an employing/sending/scholarship-organization: Personnel, scholarship holders and volunteers and visitors” in United Evangelical Mission, *Anti HIV/Aids Programme Policy, Adopted by the UEM General Assembly in Manila*, October 2004.

their stories in order to grasp the centrality of gender and the importance of mainstreaming it in projects and programmes. All interventions need to systematically mainstream gender into all stages i.e., planning, implementation, monitoring and evaluation of all projects and programmes.

Lack of systematic mainstreaming of HIV/AIDS stigma

It is acknowledged worldwide that the impact and consequences for both individuals and communities of HIV-related stigma are greater than from HIV itself. However, to date, most interventions have not systematically mainstreamed stigma eradication into all stages i.e. planning, implementation, monitoring and evaluation of all projects and programmes. Seeking partnership with PLWHA in all interventions is one such way of breaking the power the stigma to frustrate many well intentioned projects and programmes.

Difficulty of some PLWHA acknowledging their HIV status publicly

Openness about one's own HIV status to family, community or in the workplace is more difficult in some countries or cultures than others. In some cases, precautions are needed to protect people who disclose their positive HIV-status, since this can create serious repercussions for them in the workplace and within their families and communities. Stigma and discrimination manifest themselves in different ways, ranging from almost invisible types of social behaviour to physical violence. Similarly, PLWHA's fears may range from purely personal (and not always accurate) perceptions of discrimination all the way to objectively based fears of rejection and violence.⁸⁷

Many PLWHA lack the skills to openly talk with churches

Lack of skills can create a variety of obstacles. Firstly, not everybody is born with the natural capacity to speak about issues such as sexuality and health – it is a skill that most often has to be learned. Secondly, over time, facing a hostile or uncomprehending environment can lead to “burnout” unless a person is either very strong to start with or has been through an empowerment process. For both these reasons, communication and personal empowerment counselling should be part of a generic training package for PLWHA. As well, such training must be reinforced by ongoing support for PLWHA if their effectiveness is to remain high and their motivation strong.

Thirdly, special orientation or job-specific training may be required to compensate for the lack of particular technical skills or knowledge.⁸⁸ This focuses attention on the question of appropriate hiring. Clearly, hiring people solely because they are HIV-positive, and without regard to their particular skills and capabilities, is tokenistic; it puts the emphasis on the virus rather than on the person and his or her character and

⁸⁷ See generally, section 4.3 Confidentiality in World Council of Churches, *Working with People Living with HIV/AIDS Organizations: Guidelines*, 2005.

⁸⁸ See “4.4 Tokenism” and “4.7 Capacity Building” in World Council of Churches, *Working with People Living with HIV/AIDS Organizations: Guidelines*, 2005.

abilities. At the same time, those responsible for hiring should recognize the value of the PLWHA's experience-based expertise and include this in their decision-making. In this context, additional technical training may be necessary.

Some churches are ill prepared to involve PLWHA

Despite commitments by churches to involve PLWHA in the life of churches and faith-based organizations⁸⁹ there are currently too few documented reports of churches collaborating with or involving PLWHA in the life of the church. This may be because of a lack of awareness by churches of the importance of making their work with PLWHA organizations known and available.

Emulation of good practice by churches is one way of propagating PLWHA involvement. This document and the accompanying document, World Council of Churches, *Working with People Living with HIV/AIDS Organizations: Guidelines*, 2005, cite a number of examples of good practice in church and PLWHA organization partnerships. Furthermore, publicizing church and PLWHA partnerships assist in breaking down misconceptions about the role of churches in the HIV response.

Questions of sustainability

It has to be recognized that HIV-positive people may fall ill because of their HIV infection and that some people will die. This poses various challenges for churches ranging from the provision of health care to reasonable accommodation to the sustainability of programmes and partnerships. In high prevalence countries, churches need to incorporate HIV-related illness and death into all present and future planning and programming for staff, clergy and volunteers requirements, as many will die and churches need to be prepared for this eventuality.

Commissioner Margaret Sutherland, International Secretary for Africa, the Salvation Army eloquently described the situation:

THINK of Corps officers being exhausted by the demands made on them for conducting funerals and comforting the bereaved. They may be called out any hour of the day or night. Many have had no free time for months. In addition they are almost certain to be needed at funerals of their own family members, often involving long journeys to their rural homes, which may take several days. Anyone attending a funeral is expected to make a financial contribution – another continual demand. In addition they may be expected to care for a sick relative or take in an orphaned child following the death of a relative. There is no child allowance for such children – a further financial burden. Some officers care for several such children.

⁸⁹ See "4.4 Tokenism" in World Council of Churches, *Working with People Living with HIV/AIDS Organizations: Guidelines*, 2005.

THINK of a territorial headquarters, where every week at least one employee or officer requests time off to attend a funeral – often meaning several days' absence. You try to exercise some control over this but what can you do when culture demands that relatives are present? Not to be there would be a great offence to the family. Territorial leaders are not immune themselves from these demands, putting extra strain on them as they make their own visits to family funerals. With the extended family system in Africa, such demands are many.

THINK of a territorial commander who hears of yet another officer dying of AIDS. No one says it is AIDS, of course, but everybody knows. How does that TC deal with the further complication that the afflicted person is deemed by many to be a sinner and that AIDS is his punishment? How does the territory meet the expenses for long term care of the sick officer?⁹⁰

Obviously, the risk of falling sick or dying exists for all employees or members of churches, whatever their HIV status. However, assuming an absence of antiretroviral therapy, the odds are greater (and certainly more highly publicized) for PLWHA than for many other groups of people. The churches response to HIV and AIDS is inextricably linked to providing or obtaining access to ARV therapy.

In some countries, cultural practices surrounding death result in expensive and week-long funerals, creating both an economic burden on the family as well as loss of productivity for the community and society. These issues should not be avoided, since they are real. They should be discussed in order to anticipate their impact on sustainability, including the response of churches. Churches also have a role in questioning and changing such practices, particularly in societies reeling from the impact of HIV and ongoing deaths in communities. Resources, where they still exist, need to be maintained for the living such as spouses and orphaned children, rather than being dissipated on the dead.

3.6 What benefits can partnerships bring for churches?

The Lutheran World Federation in its Action Plan under the section, The church is “converted”, stated:

Those who are HIV-positive or ill with AIDS have gifts to offer and wisdom to share with their community, especially the wisdom of what it means to live with HIV and AIDS. They have the knowledge, competence, interest and ability to give prophetic voice to their needs and hopes, their dreams and fears, and to motivate the church to respond. As such persons share their stories and their lives, and as the church dares to listen, the church can be moved to repent of how it has sinned against those who are affected by HIV and AIDS, due to fear, lack of information, stigmatization, or a failure to act. Such persons have been isolated or

⁹⁰ Sutherland, Commissioner Margaret. *The Salvation Army International Headquarters, AFRICA AND HIV/AIDS*. From a paper presented by Commissioner Margaret Sutherland, International Secretary for Africa. September 2003.

deliberately excluded from the community. This is most disturbing when this exclusion has been legitimized with theological or moral reasons by church leaders.

The church is called by Christ to repent, turning around to love those whom it has shunned⁹¹. It must convey accurate information, be hospitable, and do what is needed to protect and ensure quality of life for those who are ill and protection for all who are vulnerable⁹².

By building partnerships, a church can fulfil its mission and ministry of serving the marginalised and suffering (Matthew 25:31–46), widen and sustain the impact of its work and gain the wide variety of resources that it needs to carry out its work well. With regards to HIV and AIDS, different people, groups and organizations can offer many different kinds of valuable support, including:

- access to people and places;
- influence;
- good ideas;
- insight;
- “in kind” support;
- a helping hand;
- money;
- knowledge and skills;
- political support;
- practical support; and
- lessons learned.

⁹¹ 1 John 4:7-21 underlines, “those who say I love God and hate their sisters and brothers are liars, for unless you love your sisters and brothers whom you see, you cannot love God whom you have never seen.”

⁹² The Lutheran World Federation, *Compassion, Conversion, Care: Responding as churches to the HIV/AIDS pandemic. An Action Plan of the Lutheran World Federation*, 18 January 2002

Gaining access to the above resources can help a church and the community, in their response to HIV and AIDS, to create:

- a wider response – with different types of organizations and sectors becoming involved.
- a more co-ordinated and coherent response – including a better referral system among different organizations.
- a larger response – with innovative community efforts being “scaled up” by larger institutions, such as government.
- better support and policies for people living with HIV and AIDS.
- stronger services and increased access for vulnerable communities.
- more effective and creative HIV and AIDS programmes – through the sharing of lessons and experiences.

This is what building partnerships is all about. It means working with others to make the most of strengths and opportunities, as well as to address weaknesses and barriers, in responding to HIV and AIDS.

Reflection

Covenant 2: Love and HIV/AIDS Care⁹³

We shall remember, proclaim and act on the fact that love is from God and everyone who loves is born of God and knows God. Those who say ‘I love God,’ and hate their sisters and brothers are liars, for unless you love your sisters and brothers whom you see, you cannot love God whom you have never seen (I John 4:7–21). We shall, therefore, do all that is necessary and within our power to encourage both men and women to love, care, support and heal all those who are infected and affected by HIV/AIDS in our communities, countries and continent.

Refer to their list of potential partners and name the kinds of resources that each partner could bring to the local HIV/AIDS response.

Reflect on the kind of resources PLWHA can bring to your church’s response to HIV.

3.7 How do partnerships relate to programme work?⁹⁴

Partnerships complement a church’s programmes. Through developing programmes, a church can respond directly to specific local needs and priorities for action. Through building partnerships, churches can improve the overall environment for responding to HIV and AIDS in a community or a country. For this reason, a church should include building partnerships within its overall strategic plan.

⁹³ All Africa Conference of Churches (AACC), *The Covenant Document on HIV/AIDS*, All Africa Conference of Churches (AACC) 8th General Assembly, Yaoundé, Cameroon, 22-27 November 2003.

⁹⁴ Adapted from “Solidarity and Sustainability Workshop”, COMUNIDEC and the Alliance, Ecuador, May 1997. <http://www.aidsalliance.org/eng/>

Example: a church working with young people wants to prevent the spread of HIV among young people in its town. Through one of its programmes, the church works directly with young people in school, so that they have the help and education that they need to reduce their risk of HIV infection. Through one of its partnerships, the church works with key people in the Ministry of Education, so that they might support sexual health education in schools. The church's partnership is helping to improve the overall environment in which other churches and NGOs work and in which young people protect themselves from HIV.

Reflection

Look at one of your church's existing programmes, and discuss what partnerships might help their work in this area.

- **Church's Aim:** e.g., to prevent the spread of HIV among young people in our town.
- **Programmes/Project:** e.g., partner with young people in school. Strategy, ongoing HIV education.
- **Partnerships:** e.g., partner with Ministry of Education. Strategy, monthly meetings with key ministry staff.

3.8 What HIV and AIDS issues affect partnerships?⁹⁵

The sensitivities and complexities of HIV and AIDS can pose a special challenge to churches as they build partnerships. For example, a potential partner may be afraid of AIDS, or be reluctant to be associated with a church which has difficulties discussing issues of human sexuality and sexual health. This can make it difficult to engage partners and to get them involved.

The following applies to all partnerships and is relevant to partnerships developed between churches and PLWHA organizations. HIV and AIDS issues to consider when building partnerships include the following:

- Personal attitudes and beliefs. Partners may not feel able to talk openly about HIV and AIDS.
- Institutional practices, policies, or beliefs. Partners will uphold institutional policies – unless they are convinced otherwise.
- The visibility of HIV and AIDS in a community. If it is not visible, partners may not believe that it exists. If it is visible, they may want to cover it up.
- Maintaining confidentiality. Partners may want to know or tell others about the HIV status of specific individuals.
- Gender, class, age, race, ethnicity, sexual identity, and context, all of which expose PLWHA to different experiences of stigma.
- Language and jargon. Partners may not be familiar with specialised words used to describe HIV and AIDS work.

⁹⁵ Adapted from "NGO Skills Building Session", the Alliance, World AIDS Conference, Vancouver, July 1996. <http://www.aidsalliance.org/eng/>

- Scandals and scare stories. Partners may not believe accurate, scientific information about HIV and AIDS.
- Competing priorities. Partners might be more interested in addressing other social issues, or responding to a recent crisis.
- Subject fatigue. Partners might not want to hear any more about HIV and AIDS.

Exercise

Discuss with other people which of the above HIV- and AIDS-related issues they have encountered in working with various partners and any strategies developed for addressing them.

Scripture

Read Nehemiah 1:11–18. Discuss a number of strategies that were employed by Nehemiah in his project of rebuilding the walls of Jerusalem to avoid some of the above tabulated complications that can complicate partnership.

3.9 Appreciating different perspectives

In order to build a strong and effective partnership, a church needs to get to know and understand its partner.

A first step in making a “partner analysis” is to think about how a church and its partners view each other. Partners may have negative or positive views about churches, or they may not know what churches do. Also, partners from different sectors might be more or less inclined to talk about HIV and AIDS or sexuality, or they might have set opinions on these topics. In exploring how a church and its partners view each other, both partners can find ways to reduce misunderstanding, to accept differences, or to find a basis for mutual respect.

Exercise

Undertake a session of exercise between your church and the partner. Ask each to list their views of the other.

- Why do our partners view the church as they do? Why does the church view its partners the way it does?
- Are the church’s and the partner’s views of each other accurate, or are they based upon emotion, stereotypes or lack of information?
- How can each partner address misconceptions?

Scripture

- Read Matthew 25:14–30
- Which of these servants tend to represent the churches’ interaction with partners?

- | |
|---|
| <ul style="list-style-type: none">• Which of the servants might represent a more successful relationship? |
|---|

3.10 What church issues affect partnerships?⁹⁶

The views that others have of a church can also make it difficult to build partnerships. Partners may not know about the church or understand a church's positive role. For examples:

- a businessperson may think that a church lacks credibility as not-for-profit organizations do not operate with the “reality” of market forces;
- a donor may receive so many requests from different churches and NGOs – making it hard to distinguish one from the other; and
- a PLWHA organization may view your church negatively due to issues such as prevention or stigmatization.

Church issues to consider when building partnerships include the following:

- Negative images of churches. Partners may think that churches can not be trusted to get results, or that they will create problems by refusing to face difficult issues.
- Perceptions about a church's resources. Partners may under-estimate, or over-estimate, what a church can do.
- A church's reputation. Partners may seek out only the most prominent churches, or avoid ones that are thought of as too “vocal” or “fringe”.
- Balance with other areas of a church's work. Partnerships can consume much time and take away energy needed for programme activities.
- Competition among churches. Partnerships can create an atmosphere of tension or mistrust among other churches and NGOs.
- The dynamics of gender, class, age, sexual orientation and economic context in their projects and programmes.

<h4>Exercise</h4>

- | |
|---|
| <ol style="list-style-type: none">1. Ask participants to discuss the specific issues that they have encountered while building partnerships, and to explain how they have addressed them.2. Ask participants to describe what a strong and effective response to HIV and AIDS in their area would look like – including what type of people and organizations would be involved. |
|---|

⁹⁶ Adapted from “NGO Skills Building Session”, the Alliance, World AIDS Conference, Vancouver, July 1996. <http://www.aidsalliance.org/eng/>

3.11 What does building partnerships mean in practice?

HIV is challenging churches in many ways but before describing what partnering means in practice, it is helpful to be clear on the role of churches and faith-based organizations. Michael Czerny S.J assessed the situation as follows:

When we ... declare, “the Church has done much ... and much more is needed,” we can easily think they mean a more sophisticated response on a larger scale. But as Cardinal Turkson said ... the Church is the only institution that meets hundreds of people each week on a very personal level and at the same time acts publicly and socially. Who else can do both so regularly? In its AIDS ministry, the Church faces the biggest combined social, cultural, economic, medical and political issue and, at the same time, she deals with individual persons one by one, those infected by HIV/AIDS and their family much affected by it. So to say “much more is needed” does not mean “bigger and more complex”; it means multiplying the small-scale, close-to-the-ground, highly personal approaches and extending them to more and more people infected and affected. The response of the Church to HIV/AIDS needs to be as extensive, broad and deep as the mission of the Church herself...

So let us be clear: HIV/AIDS, for the Church, is a huge problem, but it is not a ‘massive’ one to be addressed on a large scale and in the millions. Rather, there is and will be a great variety and nearly infinite multiplicity of genuinely pastoral responses. This is how the Church tackles a huge problem like sin, or ignorance, or HIV/AIDS⁹⁷.

So in a way, working on HIV requires more of the same. Partnering with PLWHA organizations and individuals means recognizing and integrating the lived experience and expertise of PLWHA, often church members, into the on going work of churches is one aspect of this. These expertise and experiences will differ between each PLWHA as PLWHA are a very varied group of people, whose lived experience is determined by their class, gender, race, age sexual orientation and economic context. In integrating the lived experience and expertise of PLWHA, churches are adding another dimension to their response to HIV – one that is essential to ensure that the services provided are those that are in reality needed. Creating partnerships with PLWHA means involving them in planning and carrying out relevant programmes and services. It means talking to individuals and groups of PLWHA to determine their needs and their potential to provide inspiration or strength to others in similar situations. Box 14 outlines what partnerships can look like at different levels of church work.

⁹⁷ Czerny Michael S.J., *Response to Rev. Robert J. Vitillo’s “Pastoral and Theological Challenges of HIV and AIDS”*. National Seminar for Priests in Ghana, Accra, Ghana, 16-17 June 2004.

Box 14: Partnerships in practice in all the endeavours of churches

Church Leadership

- Reconciliation with PLWHA is the purview of faith-based organizations. Declarations by churches have highlighted the role that churches have played in instigating stigma and responding inappropriately to HIV. In effecting reconciliation, churches can, for example, hold public events together with PLWHA, promote the destigmatization of HIV and the eradication of discrimination against PLWHA; use spiritual teachings or religious scriptures to emphasize compassion, healing and support for PLWHA. Furthermore, reconciliation is not confined to church structures and liturgy. There are different levels of reconciliation that need to happen i.e. in individuals, between individuals, in communities and between communities as well as between individuals and their churches.
- Work with other religious leaders, faith-based coalitions and PLWHA to find common ground on beliefs and spiritual teachings that can assist in HIV prevention, eradication of HIV stigma and supporting PLWHA have the same inherent human dignity
- Using declarations made by church bodies, draw up an action plan with PLWHA for the church and implement it.
- Revise or adopt HIV and AIDS workplace policies for members and employees of churches and faith based organizations who are living with HIV or AIDS (regarding ethics, antidiscrimination, health care and employment).
- Churches and faith based organizations need to ensure that their work on HIV prevention and care, and partnerships with PLWHA is publicized so that it becomes known the extent of churches involvement and their support of PLWHA.
- Develop information materials in local languages on HIV prevention, faith-based responses that support prevention and care, and support of PLWHA.
- Create a local or national faith-based council to be a focal point for HIV and AIDS issues.
- Support religious and government policies that protect women's property, inheritance and work rights and strengthen their position in society.
- Promote understanding and support among the religious hierarchy on women's needs for reproductive health counselling and services.
- Coordinate with governments, the United Nations, the Global Fund Country Coordinating Mechanism and NGOs for achieving Millennium Development Goals and UNGASS targets; implementing access to medical care, including anti-retroviral therapy; increasing HIV prevention; and efforts to create a non-stigmatizing and non-discriminatory society.

Theological Training

- In theological and other educational institutions, discuss religious doctrine,

ethical positions and religious policy regarding issues pertaining to the effective prevention of HIV and the relief of suffering. Include people with HIV and AIDS theological debates as a way of affirming and enhancing their dignity.

- Develop curricula with input from the lived experience of PLWHA that focus on a theology of compassion, support and healing related to HIV and AIDS and which discusses judgement and condemnation.
- Review spiritual writings, local sayings, beliefs and traditions that support HIV prevention and AIDS care. Look at moral prescripts, parables and sermons and find ways to interpret the messages contained there in light of HIV and AIDS. Re-examine what is written about ministering and pastoral roles and responsibilities to care for the sick, the elderly, orphans and widows. Find ways to help people renew their duty to alleviate suffering, to affirm personal faith and to lead a life that fully respects the dignity and rights of others.

Faith-based organizations/ international work

- Integrate HIV prevention, care, support and treatment
- Involve PLWHA in programme and project choice, design, planning, implementation, monitoring and evaluation. Faith-based organizations can make this a condition of funding or project support.
- Support sister churches financially or in kind. Promote PLWHA involvement by example.
- Continue or increase micro-credit or other programmes to support communities, including PLWHA, to be able to provide for themselves.

Parish Priest/ minister/ representative

- Lead by example by visiting and ministering to PLWHA in your church, and by involving PLWHA in the life of the church. Call for understanding of the emotional and physical and for compassion and protection of PLWHA and those affected.
- Integrate PLWHA as resource people into the parish response to HIV and AIDS
- Discuss with PLWHA their needs so that mismatches of needs and services are avoided and to receive feed back on the appropriateness of services, gaps whether ALL church run services are accepting of and involving PLWHA.
- Talk to parents (from the pulpit and individually) about HIV and AIDS and stress that they are the first line of defence in protecting their children. Encourage and support them to talk to their children about human sexuality, positive values and personal responsibility. Using the basic facts, talk about the reality and danger of HIV. Let people know how HIV is transmitted and provide clear and accurate information on how HIV transmission can be prevented.
- Talk to your congregation about the spiritual dimensions of human sexuality and about the need to protect others from harm including protecting young people who may be subject to incest, sexual abuse, exploitation, or violence.
- Develop or provide education to young people on HIV prevention, including

input from PLWHA.

- HIV-positive parents might need or want to prepare wills, designate someone to care for their children after their death, make peace with themselves and others, and do other things to protect those they love. HIV-positive parents may also need counselling and support to help them talk to their children about their illness. Churches in collaboration with PLWHA organizations are able to broach these subjects, provide the technical expertise to ensure that wishes are respected and to accompanying the person through these events. Children need help and spiritual guidance to understand and accept the death of parents.
- Through teaching, preaching, and exercising pastoral care religious leaders can help people with HIV and AIDS live longer, more meaningful and dignified lives.
- When people are dying, religious leaders can help prepare people to meet death with dignity and serenity.

Young people groups

- Use religious youth organizations to talk to young people themselves – including PLWHA or those people affected – about their concerns and hopes, encouraging open discussion of values, sexual integrity and healthy relationships.
- Carry out HIV-prevention education through youth groups and other religious youth networks. PLWHA can be useful peer educators for this.
- In hard hit communities engage young people:
 - Peer-to-peer support groups and prevention clubs can be organized through existing religious youth groups.
 - Encourage the participation of young people in developing and running religious and community programmes that inform people about HIV and prevention.
 - PLWHA home-based care e.g. sweeping the person's yard, running errands etc.

Women's groups

- Can be used for HIV prevention through providing information and discussing issues arising from ABC prevention.
- Are a useful forum for providing education on antiretroviral therapy and discussion of issues around drug adherence, side effects and minimizing them, and drug resistance.
- Provide an opportunity for an HIV-positive woman to meet others in the same situation, and enables women to share their experiences, fears and uncertainties in a safe, supportive and non-judgemental environment. Such groups can also supports women with issues such as discrimination, sexual health awareness, sexual violence, relationships, parenting and future options.

Care Services

- Ensure that religious-run health and social services are welcoming to PLWHA, young people and sensitive to the needs of young women. Such services include pre-marital counselling, voluntary and confidential counselling and HIV testing, reproductive health care, drug and alcohol abuse

prevention, HIV treatment, and stress and grief counselling. Get feedback from PLWHA on the acceptability of the services and whether they encounter discrimination in their provision.

- Hygiene in medical settings is important; in relation to HIV the highest standards are essential because the impaired immune system of HIV-positive people renders them especially vulnerable to infection. Ensure that standards are maintained in religious-run facilities.
- Involve PLWHA in antiretroviral therapy preparedness training for medical staff.
- Encourage health facilities to provide appropriate antiretroviral treatment during and after childbirth to reduce HIV transmission to infants.
- Support or organize health, counselling and social services that are ‘friendly’ to women and that guide and support them in their decisions about pregnancy. If pregnant, women need services that offer safe deliveries and, if needed, counselling and treatment to reduce the risk of HIV transmission to infants.
- Strengthen home- and community-based care for PLWHA. Women and girls usually do most of the caring for HIV-positive family members and are in need of emotional support. Encourage men to take on involvement in community care.

Religious-run schools and orphanages

- Ensure that sexual health education, including scientific facts on HIV prevention, is available to young people in religious-run schools as well as through religious education, in prayer or meditation groups. For example, it is more important to teach an understanding of sexual health than to teach people not to share tooth brushes.
- Reduce or abolish school fees for AIDS orphans and the children of PLWHA.
- Find ways of providing support for communities caring for large numbers of orphans and vulnerable children. Improvements could be in the areas of health, education, and spiritual and psychosocial support, nutrition, water and sanitation, agricultural productivity, and self-help, income-generation or micro-credit schemes.
- Develop adoption programmes for orphans. Millions of orphans being created by the death of parents from AIDS-related causes and many extended families are unable or not present to care for orphans, leaving institutionalizing of orphans or adoption as some of the limited options available for caring for them.

Also see UNAIDS, UNICEF and World Conference of Religions for Peace. *What religious leaders can do about HIV/AIDS: action for children and young people* (2003).

Building a partnership requires finding partners who will not compromise the teachings of your church or faith-based organization. For faith-based responses this is particularly important as faith systems underpin the rationale for their existence. A partnership also requires resources for projects and programmes, which are in line with the precepts of the partners. And in building partnerships with PLWHA it is important not to be tokenistic and to assist in building the capacity of the

organization. Boxes 15 and 16 provide information on successful faith-based partnership with PLWHA organizations.

Box 15: Providing hope amidst despair – the example of BOCAIP⁹⁸

Botswana Christian AIDS Intervention Programme (BOCAIP), established in 1996, has a vision of an HIV/AIDS intervention strategy based on Christian values and approach was shared by the churches, the community, the para-church organizations and the Government of Botswana. For the first three years, there was little or no funding and the various centres relied on part time volunteers because they could not afford to hire full-time staff. However, the work had to proceed, which meant services were delivered with minimal resources acquired from the churches in the locality.

It was on the basis of such dedication and sacrifice that BOCAIP earned the respect of donors. In 1999, the first major donor, Bristol Myers Squibb, through its "Secure the Future" foundation made a commitment to support the work of BOCAIP for three years. This same foundation now funds some of the work in the field of orphan care undertaken by BOCAIP centres.

Many other donors, including Norwegian Church Aid, SIDA (Swedish International Development Agency), CIDA (Canadian International Development Agency) (in partnership with the Mennonite Central Committee), UNICEF, the Government of Botswana, the Self-Help Fund of the United States ambassador in Botswana and others have made donations for specific projects. All, entities which came into partnership with BOCAIP, buy into current activities such as mobilizing communities to respond to the pandemic by equipping them with the requisite knowledge and skills, and stimulating them to initiate community-based initiatives that would respond to their specific needs.

Training of counsellors is a major part of the service offered by BOCAIP as more groups, organizations and government ministries seek training. Interested Christian community members, including pastors, are trained in counselling people infected and affected by HIV in a six-week training course spread over about six months. The centres draw their staff from these trained individuals who, in turn, offer counselling to anyone who seeks it, but particularly on issues relating to HIV and AIDS.

Other projects that BOCAIP undertakes include education on HIV/AIDS in the community, youth work, and support groups for PLWHA, income-generating projects, emergency material assistance for food and school uniforms, and orphan day-care projects. These community-based initiatives have grown to include 12

⁹⁸ Thiessen, H.R., *Providing hope amidst despair - the example of BOCAIP*, EHAIA News No. 3 5. <http://www.wcc-coe.org/wcc/what/mission/ehaia-news-e.htm>

centres situated all over the country, and the government is urging BOCAIP to open more centres.

BOCAIP is being replicated in other countries, for example, Liberia. As a result of challenges encountered in the course of its operation, BOCAIP wanted to share its experiences with other Christian organizations responding to the AIDS pandemic in Africa. This led to BOCAIP organizing and hosting the “Working Together Conference” in June 2002, with 19 countries represented. The participants underscored the need to network and share information and experiences. One of the outcomes of the conference was the formation of the Pan African Christian AIDS Network (PACANet)⁹⁹ <http://www.pacanet.org>

Box 16: Norwegian Church Aid¹⁰⁰

Norwegian Church Aid (NCA) is cooperating with and supporting PLWHA organizations and networks in several countries. One of the well-established partnerships is with Gente Positiva <http://www.gentepositiva.org.gt/> in Guatemala, a partnership that has generated a lot of interesting and valuable experiences for NCA at global level. In some places, NCA’s partnership with PLWHA networks and organizations is limited to regular project support such as the national or local PLWHA association applies for funds to run a self help group or to conduct a workshop on legal right. However, PLWHA organizations and networks are increasingly being used as a resource for strategic partnerships which includes competence exchange, joint advocacy campaigns etc.

In NCA’s Global Strategic Plan for 2005–2009, it is a clear policy guideline that GIPA is to be prioritized in programme and policy development, implementation and evaluation. This Strategic Plan is a direct result of the experiences and learning processes that the organization has undergone in cooperation with networks and organizations for PLWHA. Support to and cooperation with PLWHA networks and organizations is another priority. As an example, ANERELA+ has been identified as a resource partner, as NCA has already been engaged in very fruitful partnerships with both national and regional branches of ANERELA+.

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⁹⁹ The Pan African Christian HIV/AIDS Network (PACANet) is a coordinated Christian response to the HIV/ AIDS pandemic across the African Continent. PACANet exists to link Churches, Christian organizations, and Christian Networks to enhance their HIV/AIDS responses by sharing resources, ideas, skills, experiences, and stimulating strategic partnerships.

¹⁰⁰ Communication with Anne-Marie Helland, Special Advisor, Department for Advocacy and International Development Policy, Norwegian Church Aid. anne-marie.helland@nca.no

NCA is also working in a close partnership with the Norwegian Association Against AIDS (Pluss-LMA). This partnership is especially related to advocacy and policy debate in the Norwegian context, in addition to general information exchange and networking.

The lessons learnt by NCA include:

- Local faith-based structures should be well equipped to house PLWHA networks. Churches and mosques could easily offer space for meetings, secretariats etc. Where this has been implemented, NCA believe that the stigma reduction is tangible. When faith-based structures openly support and host PLWHA networks, this sends a clear message to the local community.
- The building and strengthening of PLWHA networks is essential to secure a rights based approach to HIV and AIDS. PLWHA organizations and networks need to be empowered and structured in a way that allows them to fight for their own rights instead of having people and organizations advocating on “their behalf”, as the tendency has been.
- GIPA is not about tokenism – it is about comprehensive behaviour and attitude change that needs to be reflected throughout all of our work, no matter if we are a local church congregation or an international NGO. Sometimes people believe that if they facilitate a PLWHA network or a self help group then this is enough.

Discuss

- Has your church’s leadership been part of the process of forming a declaration?
- Who holds the leadership responsible for implementing the declaration?
- Has the church leadership formulated a strategic plan/plan of action on HIV? Is it operational?
- What would a strong and effective response to HIV and AIDS in your parish look like?
- Are there partnerships with local PLWHA organizations?
- Are there areas where this partnership could be expanded?
- Do you receive feedback from PLWHA about services provided and whether the partnership is decreasing discrimination?

Chapter 4

Troubleshooting in partnerships

This chapter highlights some issues which need to be taken into account by both parties to a partnership so that it functions harmoniously, smoothly and is sustainable. The issues highlighted include assessing the reasons for entering a partnership, sustaining a partnership, sensitive language, formation and use of messages, and how to respond to conflict and crisis. The information is designed to minimize potential conflict by promoting awareness of what can go wrong before problems arise, creating an environment of harmony within a partnership.

4.1 Thinking about the reasons for and against a partnership

Even if it is clear to a church, which its priority partners should be, it may still have some reservations about working with specific individuals or sectors. In reality, there are benefits and constraints to most relationships.

Understanding the reasons for and against forming a partnership is vital in helping a church decide what is best for the organization, and what it can realistically hope to achieve with different partners. It can help a church to enter a partnership with “open eyes” – just as aware of disadvantages as advantages.

Example: NGOs and community groups, Ecuador

At a training workshop, a group of local NGOs involved in HIV and AIDS work decided to focus on relations with the local church as a priority for building partnerships. Before developing specific, individual plans, the NGOs had a “brainstorm” about the pros and cons of working with that partner.

Our partner, the local church¹⁰¹:

For	Against
Brings people together	Is very conservative
Can convince people	Has many myths and prejudices about sexuality
Focuses on the family	Sometimes focuses too strongly on the family
Has political influence on theory, not action	Has limited knowledge about HIV and AIDS

¹⁰¹ Adapted from “Solidarity and Sustainability Workshop”, COMUNIDEC and the Alliance, Ecuador, May 1997. <http://www.aidsalliance.org/eng/>

Has economic resources	Can have a paternalistic attitude
Has a lasting presence in communities – so helps sustainability	
Includes some very progressive people	Includes some fanatical people
Carries out door-to-door work in communities	

Exercise

Consider the benefits and constraints of working with a partner

- Select a partner that your church wants to work with.
- Discuss and list the positive and negative experiences – or pros and cons – that working with this partner can bring.
- Discuss the balance between pros and cons, and what your church can do to make the most of the pros and to cope with the cons.
- What is the best and the worst thing about the partner?
- How might working with this partner affect the church’s relationships with other individuals and organizations?
- How might working with this partner affect the church’s programmes and relationships with the community?
- Despite the constraints, does the church want to continue to build this relationship?

4.2 Monitoring a partnership: understanding the ups and downs

During relationships with different partners, almost all churches experience times when the relationship goes well, and times when it does not. Mapping out a partnership’s ups and downs – or high points and low points – can help to identify strengths and weaknesses in a relationship. This can be particularly useful if a church is experiencing a difficult period in a partnership – for example if there is a crisis, or if a church is unsure whether to continue to invest time and energy with a partner. This activity can also help a church monitor its partnerships – to see how the partnership has progressed from a starting point, and to see what lessons have been learned along the way.

Exercise

1. Make a time-line of a relationship with a priority partner – drawing the ups and downs that the two have shared. For example, a successful collaboration may appear as a peak, while a disagreement may be a trough.
2. Discuss the time-line and describe why the high points and low points happened, and what was learned from them. For example:

- When and how have the church and its partner worked well together or worked against each other?
- What does the pattern of highs and lows show about the relationship? Are there more highs than lows? Were there extreme highs and extreme lows, or a reasonably straight path?
- Were the ups and downs mainly due to external factors, or internal reasons within the partnership?
- Based on the history between the church and the partner, is it likely to reach its future goals for the partnership?

Some possible reasons for highs and lows might include:

- friendly/tense relations; frequent/infrequent communication; strong/weak communication; or
- working together/working at odds with each other.

4.3 Using language

Language is the most important method for communicating with others. The language that people use tells others who they are, what they do, and what they care about. Language has power – to make people feel good or bad, to bring people together or keep them apart. People involved in HIV and AIDS speak many languages, and some use terminology, or special groups of words, to communicate with each other. While this can deepen understanding about specific aspects of HIV and AIDS, it can also keep other people at a distance. HIV and AIDS affect all sectors of society, and so it is important that different groups find a common language, as a basis for joint action.

In **Annex 2**, The Covenant Document on HIV/AIDS, provides biblical basis for constructive engagement with PLWHA in all the issues of the epidemic. It gives a language to both the churches and PLWHA, and for facilitating partnership in the struggle against HIV/AIDS. In **Annex 3**, there is a list of appropriate and inappropriate terminology for discussing HIV- and AIDS-related issues. Familiarity with these terms and their meanings may aid sensitive and constructive communication.

Example: NGOs and community groups, Sri Lanka¹⁰²

At a training workshop, NGOs and community groups expressed that they were unsure about what language to use – about HIV and AIDS, NGOs and development – when documenting their work and communicating with partners. Therefore, they carried out a “language brainstorm” exercise – in both Sinhala (the local language) and English – to explore how comfortable they felt about using certain words and terms when speaking with their partners. They considered issues such as whether the words were understandable and technically correct, and if they would help to communicate a positive image of NGOs and HIV and AIDS work.

¹⁰² Adapted from “Documentation Workshop”, Alliance Lanka and the Alliance, Sri Lanka, July 1997. <http://www.aidsalliance.org/eng/>

Happy to use	Not sure	Not happy to use
<ul style="list-style-type: none"> • People living with HIV/AIDS • sustainability • participation • lessons learned • safer sex • HIV positive • empowerment 	<ul style="list-style-type: none"> • top down • high risk group • NGO • CBO • bottom up • victim • homosexual 	<ul style="list-style-type: none"> • prostitute • protease inhibitor • contagious • failure • ASO (AIDS Service Organization) • safe sex • AIDS positive

Exercise

What might be the consequences of using language that a partner finds inappropriate, or does not understand?

Does the church need to change some of the words that it uses in its daily communication? Why?

Are there simpler alternatives to some of the jargon?

Scripture

Read 1 Corinthians 9:19–25

In the light of the above scripture, how should churches present themselves to their partners?

Do you think churches have the obligation to develop and use diplomatic/acceptable language to their partners?

4.4 Getting the message across

Messages help a church or faith-based organization communicate effectively with its partners. These are forceful statements, which help a church or faith-based organization to connect quickly with its partners, in a way that they can appreciate and remember. A church or faith-based organization can include these messages in brochures and other materials about the organization. They can also be used as a reminder of points to be made when meeting with partners, making presentations, or giving media interviews.

Good messages reflect the church’s or faith-based organization’s identity as an organization, as well as its strengths, experience and expertise. People in a church or faith-based organization should come to a consensus over messages, support them and use them consistently.

Powerful messages are:

- short;
- simple;
- positive;
- accurate;
- consistent; and
- action-orientated

Example: ANERELA+ (African Network of Religious Leaders Living with or personally affected by HIV and AIDS)

Vision: an African Region where religious leaders living positively with and affected by HIV and AIDS are empowered to live openly as witnesses to hope and be forces for change in their congregations and communities.

1. (Message about HIV/AIDS and why it is important)... HIV/AIDS is a reality, and it affects individuals, communities and our continent. HIV/AIDS in Africa is not only a health problem, but also a socio-economic problem affecting all aspects of society.
2. (Message about what ANERELA+ does and stands for)... ANERELA+ is the only self-help group for religious leaders living with or personally affected by HIV and AIDS in Africa. We are part of the world-wide effort to prevent the spread of HIV and to care for people who are affected.
3. (Message about how other people can work with the ANERELA+)... we are not the problem, but part of the solution. Everyone has a role to play in supporting people living with HIV/AIDS in the church and in the community.

4.5 Responding to crises

The process of building partnerships does not always go smoothly. Therefore, it is important that a church finds constructive ways to cope with problems and crises. Some differences of opinion or values may make it difficult for a church to work with a particular partner. Through on-going communication with a partner, a church can often, but not always, find a way to overcome these obstacles. Even if a church decides not to continue with the partnership, it can at least understand what the differences are about and base its decision upon facts.

Annex 1

List of Declarations and Policy Statements by Churches and Faith-based Organizations from 2001 to 2004

2001

All Africa Conference of Churches, *Mukono - Kampala Declaration*. Mukono - Kampala, Uganda, 15–17 January 2001.

Church of Norway, *Statement from the Bishops' Conference*. April 2001

All Africa Conference of Churches, *The Dakar Declaration*. Dakar, Senegal, 23–25 April 2001.

Southern African Bishops Conference. *A Message of Hope to the People of God from the Catholic Bishops of South Africa, Botswana, and Swaziland*. Pretoria, South Africa, 30 July 2001.

Anglican Communion across Africa. *All Africa Anglican AIDS Planning Framework "Our Vision, Our Hope" The First Step*. Johannesburg, South Africa, 22 August 2001.

The Ecumenical Response to HIV/AIDS in Africa (EHAIA). *Plan of Action, Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa*. Nairobi, Kenya, 25–28 November 2001

Christian Conference of Asia, *Consultation on HIV/AIDS: A challenge for religious response: Statement*. Chiang Mai, Thailand, 25–30 November 2001.

2002

The Lutheran World Federation, *Compassion, Conversion, Care: Responding as churches to the HIV/AIDS pandemic. An Action Plan of the Lutheran World Federation*, 18 January 2002.

Anglican Primates, *Report of the Meeting of Primates of the Anglican Communion: Appendix III Statement of Anglican Primates on HIV/AIDS*, Canterbury, United Kingdom, 17 April 2002.

Pan-African Lutheran Church Leadership, *Breaking the Silence, Commitments of the Pan-African Lutheran Church Leadership Consultation in response to the HIV/AIDS pandemic*. Nairobi, Kenya, 2–6 May 2002

World Council of Churches (WCC) and Christian Conference of Asia (CCA). *Report of the WCC-CCA Consultation on 'An Ecumenical Agenda to combat HIV/AIDS in South Asia'*. Colombo, Sri Lanka, 24–26 July 2002.

Council of Anglican Provinces in Africa (CAPA). *Statement from CAPA AIDS Board Meeting*. Nairobi, Kenya, 19–22 August 2002.

World YWCA. *Executive Committee*. Geneva, Switzerland, November 2002

World YWCA. *Executive Committee: HIV/AIDS Policy*. Geneva, Switzerland, November 2002

2003

Lutheran World Federation, *Latin America Regional Consultation on the Lutheran World Federation Plan of Action, "Compassion, Conversion, Care" – Justice, conversion and integration*, Catia la Mar, Venezuela, March 2003.

Primates of the Anglican Communion. *Pastoral letter from the Primates of the Anglican Communion*. 27 May 2003.

Council for World Mission. *Assembly Statement*. Ayr, Scotland, 15–25 June 2003

Lutheran World Federation, *Adopted version of message from the Tenth Assembly*, Winnipeg, Canada, 21–31 July 2003.

World YWCA. *World Council Resolution: Reproductive Health and Sexuality*. Brisbane, Australia, July 2003.

Norwegian Church Aid. *HIV/AIDS, A policy statement from Norwegian Church Aid*. Approved by NCA Board 29 September 2003.

Symposium of Episcopal Conferences of Africa and Madagascar, *The Church in Africa in face of HIV/AIDS Pandemic, Message issued by Symposium of Episcopal Conferences of Africa and Madagascar (SECAM)*, Dakar, Senegal, 7 October 2003.

East - Central Africa Division of Seventh-day Adventist Church. *East - Central Africa Division (ECD) of Seventh-day Adventist (SDA) Church Regional Workshop on HIV/AIDS. The Nairobi Declaration*. Nairobi Kenya, 10–13 November 2003.

Church of Nigeria (Anglican Communion). *Communiqué, National HIV/AIDS Strategic planning and policy development workshop*. Abuja, Nigeria, 10–14 November 2003.

Interfaith: Christian Conference of Asia, World Council of Churches, Christian Aid, Norwegian Church Aid, United Evangelical Mission, Church of Christ in Thailand AIDS Ministry and Ecumenical Coalition on Tourism, *For we are Neighbours: Statement from the Interfaith AIDS Conference*, Bangkok, Thailand, 20–25 November 2003.

Catholic Bishops of Myanmar. *Pastoral Letter on HIV/AIDS and the Response of the Church*. December 2003

Indian Catholic Bishops. *Pastoral Letter from Indian Bishops for World AIDS Day 2003: The challenge to be his Light today*. 1 December 2003.

Lutheran World Federation and the United Evangelical Mission, "*Covenant of life*"-*Statement of Commitment of the Asian Church Leadership Consultation on HIV/AIDS*, Batam Island, Indonesia, 1–4 December 2003.

Memorandum of Intention, Strategy consultation on Churches and HIV/AIDS in central and eastern Europe. St. Petersburg, Russia, 15–18 December 2003.

2004

Romanian Orthodox Church. His Beatitude Teoctist, Patriarch of the Romanian Orthodox Church. *A message, urging to love and tolerance for those suffering from AIDS/HIV*. Romania, 27 January 2004.

Regional Meeting facilitated by the Latin American Council of Churches (CLAI) and supported by the World Council of Churches (WCC), *The Church and HIV/AIDS in Latin America and the Caribbean*, Panama City, Panama, 27 January–1 February 2004.

World YWCA. *YMCA Global Capacity Building Forum on HIV/AIDS: Strategic Framework for a Global YMCA Action Plan on HIV/AIDS*. Durban, South Africa. March 2004.

World YMCA. *YMCA Global Capacity Building Forum on HIV/AIDS: YMCA Movement Statement on HIV/AIDS*. Durban, South Africa. March 2004.

World Council of Churches' Pacific Member Churches, *The Nadi Declaration: A statement of the world council of churches' Pacific Member Churches on HIV/AIDS*. Nadi, Fiji, 29 March–1 April 2004,

World YMCA. *Recommendations on HIV/AIDS adopted by the World Alliance Executive Committee*. Hong Kong, 2 April 2004.

The United Methodist Church. *Global AIDS Fund Resolution – Adopted by 2004 General Conference*. Pennsylvania, United States, 27 April–7 May 2004

The United Methodist Church. *Drugs and AIDS Resolution – Adopted by 2004 General Conference*. Pennsylvania, United States, 27 April–7 May 2004

Asian Muslim Action Network, Asian Resource Foundation and Thai Muslim Network. *International Pre-conference Muslim Workshop on HIV/AIDS. In the name of Allah, the Beneficent, the Merciful*. Bangkok, Thailand, 9 July 2004.

Provincial Anglican Bishop. *Communique, The Province of Central Africa Bishops Retreat*, Malawi, 13 - 14 July, 2004.

United Evangelical Mission, Anti HIV/Aids Programme Policy, Adopted by the UEM General Assembly in Manila, October 2004.

Latin America, *Message from Churches, Organizations and Programmes on World AIDS Day 2004, Women, Girls and HIV/AIDS*. 1 December 2004.

Interfaith. *International Interfaith Conference on Prevention and Control of HIV/AIDS, Delhi Declaration*. Delhi, India, 1–2 December 2004

The Cairo Declaration of Religious Leaders in the Arab States in Response to the HIV/AIDS Epidemic. Cairo, Egypt, 11–13 December 2004.

Annex 2

The Covenant document on HIV/AIDS¹⁰³

Preamble

The Lord God is the creator of heaven and earth; the creator of all life forms in the earth community. He created all life and everything good. In this HIV/AIDS era, he sees the misery of his people, who are infected and affected by this disease; He has heard their cry on the account of this epidemic. He knows their sufferings and he has come down to deliver them from HIV/AIDS. So he calls to send us to the infected and affected, to bring his people, his creation, out of the HIV/AIDS epidemic. Now therefore this Assembly recognizes God's call to us and hence makes this covenant with God today:

Covenant 1: Life and HIV/AIDS Prevention

We shall remember, proclaim and act on the fact that, the Lord our God created all people and all life and created life very good (Genesis 1–2) We shall, therefore, seriously and effectively undertake HIV/AIDS prevention for all people - Christians and non-Christians. married and single, young and old, women and men, poor and rich, black, white, yellow, all people everywhere-, for this disease destroys life and its goodness, thus violating God's creation and will.

Covenant 2: Love and HIV/AIDS Care

We shall remember, proclaim and act on the fact that love is from God and everyone who loves is born of God and knows God. Those who say 'I love God,' and hate their sisters and brothers are liars, for unless you love your sisters and brothers whom you see, you cannot love God whom you have never seen (I John 4:7–21). We shall, therefore, do all that is necessary and within our power to encourage both men and women to love, care, support and heal all those who are infected and affected by HIV/AIDS in our communities, countries and continent.

Covenant 3: Treatment and HIV/AIDS Drugs

We shall remember, proclaim and act on the fact that the earth and everything in it belongs to the Lord and that He has given it over to all human beings for custodianship (Psalms 24:1 and Genesis 1:29). We shall therefore, openly and persistently undertake prophetic and advocacy role for all the infected who are denied access to affordable HIV/AIDS drugs until antiretrovirals are available to all who need them.

¹⁰³ Adopted by the 8th AACC General Assembly, Yaunde, 2003.

Covenant 4: Compassion, HIV/AIDS Stigma & Discrimination

We shall remember, proclaim and act on the fact that the Lord our God, is a compassionate God, who calls upon us to be compassionate, to suffer with those who suffer, to enter their places and hearts of pain and to seek lasting change of their suffering (Luke 6:36; Matthew 25:31–46). We shall therefore, have zero tolerance for HIV/AIDS stigma and discrimination and do all that is necessary to eliminate the isolation, rejection, fear and oppression of the infected and affected in our communities. We shall declare HIV/AIDS stigma and discrimination an unacceptable sin before God and all believers and in all our communities.

Covenant 5: Poverty and HIV/AIDS

We shall remember, proclaim and act on the fact that the Lord our God, who created all the resources of the earth, blessed both women and men and gave them the resources of the earth for their sustenance (Genesis.1:28-29). We shall, therefore, work to empower all the poor and denounce all the cultural, national and international structures, laws and policies that have condemned billions to poverty thus denying them their God given rights and, in the HIV/AIDS era, exposing them to infection and denying them quality care and treatment.

Covenant 6: Gender Inequalities and HIV/AIDS

We shall remember, proclaim and act on the fact that the Lord our God, created humankind in his image. In his image, he created them male and female, he blessed them both and gave both of them leadership and resources in the earth; he made them one in Christ (Genesis 1:27–29; Galatians 3:28–29). We shall, therefore, denounce gender inequalities that lead boys and men to risky behaviour, domination and violence; that deny girls and women leadership, decision making powers and property ownership thus exposing them to violence, witchcraft accusation, widow dispossession, survival sex – fuelling HIV/AIDS infection and lack of quality care and treatment.

Covenant 7: Children and HIV/AIDS

We shall remember, proclaim and act on the fact that, Lord our God welcomes children. He has given his kingdom to them and he is the father of all orphans (Mark 9:33–37; 10:13–16; Psalms 68:5 and Psalms 146:9). We shall, therefore, work to empower and protect all children and denounce all the national and international structures, cultures, policies, laws and practices that expose children to sexual abuse and exploitation, HIV/AIDS stigma and discrimination, dispossession and poverty thus exposing them to HIV/AIDS infection and lack of quality care.

Covenant 8: Church, PLWHA and HIV/AIDS

We shall remember, proclaim and act on the fact that we are one body of Christ and if one member suffers, we all suffer together with it; that the Lord our God identifies with the suffering and marginalized and heals the sick (1 Corinthians 14:26; Matthew 25:31–46). We shall, therefore, become a community of compassion and healing, a safe place for all PLWHA to live openly and productively with their status.

Covenant 9: Human Sexuality and HIV/AIDS

We shall remember, proclaim and act on the fact that the Lord our God, created human sexuality and created it good (Genesis 2:18–25). We shall, therefore, test for infection, denounce sexual violence, abstain before marriage, be faithful in marriage and practice protected sex to avoid HIV/AIDS infection and plunder on life, for all life is sacred and prevention should be seriously pursued to protect life.

Covenant 10: Justice and HIV/AIDS

We shall remember, proclaim and act on the fact that the Lord our God, sees, hears, knows the suffering of people and comes down to liberate them (Exodus 3:1–12; Luke 4:16–22). We shall, therefore, declare the jubilee and we shall proclaim liberty throughout the land and to all its inhabitants (Leviticus 25:10), for unless and until justice is served to all people in the world, until justice rolls down like waters and righteousness like an ever-flowing stream, HIV/AIDS cannot be uprooted.

Annex 3

Sensitive language use vis-à-vis HIV and AIDS

Churches have a valuable role in informing members about HIV. But at times, churches have also used terms which can be misleading about the virus, or harmful to people who are living with HIV or AIDS. The appropriate use of language respects the dignity and rights of all concerned, avoids contributing to the stigmatization and rejection of PLWHA and assists in creating the social changes required to overcome the epidemic.

Some general rules are:

- Language should be inclusive and not create and reinforce an “us and them” mentality or approach. Care should be taken with the use of pronouns such as “we”, “they”, “you”, “them”, “their” etc.
- Language should be value neutral, gender sensitive and should be empowering rather than disempowering. Terms and images such as "promiscuous", "drug abuse" and all derogatory terms alienate rather than create the trust and respect required.
- HIV/AIDS prevention messages should show that HIV and AIDS affect all people – all ages, cultures, races, genders and sexual orientations.
- Images of PLWHA “at death’s door” and images of PLWHA as unable to live fulfilling lives because of their HIV-positive status should be avoided.
- Describing HIV and AIDS as a scourge or plague should also be avoided; HIV is simply an infection which has reached epidemic proportions
- It is better if vocabulary is drawn from the vocabulary of peace and human development, rather than from the vocabulary of war and condemnation. For example, “HIV/AIDS response” is better than the “fight against HIV/AIDS”.
- “How did you become HIV infected?” is a question that should not be asked. Of far greater importance is “How are you living with HIV?”

Below are some examples of stigmatizing or inaccurate terms, together with suggestions of alternative terms and phrases:

1. Use: HIV infection, HIV-positive, HIV/AIDS, HIV and AIDS, HIV or AIDS

Do not use: "AIDS" if the intention is to refer to HIV

AIDS is a range of conditions which occur when a person's immune system is seriously damaged by HIV infection. Someone who has HIV infection has antibodies to the virus but may not have developed any of the illnesses which constitute AIDS.

Do not use: AIDS Virus, HIV Virus

There is no such thing as the AIDS virus. There is only HIV (Human Immunodeficiency Virus) - the virus that can cause AIDS. The term "HIV virus" actually means Human Immunodeficiency Virus virus, which is not correct.

Prefer not to use HIV/AIDS

HIV is a retrovirus (the infectious agent), AIDS is the syndrome of a damaged immune system. Using the term 'HIV/AIDS' may give the wrong impression that there is one disease called HIV/AIDS. Always specify either HIV or AIDS when possible.

2. Use: Person Living with HIV or Person Living with HIV/AIDS or People Living with HIV/AIDS (PLWHA)

Do not use: AIDS victim or sufferer

Many PLWHA feel these terms imply they are powerless, with no control over their health or lives.

Do not use: innocent victims

This term wrongly implies that people infected through mother to child transmission or by medical means are innocent, This also implies that people infected with HIV through other ways are guilty of some wrong-doing and somehow deserving of punishment. This feeds stigmatization of and discrimination against PLWHA, and should be avoided.

Do not use: AIDS carrier

This term is highly offensive and stigmatizing to many people with HIV and AIDS. It is also incorrect: the infective agent is HIV. You cannot catch AIDS. This term may also give the impression that people can protect themselves by choosing a partner based on their appearance or by avoiding someone who they know is living with AIDS.

Do not use: full blown AIDS

This term implies there is such a thing as "half-blown AIDS". A person only has AIDS when they present with AIDS-defining illnesses such as certain opportunistic infections, or when the CD4 level falls below a certain point.

Do not use: AIDS patient

Use "AIDS patient" only to describe someone who has AIDS and who is, in the context, in a medical setting. Most of the time, a person with AIDS is not in the role of a patient.

3. Use: affected communities or high-risk behaviours (i.e. unsafe sex, or sharing syringes or needles)

Do not use: high risk group

For example. truck drivers, homosexuals, migrants, sex workers, injecting drug users have been labelled 'high risk' groups in the past. This is unhelpful as it implies that membership of a particular group, rather than behaviours (e.g., unprotected sex, using contaminated syringes), is the significant factor in HIV transmission. This term may lull people who do not identify with a high risk group into a false sense of security. It

is high-risk behaviours such as unsafe sex or unsafe injecting practices that can transmit HIV, not being a member of particular group.

4. Use: for your country, i.e. Sri Lanka or Jamaica, use: Sri Lankan population/Jamaican population, HIV-negative people, all Sri Lankans/all Jamaicans.

Do not use: general population

This implies that people in the populations targeted for HIV prevention, education and care are not part of the general population. It artificially divides the world into those who are infected or likely to be exposed to HIV, and those who are not; falsely implying that identity, rather than behaviour, is the critical factor in HIV transmission.

5. Use: blood, semen, pre-ejaculate, vaginal fluids, breast milk.

Do not use: body fluids

Confusion about the body fluids that can transmit HIV is a common cause of fear and misunderstanding about HIV, and continues to cause stigmatization of discrimination against PLWHA. If undertaking education always explain which body fluids contain HIV in sufficient concentrations to be implicated in HIV transmission (i.e., blood, semen, pre-ejaculate, vaginal fluids and breast milk). Emphasise that HIV cannot be transmitted through body fluids such as saliva, sweat, tears or urine.

6. Use: sex worker, which reflects the employment aspect of sex work.

Do not use: prostitute or whore

Prostitute and whore are considered disparaging and stigmatizing terms that do not reflect the fact that sex work is a form of employment, not a way of life.

7. Use: Person who injects drugs, people who inject drugs, injecting drug users (IDUs). These days the most commonly used form is injecting drug users (IDUs).

Do not use: junkie, druggie or drug addict

Illicit drug use is only one part of an injecting drug user's life. Terms such as “junkie” and “druggie” promote stereotyped images that are not accurate.

8. Use: Men who have sex with men (MSM), gay and homosexual

Men who have sex with men (MSM) are not a group of people, but rather a social phenomenon. Many MSM do not see themselves as homosexual and many are also married or have sex with women. In some regions, there are high levels of bisexual behaviours among men.

In most parts of the world, there are groups of “self-identified homosexual” who use various terms to identify themselves. Such terminology is found in most, if not all, cultures. Some terms denote effeminate men; while others denote more masculine men. Those men in many places form a sub-culture. It is important to bear in mind that all MSM do not necessary feel that they belong to this subculture, the fact that they have sex with another man is, in many cases, just something they do, something that just happens.

Even in these places where there is a visibility and certain openness of MSM, there are many other men, possibly a majority of the total, who do not self-identify as gay or bisexual, because of stigmatization or fear of discrimination or because of a lack of role models, among other reasons. However, self-identification is not essential for recognition that same-sex behaviour exists.

Do not use: queen, queer, poof, faggot, bum boy etc.

Annex 4

Glossary

Acquired Immunodeficiency Syndrome (AIDS) is the late stage of the infection caused by the Human Immunodeficiency Virus (HIV). A person living with HIV can look and feel healthy for a long time before signs of AIDS appear. However, HIV weakens the body's defence (immune) system until it can no longer fight off diseases such as tumours and cancers, and infections such as pneumonia, diarrhoea, TB and other illnesses.

AIDS-competent church:

- whose teaching and practice indicate clearly that stigma and discrimination against PLWHAs is sin and against the will of God;
- which, along with its ecumenical partners, has a full understanding of the severity of the HIV/AIDS pandemic in Africa;
- which reaches out and responds to collaborative efforts in the field of HIV/AIDS;
- which find its role in prevention of HIV/AIDS, taking into consideration pastoral, cultural and gender issues; and
- which use its resources and structures to provide care, counselling and support for those affected.

Antiretroviral (ARV) therapy, (ART), consists of drugs used in the treatment of HIV infection. They work against HIV infection itself by slowing down the reproduction of HIV in the body but are not a cure.

CD4 (T4) or CD4+ cells

1. A type of T cell involved in protecting against bacterial, viral, fungal, and protozoal infections. These cells normally orchestrate the immune response, signaling other cells in the immune system to perform their special functions. Also known as T helper cells.

2. HIV's preferred targets are cells that have a docking molecule called "cluster designation 4" (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (or CD4+) cells. Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4+ lymphocyte levels appear to be the best indicator for developing opportunistic infections. Although CD4 counts fall, the total T cell level remains fairly constant through the course of HIV disease, due to a concomitant increase in the CD8+ cells. The ratio of CD4+ to CD8+ cells is therefore an important measure of disease progression.

CD8 (T8) cells are white blood cells with the CD8 protein on their surface. These white blood cells kill some cancer cells and cells infected by intracellular pathogens (some bacteria, viruses, and mycoplasma). Also called cytotoxic T cells, T8 cells, cytotoxic T lymphocytes.

Condoms: used consistently and correctly male latex condoms provide a high level of protection against HIV infection and also stop the transmission of other sexually transmitted infections. Male condoms are usually made out of latex, they should be stored carefully avoiding prolonged exposure to heat, and should be used with a water-based lubricant. A female condom is available, which is used by a woman and fits inside the vagina.

Human Immunodeficiency Virus (HIV): the virus that causes AIDS or Acquired Immunodeficiency Syndrome. HIV attacks the body's immune system – the system that fights against infections.

HIV-negative indicates that there is no evidence of infection with HIV (e.g. absence of antibodies against HIV) in a blood or tissue test. Note that in the period between infection and antibodies being detectable (the window period, generally up to six months), a HIV test will produce a negative result – a false negative.

HIV-positive indicates infection with HIV (e.g., presence of antibodies against HIV) on a test of blood or tissue. A test may occasionally show false positive results.

Malaria: a life-threatening parasitic disease transmitted by mosquitoes from person to person through the bite of a female Anopheles mosquito, which requires blood to nurture her eggs.

Today, approximately 40% of the world's population, mostly those people living in the world's poorest countries, is at risk of malaria. Malaria causes more than 300 million acute illnesses and at least one million deaths annually. Of deaths due to malaria 90% occur in sub-Saharan Africa mostly among young children. Malaria, together with HIV and AIDS and TB, is one of the major public health challenges undermining development in the poorest countries in the world.

Masturbation: self-stimulation of the male or female sex organs to the point of intense pleasure or orgasm. Masturbation is not bad for you physically, sexually or emotionally and can be, in fact, good for you. Masturbation is medically viewed as a normal and healthy sexual activity.

Mutual Masturbation: involves each partner masturbating the other, and will break down inhibitions and allow you to get even closer. Masturbating your partner in the way he or she enjoys is an important part of lovemaking. Both men and women need to learn how to handle each other's genitals with tenderness and sensitivity. Furthermore, mutual masturbation is a safe sex practice as it involves no penetrative sexual intercourse.

Needle and Syringe Exchange Programmes (NSP): established in the 1980s, NSPs were developed with the intention to pragmatically reduce the risk of transmission of blood borne infections including HIV by providing clean needles and syringes to injecting drug users (IDUs). On the basis of a substantial body of research literature, NSPs have effectively contributed to reducing the spread of blood borne infections – including HIV – among IDU populations. In countries and regions, where NSPs were established as part of a broad response and early on, HIV epidemics were largely prevented in populations of IDUs. However, in many countries, NSPs remain illegal.

Opportunistic Infections: illnesses caused by various organisms, such as bacteria, parasites and viruses, some of which usually do not cause disease in persons with healthy immune systems.

Oral Sex: using the mouth to stimulate a person's sexual organ, regarded as a low-risk sexual activity for HIV transmission.

Peer Support: providing emotional and practical support to people living with HIV or AIDS by linking them with other HIV-positive people, some of who may be trained and experienced in providing support. Being newly diagnosed as HIV-positive or having lived with HIV for a number of years presents many challenges and uncertainties, including isolation. Peer support can help resolve some of these problems as well as clarify feelings and thoughts.

Individual peer support involves speaking with HIV-positive people on a one-to-one basis over the telephone or in person. Advice and information on issues that may be affecting a person's health, lifestyle and future can be provided. These can include treatments, relationships, disclosure, self-confidence, friendships, sexuality and other issues related to living with HIV. Peer support discussion groups are a forum for meeting other PLWHA as well as for discussing issues around HIV and AIDS.

Penetrative sex: when a man's penis penetrates the vagina or anus (of a woman or a man). HIV can be transmitted through unprotected (i.e. without the protection of a condom) penetrative sex.

People living with HIV or AIDS (PLWHA):

It is preferable to use 'people living with HIV/AIDS (PLWHA)', since this reflects the fact that a HIV-positive person can continue to live well and productively for many years. It is a term of empowerment emphasizing living with HIV and AIDS rather than dying from AIDS.

It is preferable to avoid certain terms: AIDS patient should only be used in a medical context (most of the time, a person with AIDS is not in the role of patient); the term AIDS victim or AIDS sufferer implies that the individual in question is powerless, with no control over his/her life. Referring to PLWHA as innocent victims (which is often used to describe HIV-positive children or people who have acquired HIV medically) wrongly implies that people infected in other ways are somehow deserving of punishment.

Post-exposure prophylaxis (PEP): antiretroviral therapy for HIV designed to reduce (but not eliminate) the possibility of infection with the virus after a known exposure. PEP must be begun as soon as possible after likely exposure to HIV under medical supervision. Different countries have adopted different protocols for the use of PEP; many exclude non-occupational exposure.

Red Ribbon: the international symbol of HIV and AIDS awareness worn by people all year round and particularly around World AIDS Day. It is a symbol of hope and solidarity. Hope that the search for a vaccine and cure to stop AIDS is successful and the quality of life improves for people living with AIDS. The Red Ribbon is also a

message of support for people living with and affected by HIV and AIDS. The developers of the red ribbon symbol waived their rights to copyright and the symbol may therefore be used by anyone.

Safer sex: taking precautions to decrease the potential of transmitting or acquiring STIs, including HIV, while having sexual intercourse. Using condoms correctly and consistently during sexual intercourse is considered safer sex. Non-penetrative sex is also safer sex.

Sexually Transmitted Infections (STIs): infections diseases transmitted through sexual activity such as Chlamydia, gonorrhoea genital warts, ulcers and syphilis. Some signs of infection are if the urethra ever burns or itches, particularly when urinating, or if there is a greenish, yellowish, foamy, bloody, or foul-smelling discharge from the urethra. Using condoms can prevent transmission of STIs including chlamydia and gonorrhoea, which if not treated can have serious health consequences. Untreated STIs increase the likelihood of HIV transmission during sexual activity.

Tuberculosis (TB): like the common cold, it spreads through the air. Only people who are ill with TB in their lungs are infectious. When infectious people cough, sneeze, talk or spit, they propel TB germs, known as bacilli, into the air. A person needs only to inhale a small number of these to be infected. Left untreated, each person with active TB disease will infect on average between 10 and 15 people every year. But people infected with TB bacilli will not necessarily become sick with the disease. The immune system "walls off" the TB bacilli which, protected by a thick waxy coat, can lie dormant for years. When someone's immune system is weakened, the chances of becoming ill are greater.

HIV and TB form a lethal combination, each speeding the other's progress. HIV weakens the immune system. Someone who is HIV-positive and infected with TB is many times more likely to become ill with TB than someone infected with TB who is HIV-negative. TB is a leading cause of death among people who are HIV-positive, accounting for about 13% of AIDS deaths worldwide. In Africa, HIV is the single most important factor determining the increased incidence of TB in the past 10 years.

Universal blood precautions: a simple standard of infection-control practice used to minimize the risk of infection with blood-borne pathogens, including HIV and hepatitis. Universal precautions involve the use of protective barriers such as gloves, gowns, aprons, masks, or protective eyewear, which can reduce the risk of exposure of the person's skin or mucous membranes to potentially infective materials.

Unsafe sex: penetrative sexual intercourse without using a condom. This puts each person at risk of transmitting or acquiring STIs, including HIV.

Viral load: the amount of HIV circulating in a person's blood. Monitoring a person's viral load is important because of the apparent correlation between the amount of virus in the blood and the severity of the disease: sicker patients generally have more virus than those with less advanced disease. A new, sensitive, rapid test – called the viral load assay for HIV-1 infection – can be used to monitor the HIV viral load. This procedure may help clinicians to decide when to give anti-HIV therapy or to switch

drugs. It may also help investigators determine more quickly if experimental HIV therapies are effective.

Viral load test: measures the quantity of HIV RNA in the blood. Results are expressed as the number of copies per millilitre of blood plasma. Research indicates that viral load is a better predictor of the risk of HIV disease progression than the CD4 count. The lower the viral load, the longer the time to AIDS diagnosis and the longer the survival time. Viral load testing for HIV infection is being used to determine when to initiate and/or change therapy.

Voluntary counselling and testing (VCT): the process of undergoing a HIV test. It is confidential and includes pre-test counselling, testing after you agree to be tested and post-test counselling no matter whether the result is positive or negative.

World AIDS Day: held each year on 1 December and is a day of international, national and local support for the fight against HIV/AIDS and solidarity with people living with HIV/AIDS.

Annex 5

PLWHA Networks Contact Details

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