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4 Religion and HIV/AIDS: the defining issue of our time

Three case studies: findings and bibliography for the Knowledge Forum on Religion and Development Policy.

'"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 run' approach."

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

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, some 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 Africa remains the worst-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 over 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 and over) 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 as compared with 2004.
- Access to treatment and care has greatly increased in recent years. Through the

expanded provision of antiretrovirals, an estimated two million life years have been 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 population groups.

Source: UNAIDS, December 2006

Churches, mosques and faith-based organisations play a potentially valuable role in the international AIDS response. Unfortunately, policymaking 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 improve mutual recognition between churches and faith-based organisations on the one hand and policymaking organisations, international donors and a larger number of actors on the other.

We present the findings of three case studies about the contribution of religion and religious organisations to the international AIDS response. We also draw on existing research reports and literature. This article mainly addresses aspects of traditional, Christian and Islamic faith-based perspectives, regarding their response to AIDS in an African context. This, of course, limits the perspective in both geographical and religious terms. However, it does mean that the outlines presented are likely to be broader in 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 contextual domains that are virtually universal in communications about HIV preventive behaviour: government policy, socioeconomic 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 prejudice.

The understanding of HIV prevention proposed in this paper is based on the analysis and work of Cafod, Trocaire and Veritas. In particular, 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 and WCC and is reflected in the work and writing of progressive Islamic organisations.

An effective response to HIV/AIDS requires a combination of initiatives within three different areas:

- **Reducing 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. At a still deeper level, 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.
- **Reducing risk**: reducing the immediate risk of infection through bodily fluids or person-to-person contact (sex partners, mother-to-child).
- **Mitigating impact**: mitigating the effects on individuals, such as illness, death, stigma, increased poverty, increased gender inequality, increased number of orphans and vulnerable children, 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 will be of limited effectiveness, even in the immediate term.

a) Reducing 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 (i.e. gender relations), individuals, communities and countries. Such imbalances significantly curtail the behaviour choices of those who are disempowered, making 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 have still too often been interpreted as being solely concerned with immediate risk reduction. These deeper causative factors are consigned to separating 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 irrevocably intermeshed and interconnected, 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 of HIV infection to themselves and others. 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 Box 1. In practice, the term 'HIV prevention' is most often used to refer to one or a number of these risk reduction strategies. This 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 obstructive and destructive polarisation.

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 decide what changes are possible or desirable (given their circumstances) which will reduce the level of risk.

Prevention of HIV: 1. Reducing the Risk

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 STDs
- Prevention of forced sex

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 realistically aim at or opt for. They are also helped 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, psychosocial 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 stigmatisation that so often fan the pandemic.

In conclusion: the combination of the three layers creates 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 the aspects of this cycle. The challenge is for each actor to identify their 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 valuable role, potential and actual, that faith-based organisations play, or could play, in the international AIDS response. This is particularly relevant in relation to the broad prevention perspective described above. Donors and policymaking organisations are often active in areas of economic and social justice at local national and international level, and are therefore engaged in 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 those living with infection. They also provide individuals and communities with an understanding of the risks of HIV infection to themselves and others and give clear messages on risk reduction – although these do not always provide accurate and complete information.

Moreover, churches and faith-based organisations have a long-term presence in regions and situations at risk (to a greater degree than other actors), focusing on the most marginalised in society and holding the trust of 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. It is true that they are not always uncontested as concerns their transfer of religious beliefs and values, but no sweeping generalisations should be made here.

On the other hand, policymaking organisations, international donors and other actors often fail to recognise the broad role that churches and faith-based 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 of churches and other faith-based organisations thay they themselves often view their own role in the AIDS response in the same reductionist way. Moreover, on HIV/AIDS related attributes, they continue to score rather low. The following are typical:

- Lack of policy to deal with HIV/AIDS within the church;
- Comparatively low mainstreaming of HIV/AIDS within the church's theology;
- Great difficulty in addressing issues of sexuality and patriarchy by and in the church;
- Churches often underestimate the role and position of women with regard to HIV/AIDS. Women are worst affected, yet this fact is insufficiently recognised by churches and faith-based organisations;
- Great difficulty addressing the imbalance in power relations between men and women;
- Lack of networking and collaboration;
- Although things are gradually changing for the better, stigma and discrimination are at times rife and the language used in dealing with the pandemic can in itself be stigmatising;
- The focus is still too often on individual sins instead of the structural sin (injustice) of the society/community;
- Young people are the most vulnerable yet at the same time, there has been an exodus of young people from the church because of the beliefs and the values held at church leadership level;
- Lack of advocacy and activism.

(Source: The Ecumenical HIV/AIDS Initiative in Africa)

AIDS-competent churches

However, over the last five to six years the various churches and faith-based organisations have been working hard on their 'theology in times of AIDS'. The most perceptible outcome of these theology-oriented activities is a growing understanding among academic theologians and church leaders of the relationship between scriptural messages about compassion, forgiveness and acceptance, and the presence and impact of HIV/AIDS in church communities. For example, this understanding is affecting the way church leaders and their congregations perceive and care for community members who are infected or affected by HIV and AIDS. It is also impacting 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 Christians living with AIDS have found support and comfort in Bible-study groups which focus on the life of Jesus Christ as someone who stood up for the marginalised and stigmatised. Those groups often confront traditional church leaders with texts from the Bible (Luke 3: 16-22; Mark 1; John 8; 1 Peter 4) and demand a 'living' church that is AIDS-competent and demonstrates commitment, support and care for people living with AIDS.

Characteristics of 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 have basic information about transmission and prevention.

- Leaders and members of the community reach out with 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: *The Ecumenical HIV/AIDS Initiative in Africa*

Islam

In Muslim societies, an increasing number of religious leaders have started to acknowledge the impact of the HIV/AIDS pandemic. According to Jaap Breetvelt, formerly on the staff of Kerk in Actie, Islamic texts are flexible and can be adapted for all times and contexts. In his view, the way in which the Gospels tend to be interpreted and misinterpreted by preachers (especially men) working from various translations of the Bible has a parallel in Islam. The Koran and Hadith texts and the practices based on customs and traditions are often misinterpreted as being grounded in Islam.

Breetvelt furthermore states that in the literature, most authors indicate that Islam gives women absolute right to contraception. Islam gives women the right to sexual health by discouraging practices that were 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, these rights are exclusively to be exercised within marital relations.

Breetvelt also quotes the work of the Islamic Medical Association of Uganda, which has looked at important issues in the struggle against HIV/AIDS from an Islamic perspective:

- *Abstinence:* a number of Koranic texts and Ahadith state that 'Allah has prepared forgiveness and great reward to men and women who guard their chastity'.
- *Being faithful*: adultery is condemned as a great sin; an adulterer is not considered a believer at the time of having illicit 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 create any illness without also providing specific treatment for it.
- *Stigma and discrimination:* Suspicion is sinful and should therefore be avoided. In their love and sympathy for one another, believers are like one body: when one part is affected with pain, the whole body responds through wakefulness and fever.
- *Counselling:* It is the duty of those who possess knowledge to impart it to their neighbours through good counsel, to join what is lawful and forbid what is prohibited. This is the will of Allah. Equally, it is the duty of the ignorant to acquire knowledge from their more learned neighbours. Allah truly forgives all sin.
- *Morals:* Muslim leaders to whom Allah has given power are called to remain constant in prayer and to be charitable givers.
- *Young people to practise abstinence:* Young people are to choose the right companions, to listen to the advice of their parents and elders, to have good morals and be decently dressed. Females and males should be separated.

For a good example of a modern Islamic way of addressing 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. According to Ragab, certain Islamic sacred and theological texts are compatible with more egalitarian notions on reproductive and sexual health. The key issues are choice, dignity, and being free of the risk of disease and its side effects.

Contextual Muslim theology in Africa, as found in publications by the South African organisation Positive Muslims, has produced an equally broad analysis of the AIDS pandemic, as indicated in the introduction to 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. This section elaborates on some examples of the difficulties, dilemmas and potential of religion and the values it promotes to bring about sustainable behavioural change. This section draws heavily on studies by Jaap Breetvelt, who is engaged in major research on the involvement of African churches in the international AIDS response. In his studies on Islam and HIV/AIDS, Breetvelt did not find discussions similar to those taking place in the African Christian World about the African 'map of the universe' (ancestors, vital forces, notions about masculinity, etc.) versus European interpretations of Christianity.

The case studies and bibliography show that it is vital 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 were imported into Africa by Arab traders, colonising Europeans and Christian missionaries. Recognising and acknowledging these different value systems is essential for the development of effective and sustainable approaches to promote behavioural change.

According to Breetvelt, 'The overall issue of the relationship between the African 'map of the universe' and Western Christianity is dealt with by all writers, but in different ways. We can safely assume that there exist contradictions and 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 sexual behaviour to a great degree. These have to do with the concepts of vital force and fear of impotence, fertility, the cycle of birth, life and 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 Kä Mana as saying: "…the message of A (abstinence), B (be faithful) and C (use condoms) in HIV/AIDS prevention cannot 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, and using a condom is like taking away his masculinity.'

Gender

The theologian Madipoane Maseya states in her paper that Christian African women are 'trapped between two canons.' The African culture has its own definitions of womanhood and 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 both African culture and Christian preaching.

Becoming an ancestor

Like concepts of masculinity and gender, aspiring to become 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 notions of '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 practices. In the HIV/AIDS theologies, personal sin as the cause (or non-cause) of HIV/AIDS and liberation from sin have been mentioned as important issues for theological reflection. It should be asked to what extent these notions of sin and evil are relevant for people who see 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 they can lead to fatalistic behaviour, particularly 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 of', as was stated in one of the case studies. Effecting a sustainable behaviour change is therefore a long and cumbersome process of changing values that are strongly rooted in a given society. The different churches and faith-based organisations can potentially play an important role in slowly changing the value base that informs people's behaviour, because they offer alternative sets of values. Or, as has been 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 behaviour. The challenge is to find and support the positive forces in the different churches and faith-based organisations to bring positive messages to their churches and the people.

Behaviour change

The term 'behaviour change' has been misused and misapplied in the context of the HIV pandemic. It is too often 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 also 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 particular cultural or religious ideal. In such situations the only acceptable behaviour change is one which complies with the ideal. 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 must be understood and recognised in each specific context. Equally so, it should be recognised that no single institution, organisation or project will not normally address all these factors.

It is recommended that each actor identify their part in the cycle and know who else is involved in 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 contribute to fanning or hampering the spread of the epidemic. Acknowledging and understanding these different religiously and culturally determined concepts and values are a precondition for developing a more effective AIDS response. It is recommended to promote activities and processes of deeper reflection and learning about 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 that play a potentially 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 churches, mosques and faith-based organisations:

- are often active in areas of economic and social justice at family, local, national and international level, so tackling power imbalances;
- are among the most important providers of care, treatment, psychosocial support or livelihood initiatives that improve the physical health and economic and emotional wellbeing of people living with infection;
- 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 accurate and full information, regarding risk reduction;
- have a long-term presence in regions and situations at risk, more often than other actors. They work for the most marginalised and are trusted by local communities;
- are also potentially able 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 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 these valuable responses.

Constraints and dilemmas

- There is a tendency within churches and faith-based organisations 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 church teaching on morality.
- 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 absent. Assimilation of information (theological and factual) and behaviour change is a long process that requires long term commitment. Not all the actors in the process (e.g. 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. Chuches often still prefer to work as separate institutions.

Recommendations

However, (and here again, no easy generalisations can be made) the various churches and faith-based organisations could potentially play a more important role then they have done up to now. They still score rather low on a number of HIV/AIDS related attributes.
We recommend cooperation with churches on strengthening of these attributes so as to further maximise their potential in responding to AIDS. The following guidelines should be observed:

- Support the development of policy for dealing 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 seek to address issues of gender inequality, sexuality and patriarchy by and in 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 churches.
- Provide more public and coordinated leadership in the struggle against the AIDS epidemic.
- Come over loud and clear in every possible way and overcome any silence and denial as part of doctrine and/or treatment of staff.
- Identify all forms of stigmatisation and develop active policies on de-stigmatisation.
- Encourage members to further action for the reduction of HIV transmission.
- Churches and faith-based organisations should use their enormous resources to eliminate poverty
- Churches and their faith-based organisations 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 PLWAs) within the various churches, and supporting them in maximising their potential AIDS response.

Churches and gender

The issue of gender in relation to HIV/AIDS is mentioned in the definition of AIDS-competent churches: 'leaders have identified with and assumed their role in prevention of HIV transmission taking into consideration pastoral, cultural and gender issues. ' However, the way in which church leaders themselves view gender theologically seems to be a non-addressed issue.

It is recommended that a focus on gender be integrated into theological AIDS work, not in the least because of the gender disparities involving 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 make use of this representation and/or are not aware of the need for collaboration with others (relevant religious and non-religious actors) in relation to their visibility and position. Many churches still prefer to work as separate institutions.

It is recommended that churches and their agencies adopt a more visible profile and position themselves clearly within the variety of key actors working on HIV/AIDS in a particular country.

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