

Religion and HIV/AIDS: defining issue of our time

Compilation of findings of three case studies and literature for the Knowledge Forum on Religion and Development Policy.

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“Spirituality and religion are part and parcel of the culture of Zimbabwe. It is therefore expected that help also addresses the spiritual needs of people. Offering help is not only offering practical help, but it is also meeting spiritual needs. Christian organisations have this ‘holistic approach’ due to their Christian character and belief, which includes the spiritual needs of people. Due to this drive, there is no place for a technical “hit and hop away” approach.”

Darija Kupers, Prisma (‘Religion as driver of change: case study of two Christian HIV/AIDS organisations in Zimbabwe’)

1. Introduction

Twenty-five years into the epidemic, AIDS has become one of the defining issues of our time. A truly global problem, AIDS affects every region and every country of the world, challenging health systems and undermining our capacity to reduce poverty, promote development and maintain national security. Since 1981, 65 million people have been infected with HIV and 25 million have died of AIDS-related illnesses.

Global facts and figures:

- A total of 39.5 million people were living with HIV in 2006 (2.6 million more than in 2004). The number of new infections in 2006 rose to 4.3 million in 2006 (400 000 more than in 2004).
- Sub-Saharan remains the most affected region in the world. Two thirds of all people living with HIV live in this region—24.7 million people in 2006. Almost three quarters of all adult and child deaths due to AIDS occurred in sub-Saharan Africa—2.1 million of the global 2.9 million deaths due to AIDS.
- The number of people living with HIV increased in every region in the world in the past two years.
- The most striking increases have occurred in East Asia and in Eastern Europe and Central Asia, where the number of people living with HIV in 2006 was over one fifth (21%) higher than in 2004.
- Globally and in every region, more adult women (15 years or older) than ever before are now living with HIV. The 17.7 million women living with HIV in 2006 represent an increase of over one million compared with 2004.
- Access to treatment and care has greatly increased in recent years. Through the expanded provision of antiretroviral treatment, an estimated two million life years were gained since 2002 in low and middle-income countries.
- The centrality of high-risk behaviours (such as injecting drug use, unprotected paid sex and unprotected sex between men) is evident in the HIV epidemics of Asia, Eastern Europe and Latin America.
- Although the epidemics also extend into the general populations across the world, they remain highly concentrated around specific populations groups.

Source: UNAIDS, December 2006

Churches, mosques and faith-based organisations play a (potential) valuable role in the international AIDS response. Unfortunately policy-making organisations, international donors and other stakeholders often lack sufficient knowledge and understanding of religious dynamics and the role of religious institutions and therefore often look at this role in a simplistic and reductionist manner. In this chapter an effort is made to help create a greater mutual recognition between churches and faith based organisations on the one hand and policy-making organisations, international donors and more actors on the other. We present the findings of three case studies about the contribution of religion and religious organisations in the international AIDS response. Moreover, existing research reports and literature are used. This article mainly addresses aspects of traditional, Christian and Islamic faith-based perspectives regarding their AIDS response in an African context. This, of course limits the perspective in both geographical and religious terms. However, the presented outlines are likely to have a broader application.

2. HIV-prevention: a three-layer framework

The factors fanning the HIV pandemic and making individuals and communities vulnerable to infection with this virus are many and complex.

HIV prevention strategies, if they are to be effective in the immediate as well as the long-term, need to take account of this complexity and to mobilise multi-faceted responses involving all sectors of society.

UNAIDS identifies five domains of context that are virtually universal factors in communications for HIV preventative behaviour: government policy, socio-economic status, culture, gender relations and spirituality.

In practice however, prevention strategies have, from the outset, tended to be reduced to “magic bullet” initiatives seeming to offer instant solutions. Such approaches place their protagonists in “pro-condom” or “abstinence/fidelity only” groups, which become diametrically opposed and mutually antagonistic. Discussions, strategies and prevention programmes become polarised and confrontational. They also reduce an understanding of prevention to being wholly concerned with sexual transmission of the virus and with promoting free choices by autonomous, empowered individuals.

The complex range of issues driving the pandemic is lost from sight as proponents of these “one-liner” over-simplistic solutions hold sway. The solutions proposed from either end of this polarised or reductionist approach could themselves become hijacked by covert political, religious or cultural agendas and fuelled by mutual distrust and prejudices.

The understanding of HIV prevention proposed in this paper finds its roots in the analysis and work of Cafod, Trocaire and Veritas. Especially the work of Ann Smith and Enda McDonagh has been important for the development of an internationally respected perspective on HIV/AIDS. It has strongly influenced the perspective on HIV/AIDS of UNAIDS, WCC and is reflected in the work and writing of progressive Islamic organisations.

An effective response to HIV/Aids requires a combination of initiatives that tackle three layers:

- **Decreasing vulnerability:** decreasing the personal factors such as unemployment, personal poverty, substance abuse, stigma, peer/social pressure etc. that increase an individual’s vulnerability to infection and, deeper still, the society-wide factors that increase this vulnerability such as political, legal, cultural and religious factors as well as gender inequality, poverty (local, north-south), international trade and finance.
- **Risk reduction:** reducing the immediate risk of infection through the body fluids, (Blood, sex, mother-to-child)

- **Impact mitigation:** mitigating the effects for individuals such as, sickness, death, stigma, increased poverty, increased gender inequality, increased number of orphans & vulnerable children, etc as well as the wider social and economic effects on services, infrastructures and general development in countries worst affected by the pandemic

HIV prevention must be concerned with mitigating the impact, reducing the risks and decreasing the vulnerability factors that place people at risk. An understanding of prevention that excludes any of these layers is incomplete and can only be of limited effectiveness, even in the immediate term.

a) Decreasing the Vulnerability

Risk reduction strategies alone will not be sufficient to prevent HIV effectively, because an individual's personal strategies are conditioned by their social context. Hence the need to incorporate this third layer within a fuller understanding of HIV prevention. This third layer describes personal and societal factors that influence, and even dictate, the behaviours of individuals and communities. A key feature common to all of these factors is that they arise from and generate imbalances of power between men and women (gender relations), individuals, communities and countries. Such imbalances significantly curtail the behaviour choices of those who are disempowered and make them more vulnerable to HIV. Thus an overall HIV prevention strategy must also include initiatives that redress these imbalances of power that exist at personal or societal levels. To date, even where the influence of these factors is recognised, HIV prevention strategies are still too often interpreted as being solely concerned with immediate risk reduction. These deeper causative factors are consigned to completely separate response strategies by governments, international agencies and local civil society groupings alike. The result is a disjointed "parallel track" approach, which fails to make the connection in practical terms between HIV risks and the vulnerability factors augmenting those risks. Any initiative that seeks to address one or other of these vulnerability factors is, and must be recognised as an essential component of a wider HIV prevention strategy. These factors are irretrievably intermeshed and connected indicating once again the need for complementary and concerted responses.

b) Reducing the Risk

Risk reduction initiatives seek to provide individuals and communities with an accurate and full understanding of the risks to them and others of HIV infection. They also enable individuals to acquire the skills and resources to implement changes in their personal or professional lives in order to minimise these risks. Such initiatives are concerned with enabling individuals to adopt measures that afford them immediate protection, be it partial or complete.

Typical risk reduction strategies are listed in Box1. In practice the term "HIV prevention" is most often used to refer to one or a number of these risk reduction strategies. Such reductionist use of the term should be avoided, both because it denies the breadth and complexity of response that is needed if HIV prevention is to be effective, and because it far too readily leads to the polarisation of factions that becomes obstructive and destructive. The listing in figure 1 might misleadingly suggest that risk reduction is about choosing one or other option, more or less at random or in rigid adherence to the dictates of social, cultural or religious pressures. This framework proposes a different interpretation. It requires us instead to think of a risk reduction continuum running from high-risk activities in an individual's personal or professional life, to those carrying low or even no risk of HIV infection. Developing an appropriate risk reduction strategy, becomes a process whereby individuals identify their actual levels of risk and what changes are possible or desirable given their circumstances, which will reduce the level of risk.

Prevention of HIV: 1. Reducing the Risk
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Involves strategies concerned with immediate protection:

- Abstinence
- Delay of first sexual encounter
- Mutually faithful monogamous long-term relationships
- Reduction in number of sexual partners
- Reduction in instances of casual sex
- Condom use
- Non-penetrative sex
- Harm reduction with drug injection
- Safer blood transfusions
- Universal precautions by health workers/carers
- Prevention of mother-to-child transmission
- Voluntary Counselling and Testing
- Prompt Treatment for STIs
- Prevention of forced sex with minors

Box 1: Typical Risk Reduction Strategies

Any strategy that enables a person to move from a higher risk activity towards the lower end of the risk reduction continuum is a valid risk reduction strategy. With appropriate support, the individual is enabled to establish the goal they can (or choose to) realistically aim for and to identify what level of risk this still carries for them (and perhaps how they might work at minimising this further, over time).

c) Mitigating the Impact

In making this an essential component of the framework, the inextricable link between prevention and care, support and treatment should be stressed. Any care, treatment, psycho-social support or livelihood initiatives that improve the physical health and economic and emotional well-being of people infected and affected by HIV must be seen as valid and valuable prevention efforts. Such initiatives enable people living with HIV to contribute to the stability and further development of families and wider communities thereby preventing the decline into poverty and stigmatization that so often fan the pandemic.

In conclusion: the combination of the three layers becomes a prevention cycle. Decreasing the vulnerability reduces risk, which mitigates impact, which in turn decreases vulnerability. A single institution, organisation or project will not normally address all aspects of this cycle. The challenge is for each actor to identify its part in the cycle and to know who else is contributing to it. In this way, the role and limitations of each actor can be clearly defined and respected, and different actors can work together in complementary, multi-sectoral initiatives contributing to a single HIV-prevention programme.

3. The role of Churches and faith-based organisations in the international AIDS response

A number of international donors and policymaking organisations have acknowledged the (potential) valuable role that faith based organisations play, or could play, in the international AIDS response. Especially when looking at their role from the broad prevention perspective described above. They are often active in areas of economic and social justice at local national and international level, so tackling power imbalances. They are among the most important providers of care, treatment, psycho-social support or livelihood initiatives that improve the physical health and economic and emotional well-being of people infected. They also provide individuals and communities with an understanding of the risks to them and

others of HIV infection and have clear messages, although not always providing the accurate and full information, regarding risk reduction.

Moreover, churches and faith-based organisations have more often than other actors, a long-term presence in regions and situations at risk, opting for the most marginalised and trusted by the local communities. Finally, churches and faith-based organisations also have the ability to influence the attitudes and behaviours of their community members by building on these relationships of trust and respect. Although they are not always uncontested as concerns their transfer of (religious) beliefs and values, but no easy generalisations can be made here.

At the other hand policymaking organisations, international donors and other actors often do not recognise that broad role churches and faith base organisations play in the international AIDS response. They look at the role of churches and other faith-based organisations from the reductionist prevention perspective, resulting in polarisation: “pro-condom” or “abstinence/fidelity only”, placing their protagonists in groups, which become diametrically opposed and mutually antagonistic.

It must also be said that often churches and other faith based organisation on their turn also look at their own role in the AIDS response in the same reductionist way. Moreover, they still score rather weak on the HIV/AIDS related attributes:

- Lack of policy to deal with HIV/AIDS within the church
- Rather little mainstreaming of HIV/AIDS into the theological functioning of the church
- Great difficulties in redressing issues of sexuality and patriarchy by and in the church
- Churches often under estimate the role and position of women with regard to HIV/AIDS. Women are most affected, which is not enough recognized by churches and faith-based organisations
- Great difficulties addressing the imbalanced power relations between men and women
- Lack of networking and collaboration
- Although changing for the better, stigma and discrimination is at times rife and the language used while dealing with the pandemic can in itself be stigmatising.
- The focus is still too often on individual sins not the structural sins (structural injustice) of the society/community
- The youth are the most vulnerable yet at the same time, there has been an outflow of the youth from the church because of the beliefs and the values held at leadership level of the churches.
- Lack of advocacy and activism

(Source : Research of the Ecumenical Hiv/Aids Initiative in Africa)

Aids competent churches

However, over the last five to six years the different churches and faith-based organisations have worked hard on their “theology in times of AIDS”. The most perceptible outcome of these theology-oriented activities is a growing understanding among theological academics and church leaders of the relationship between scriptural messages around compassion, forgiveness and acceptance, and the presence and impact of HIV/AIDS in church communities. This understanding is affecting the way church leaders and their congregations for example, view and care for community members who are infected or affected by HIV and AIDS, and is affecting the way that people living with HIV/AIDS view themselves as accepted and supported by the community. Furthermore, church leaders themselves are beginning to focus on themselves as powerful role models in fighting stigma, discrimination and denial. Many Christian people living with aids have found support and comfort in bible-study groups, which focus on the life of Jesus Christ who stood up for the marginalized and stigmatized. Those groups often confront traditional church leaders with texts from the bible (Luke 3, Marc 1; John 8; Peter 4) and demand a ‘living’ – aids-competent - church with commitment, support and care for people living with aids.

Aids-competent churches

- Teaching and practice indicate that stigma and discrimination against people living with HIV and AIDS is sinful and against the will of God
- Leaders and members of the community understand the severity of the HIV/AIDS pandemic in Africa and know basic transmission and prevention information
- Leaders and members of the community reach out to collaborative efforts in the field of HIV/AIDS
- Leaders have identified with and assumed their role in prevention of HIV transmission taking into consideration pastoral, cultural and gender issues
- Church resources and structures are used to provide care, counselling and support

Box 2. (source Ecumenical Hiv/Aids Initiative in Africa)

Islam

Among Muslims an increasing number of religious leaders have started to acknowledge the impact of the HIV/Aids pandemic. Jaap Breetvelt, a former Kerk in Actie staff member, states that Islamic texts are flexible and could be adapted for all places and all times. Like texts from the gospels, which have been (mis)interpreted by mainly male preachers in different versions of the Bible, there is also a gap between Islamic theology, as expressed by the Quran and Hadith, and the practises which are based on customs and traditions but misinterpreted as grounded in Islam.

Breetvelt furthermore states that most of the authors on Islam indicate that Islam gives women absolute right to contraception. Regarding sexuality, Islam gives women the right to sexual health by discouraging all that was believed to be harmful such as anal intercourse and sex during menstruation. Islam also gives women the right to proper sex education and the right to enjoy sex. However, all these rights should not be practised outside of marital relations.

Referring to the Islamic perspectives of HIV/AIDS Breetvelt quotes the work done by the Islamic Medical Association of Uganda which has looked at important issues in the struggle against Hiv/Aids from an Islamic perspective:

- *Abstinence*: quite some Koranic texts and Ahadith refer to chastity 'as Allah has prepared forgiveness and great reward to men and women who guard their chastity'.
- *Being faithful*: adultery is condemned: it is a great sin and an adulterer is not a believer at the time of committing illegal sexual intercourse'.
- *Care and support*: Great emphasis is put on the duty of believers to 'help one another in righteousness and piety, to save a life, to spend in charity to the orphans and the poor, to those suffering hardship'.
- *Treatment*: The Muslim believer is told that Allah has created disease and also the cure, and is called to seek treatment whenever he/she is sick, because Allah did not leave any illness without specific treatment for it.
- *Stigma and discrimination*: Suspicion should be avoided as it is sin. The believers in their love and sympathy for one another are like one body: when one part is off, it is affected with pain, the whole of it responds in terms of wakefulness and fever.

- *Counselling*: By Allah it is the duty of those who possess the knowledge to impart it to their neighbours through good counsel and in joining what is lawful and forbidding what is prohibited. In the same manner it is the duty of the ignorant to acquire knowledge from their neighbours (who are learned). Verily Allah forgives all sins.
- *Morals*: The Muslim leaders, to whom Allah has given the power, are called to remain constant in prayers and give regular charity.
- *Youth to practice abstinence*: They need to choose rightful companionship, or listen to the advice of parents and elders, to have good morals, be properly dressed and there should be a separation of females and males.

For a good example of a modern Islamic way to describe the issues which are at stake with regard to sexual and reproductive health, Breetvelt quotes Dr. Ahmed Ragab, Associate Professor of Reproductive Health at the International Islamic Centre for Population Studies and Research at Al_Azhar University, Cairo. Ragab states that there are sacred and theological texts available that are compatible with more egalitarian notions on reproductive and sexual health: it is about choice, dignity, to be free of the risks of diseases and side effects.

Contextual Muslim theology in Africa as found in publications of the SA organisation Positive Muslims comes with an equally broad analysis of the AIDS-pandemic as given in the introduction of this chapter. "If we are serious about rising as witness-bearers for Allah in the matter of Justice, then we must also address the real causes of the AIDS-suffering as well as the way our behaviour strengthens unjust systems".

Religion and culture

In large parts of the developing world, unlike the more secularised western world, religion or spirituality is very much part of daily life. Religion and culture are carriers of values and beliefs that strongly determine individual behaviour. In this paragraph some examples of the difficulties, dilemma's and potential of religion and the values it promotes to bring about sustainable behavioural change are elaborated. This paragraph leans heavily on the studies of Jaap Breetvelt, who does important research on the involvement of African churches in the international AIDS response. Breetvelt did not find in his studies on Islam and HIV/AIDS similar discussions to the ones that take place in the African Christian World about the African 'map of universe' (ancestors, vital forces, notions about masculinity, etc.) versus European interpretations of Christianity.

The cases and literature show that it is utterly important to understand what it means for Africans to live in a society that is based on a traditional worldview as well as on concepts and values that have been imported into Africa by Arab traders, Europeans during the colonial period and through the arrival of the missionaries. Recognising and acknowledging these different value systems is essential for the development of effective and sustainable approaches to promote behavioural change.

Breetvelt states: "The overall issue of the relationship between the African 'map of universe' and western Christianity is treated by all writers, but in different ways. We can safely assume that there exist contradictions/differences between the two value systems, particularly with regard to the vital forces, more in general on human sexuality, that are as such relevant for our discussion about church, religion and HIV/AIDS. "

Masculinity

Traditional notions about male sexuality and gender relations determine to a large extent sexual behaviour. It has to do with concepts of vital force and fear of impotence, fertility, the cycle of birth, life, death and becoming an ancestor.

Many Africans see the body as a system of tubes; flow indicates that the body is functioning well, a blockage of tubes means disorder/disease and might badly influence other tubes. The hypothesis is that the use of a condom is perceived as blocking a tube (the penis with the ejaculation of vital fluids) and makes men impotent.

Breetvelt quotes the African philosopher Kā Mana saying: "...the message of A (abstinence), B (be faithful) and C (use condoms) in HIV/AIDS prevention can not lead to behavioural change when the traditional African concepts of masculinity are taken into account. Faithfulness is seen as diminishing his power (vital force), abstinence as an attack on his virility, using a condom is like taking away his masculinity."

Gender

Madipoane Maseya, theologian, states in her paper that African Christian Women are "trapped between two canons": The African culture has its own definitions of womanhood/manhood, coupled with expectations of the relationships between women and men. It is a patriarchal culture in which the husband determines the woman's identity; he is the owner of her body. According to Masenya, the Bible still enjoys authoritative status in the life of many women. However, this Bible has been interpreted for African Women by male preachers and teachers, or women have been socialised to male interpretation of the Bible. Thus, Christian African women have become vulnerable to HIV/AIDS due to African culture and Christian preaching.

Ancestor

Next to concepts of masculinity and gender the hope of becoming an ancestor is equally threatened by the pandemic. Breetvelt: "In some societies, like the Akan of Ghana "the man who in life was morally bankrupt is disqualified from being an ancestor, so is the one who dies tragically or through some loathsome disease like leprosy or madness. To this, we might add the modern pandemic of HIV/AIDS. "

Sin and evil

Values also differ with regard to the image of God and the notions on "sin". HIV/AIDS Christian theologies emphasise that God is love and Christ is the compassionate healer. For many African Christians these notions are not compatible with their deep conviction that God is a distant God and that in the case of disease for which no cure is available, other powers are at work. This leaves room for all sorts of extreme healing practises.

In the HIV/AIDS theologies, personal sin as (not being the) cause of HIV/AIDS and liberation from sin have been mentioned as important issues for theological reflection. The question has to be raised to what extent these notions of sin and evil are relevant for people for who evil is a malevolent force that is located externally in powers and spirits, and in sorcerers and witches evil in the individual is more likely to be seen as ritual pollution or social offence. These views result in suspicion of strangers, a fatalistic blaming of one's troubles on others, and a feeling of social shame. And finally it can lead to fatalistic behaviour, also in the era of HIV/AIDS.

These few examples illustrate the likely influence of different religious and cultural value systems on the behaviour of people. "If people have values, they don't fluctuate like money. Values are very important, and once understood, very hard to let go" was stated in one of the cases. To bring about a sustainable behaviour change therefore is about a long and cumbersome process of changing values that are strongly rooted in a given society. The different churches and faith-based organizations can potentially play an important role in slowly changing the value base that informs peoples behaviour, because they bring alternative values. Or, as was stated in Zimbabwe: "religion plays a significant role in changing attitudes of people, as it brings hope in difficult situations". Its value base can potentially offer a lasting positive alternative to deeply rooted values that have a negative effect on the behaviour of people.. The challenge is to find and support the positive forces in

the different churches and faith-based organizations to bring positive messages to both their churches and the people.

Behaviour change

The term behaviour change has been misused and abused when applied to the context of the HIV pandemic. Too often it is invested with the meaning that prevails in the West/North, where behaviour change is believed to be a clear-cut matter of personal and informed choice; decisions taken by autonomous individuals based on in-depth understanding of the facts and a total ability to govern their own lives. This individualist view fails to recognise that behaviour is influenced by circumstances and context and that for the majority of people affected by HIV in the South, and indeed in the North, the “solution” is not so simple. The term behaviour change is also occasionally invested with judgmental overtones implying fixed notions of what constitutes “good” and “bad” behaviour. This can sometimes be the case for programmes inspired by a specific cultural or religious ideal. In such situations the only acceptable behaviour change is that which complies with the ideal, and anything else is deemed unacceptable, even in the short term. Individualist and judgmental interpretations of behaviour change are both incompatible with the HIV prevention framework proposed above. In this framework, behaviour change for individuals is concerned with their capacity to identify and adopt risk reduction strategies appropriate to their circumstances, i.e. strategies that are realistic and sustainable.

Box 3. source “The reality of HIV/AIDS”

4. Conclusion and recommendations

Factors and actors

For an AIDS response to be effective in the immediate as well as the long-term, the complexity of the factors fanning the epidemic has to be understood and recognised in each specific context. Equally so one should recognise that no single institution, organisation or project will not normally address all these factors.

It is recommended for each actor to identify its part in the cycle and to know who else is contributing to it. In this way, the role and limitations of each actor can be clearly defined and respected, and different actors can work together in complementary, multi-sectoral initiatives contributing to a single AIDS response.

Religion and culture

In large parts of the developing world, unlike the more secularised western world, religion or spirituality is very much part of daily life. Religion and culture are carriers of values and beliefs that strongly determine individual behaviour, they are among the key factors that can either contribute to fanning or hampering the spread of the epidemic. The acknowledgement and understanding of these different religiously and culturally determined concepts and values are a precondition for the development of a more effective AIDS response.

It is recommended to promote activities and processes of deeper reflection and learning on culture, religion and HIV/AIDS.

The valuable role of churches, mosques and faith-based organisations

Churches, mosques and faith-based organisations are among the actors playing a (potential) valuable role in the international AIDS response, although it is clear that no easy generalisations can be made. The exact role should be looked at carefully in each specific context, but in general it can be stated that:

- They are often active in areas of economic and social justice at family, local, national and international level, so tackling power imbalances.
- They are among the most important providers of care, treatment, psychosocial support or livelihood initiatives that improve the physical health and economic and emotional well being of people infected.
- They also provide individuals and communities with an understanding of the risks to them and others of HIV infection and have clear messages, although not always providing the accurate and full information, regarding risk reduction.
- Moreover, churches, mosques and temples and faith-based organisations have more often than other actors, a long term presence in regions and situations at risk, opting for the most marginalized and trusted by the local communities
- Churches, mosques, other religious leaders and faith-based organisations also have the – potential - ability to influence the attitudes and behaviours of their community members by building on their relationships of trust and respect. Their value base can potentially offer a lasting positive alternative to deeply rooted values that have a negative effect on the behaviour of people regarding AIDS.

It is recommended for other actors to recognise the already valuable roles the different churches and faith-based organisations play in responding to AIDS and to support them in up scaling of these valuable responses.

Constraints and dilemma's

- There is a tendency within churches and fbo's to view hiv/aids mainly in a moral context. Although the case-studies show a significant change, hiv/aids is still used within some religions to promote moral church doctrine.
- Rather than accepting the clinical realities of the disease, some churches are using it as a tool for propaganda and conversion, encouraging only personal salvation as a way to cure hiv/aids.
- Factual knowledge is often missing. Assimilation of information, theological and factual, and behaviour change is a long process that requires a long term commitment. Not every actor in the process (f.i. donors) are willing to commit themselves for a long period.
- The case-studies show that, while mainstream churches enjoy considerable credibility and often have access to governments, their representation in coordinating mechanisms for hiv/aids is weak. Churches often still prefer to work as separate institutions.

Recommendations

However, and again acknowledging that no easy generalisations can be made here, the different churches and faith-based organisations could potentially play a more important role than they do so far. They still score rather weak on a number of HIV/AIDS related attributes. It is recommended to cooperate with churches around the strengthening of these attributes as to further maximize their potential in responding to AIDS:

- Support the development of policy to deal with HIV/AIDS within churches and faith based organisations;
- Support processes, people and initiatives that promote further mainstreaming of HIV/AIDS into the theological functioning of the church.
- Support activities and processes that aim redressing issues of gender inequality, sexuality and patriarchy by and in the churches
- Promote networking and collaboration with and between churches, and with faith based organisations.
- Support ongoing formation on matters regarding HIV/AIDS of church and religious leaders at all levels
- Support activities and processes that eradicate stigma and discrimination within the churches

- Provide more public and coordinated leadership in the struggle against the epidemic
- Come out loud and clear in every possible way and overcome silence and denial against their own personnel and in their teaching
- Respect every way of stigmatization and develop active policies on de-stigmatization
- Stimulate their members into further action for the reduction of HIV transmission
- Use their enormous resources in eliminating poverty
- Churches and their fbo's need to make themselves more visible and to clearly position themselves within the variety of actors working on HIV/AIDS.

Since churches are not homogeneous entities it is worth identifying positive forces including PLWA-s, within the respective Churches and support them in maximizing their churches' potential in responding to AIDS.

Churches and gender

The issue of gender in relation to HIV/AIDS is mentioned in the definition of aids-competent churches, eg. "leaders have identified with and assumed their role in prevention of HIV transmission taking into consideration pastoral, cultural and gender issues". However, how church leaders themselves look at gender from a theological point of view seems to be a non-addressed issue.

It is recommended to integrate attention for gender in their theological aids work, not in the least because of the gender disparities when it comes to stigma and discrimination: women are reported to suffer more from these exclusion mechanisms than men.

Access to funds and networks

While mainstream churches enjoy considerable credibility and often have access to government in times of national transition and crisis, their representation in coordinating mechanisms for HIV/AIDS is weak. However, their representation in these mechanisms is a vital link with long-term viability of their valuable HIV/AIDS interventions. Churches often lack the necessary skills to enable them to do so and/or are not aware of the need for collaboration with others (religious and non-religious relevant actors) in relation to their visibility and position. Quite some churches still prefer to work as separate institutions. It is recommended to churches and their agencies to make themselves visible and clearly position themselves within the variety of key actors working on HIV/AIDS in a country.

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