

This document reviews principles, processes and practical activities of Faith-based Organizations (FBO) in Sub-Saharan Africa in their efforts to combat the AIDS pandemic. The Royal Tropical Institute (RTI), Amsterdam has reviewed selected articles and documentation on FBO strategies for HIV/AIDS prevention, care and support for People Living with HIV/AIDS (PLWHA). This bulletin is written for policy makers and managers of HIV/AIDS programmes in developing countries to generate discussion about the role of FBO in addressing HIV/AIDS.

The paper reviews the actual and potential role of FBOs in developing and implementing appropriate prevention strategies, quality pastoral care, and in fostering compassionate non-judgmental service provision to PLWHA. It concludes with recommendations focusing on institutional and policy making issues and the research agenda.

Faith – Based Organizations and HIV/AIDS Prevention and Impact Mitigation in Africa

A desk review by Georges Tiendrebeogo and Michael Buyckx

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FAITH-BASED ORGANIZATIONS AND
HIV/AIDS PREVENTION AND IMPACT MITIGATION IN AFRICA



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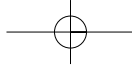
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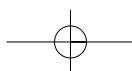
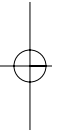
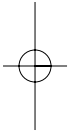
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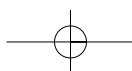
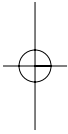
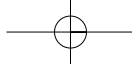
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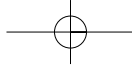




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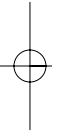
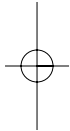




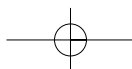
*A desk review by
Georges Tiendrebeogo and Michael Buykx*

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The Bulletin Series of the Royal Tropical Institute (KIT) deals with current themes in international development co-operation.

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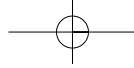
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"We are building the ship as we are sailing"
Dr. Peter Piot, quoted during the UNAIDS Five-Year Evaluation

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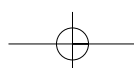
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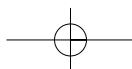
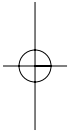
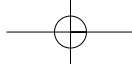
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Summary

This study reviews principles, processes and practical activities of Faith-Based Organisations (FBOs) in Sub-Saharan Africa in their efforts to combat the Acquired Immune-Deficiency Syndrome (AIDS) pandemic.

The Royal Tropical Institute (KIT), Amsterdam, with the support of the Directorate General for International Cooperation (DGIS) of the Netherlands Ministry of Foreign Affairs, has reviewed selected articles and documentation on FBO strategies for HIV/AIDS prevention, care and support for People Living With HIV/AIDS (PLWHA) in sub-Saharan Africa. KIT aims to create a knowledge base while also developing a policy strategy and advocacy for effective participation by religious leaders and organisations. The paper reviews the actual and potential role of FBOs in encouraging culturally-appropriate prevention education, in promoting quality pastoral care, and in fostering compassionate non-judgmental service provision to PLWHA.

Although the documented evidence base for the effectiveness of FBO interventions is still small, the review of lessons learnt by experts leading in the field of FBOs and HIV/AIDS provides sufficient ground to make recommendations. These lessons are based on the available documentation. The forward looking recommendations take into account the areas in which FBOs have the potential to help and areas where they may hinder effective activities. This paper should be seen as a starting point for further discussion and elaboration. This desk review aims to support policy and decision makers, religious and opinion leaders, and researchers.

The study aims to:

1. Synthesise existing documentation on FBOs and HIV/AIDS
2. Capture different religious principles and activities regarding HIV/AIDS prevention, care and treatment
3. Compile emerging lessons learned from FBOs involvement in the prevention and control of the pandemic.

Following a brief statement on religions, disease and HIV/AIDS control (Chapter 2), the paper provides a description of the methodology (Chapter 3) and an overview of the HIV/AIDS epidemic in Sub-Saharan Africa (Chapter 4). The paper's findings are presented under the following headings: an analysis of the driving principles of Christian and Muslim faiths in relation to control and prevention (Chapters 5 and 6), case studies from Senegal and Uganda

(Chapter 7), a summary of FBOs' self-assessment of their HIV/AIDS related activities, and the lessons learned during implementation (Chapter 8). A concluding Chapter 9 identifies policy issues, and provides a set of recommendations for enhancing communication and moving the agenda forward.

Religion played a role in human behaviour long before the HIV/AIDS crisis. Religious organisations were placed to respond to the pandemic, and churches were among the first to take action. Today, around the world many FBOs are involved in some form of sexual and HIV/AIDS education, care and support programmes.

The examples and cases reviewed support the strengths of FBOs in care and support and their potential in reducing stigmatisation. Effectiveness of care and support in general is hampered by lack of access to treatment.

FBO's contribution to prevention is more in terms of broader development issues such as education and social services with, and the emphasis on abstinence and faithfulness as exclusive strategies for HIV prevention. The interwoven issues of religious doctrines, ethics, morality and the official positions of religious hierarchies, when juxtaposed with issues of sexuality, gender and HIV/AIDS can be quite incompatible. In many countries, HIV/AIDS strategies such as condom promotion faced tremendous obstacles from religious organisations failing to disentangle HIV/AIDS prevention from family planning.

Conclusions

Overall, the response from the religious community has been uneven. On one hand, the primary prevention methods espoused by the major religions are in themselves valid means to prevent HIV infection spreading. The care and support provided by FBO had alleviated the suffering of many PLWHA both physically and spiritually. However, religious leaders often reach a deadlock with other stakeholders over condom use and mandatory testing before marriage. They may also have contributed to self-stigmatisation, which is common among followers who find themselves HIV positive.

The main conclusions are:

- Significant opportunities exist to enhance the debate and the involvement of FBO, and the effectiveness of FBO HIV/AIDS-related projects in Sub-Saharan Africa. FBOs have a solid record in alleviating human suffering and potential for outreach to the poor in the most remote areas of the world, including humanitarian crisis and conflict situations. Their work covers the continuum of prevention and care.
- FBOs have demonstrated their commitment to contributing to HIV prevention and impact mitigation, which is translated into resource commitment.
- Most projects are still designed on the basis of perceived needs or driven by values and moral duty, which ensure ownership, but fail to meet the needs of

some part of the population, remain local or are insufficiently backed-up by in-dept needs assessments and subsequent capacity building, monitoring and evaluation.

- There is a lack of an in-depth review studies on the scope and effects of FBOs work. Little is known about Islamic and Secular faith-based organisations in Africa.

Overall recommendations

- The main priority is to create a better understanding between religious/FBO leaders and governmental policy makers at national and international levels. This would involve greater communication and professional discussion.
- FBO care and support activities need to be complemented by public health activities that support prevention.
- If FBO projects are to be improved and scaled up, international FBOs and the HIV/AIDS institutional agencies must show greater commitment to supporting local FBO initiatives.
- FBOs should be supported in their very effective work at the grassroots level, notwithstanding the rhetoric at a higher level. Policy should be devised to further support the people on the ground via FBO activities. For example, policy makers could facilitate travel expenses for FBO workers and support communication infrastructure to stimulate ongoing exchanges.
- Training is needed to ensure increased skilled human and financial resources for the treatment, care and support activities in which FBOs have demonstrated a strong commitment and potential. This would include support for skills training and initiating community development activities.
- More research is needed to document the influence of religion on behaviour change and to assess the effects and processes of FBO work.

Institutional and policy making issues: HIV/AIDS programmes, religious and FBO leaders

- The extent to which mechanisms are in place for effective participation of FBOs in HIV/AIDS programmes should be reviewed. This includes reference to the national and global AIDS control programmes coordination, other institutional relationships, and co-ordination around FBOs' strategies and work.
- Secular stakeholders should facilitate contacts and discussion with religious leaders. Communication at the higher levels is important to keep religious leaders and FBO workers informed. At the national level, the Ministry of Health or leading institution should identify its allies, initiate contact on a basis of mutual respect, and sustain the relationship. Governments should organise conferences and subsequent follow-up to keep religious leaders informed, and to increase their participation in areas where they have shown a comparative advantage.
- Religious leaders and FBOs should also actively seek information and exchange and avoid isolation. FBOs should pursue regional, national and international networks at every opportunity.

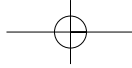
- Not all FBOs are in a position to promote condom use. They should work on their areas of comparative advantage to complement the work of other stakeholders. Religious leaders and FBO programme makers should promote alternative strategies in relation to perceived threats at the pastoral level.
- FBOs should be encouraged to give young people access to HIV/AIDS prevention services, along with expressing their message. In their own religion classes, FBOs should be supported in teaching young people how to negotiate sexual relations. Such life-saving skills are especially important for pre-adolescents who want to practice abstinence.

Research agenda

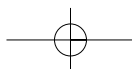
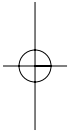
- Research could promote understanding of how religion influences sexual behaviour, service delivery, help-seeking behaviours and community participation in the context of the HIV/AIDS epidemic. Research on how religious principles, faith-based strategies (including Islamic and secular religions) and practices impact on PLWHA lives can elicit attribution and inform/improve project design and messages and strategies, and identify necessary complementary strategies by non-secular organisations.
- FBO programme makers should contribute to situational analysis and subsequent evaluations to help develop or review strategies. This process should include providing evidence of the effect and impact of programmes, e.g., on the effects of sex education on the timing of first sexual intercourse.
- National authorities and international agencies should explore with FBOs the development of behaviour change surveillance mechanisms to measure the effects of FBOs' work on sexual and reproductive health. Such reviews should also assess FBOs' need for any further information and technical assistance.
- The present study does not provide information on resource allocation and flows, participation of the religious leaders in country and international coordination, nor interfaith collaboration. Further research should look into these aspects. Some of the information is already available from government authorities, national religious institutions, international faith-based organisations, and donor agencies.

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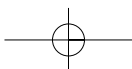
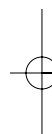
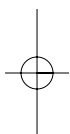
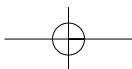


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Abbreviations

ACI	Africa Consultants International
AIDS	Acquired Immune Deficiency Syndrome
ASAYI	Anti-STDs/AIDS Youth International
CAA	Catholic AIDS Action
CBO	Church Based Organisation
DHS	Demographic and Health Survey
FBO	Faith Based Organisation
HAART	Highly Active Anti Retroviral Therapy
HIV	Human Immunodeficiency Virus
IMAU	Islamic Medical Association of Uganda
KIT	Koninklijk Instituut voor de Tropen (Royal Tropical Institute)
MAP	Medical Assistance Programme
MoH	Ministry of Health
NGO	Non Governmental Organisation
PLWHA	People Living With HIV/AIDS
SECAM	Symposium of Episcopal Conferences of Africa and Madagascar
SIDA	Syndrome d'ImmunoDéficiency Acquis
STI/STD	Sexually Transmitted Infection/Disease
TALC	Teaching AIDS at Low Cost
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization



1 Introduction

"It is now common knowledge that in HIV/AIDS, it is not the condition itself that hurts most (because many other diseases and conditions lead to serious suffering and death), but the stigma and the possibility of rejection and discrimination, misunderstanding and loss of trust that HIV positive people have to deal with."

Rev. Canon Gideon Byamugisha, Namirembe Diocese, Anglican Church of Uganda¹.

This report reviews principles, processes and practical activities of Faith-Based Organisations (FBOs) in Sub-Saharan Africa in their efforts to combat the Acquired Immune-Deficiency Syndrome (AIDS) pandemic. The Royal Tropical Institute (KIT), Amsterdam, has reviewed selected articles and documentation on FBO strategies for HIV/AIDS prevention, care and support for people living with HIV/AIDS (PLWHA). This study does not represent the doctrine of any particular organisation, nor is this review comprehensive. It is intended to serve as a launching pad for further studies.

Over the past two decades, patterns of grassroots organisations and opinion leaders are emerging in response to the HIV/AIDS pandemic. FBOs have been an integral part of this budding civil society. African governments, UNAIDS Secretariat and Co-sponsors, international organisations and development partners support the promise of a multi-sectoral approach for opening up the response to the pandemic and creating HIV/AIDS-competent societies.

Religion played a role in human behaviour long before the HIV/AIDS crisis. Religious organisations were well placed to respond to the pandemic, and churches were among the first to take action. Today, around the world, many FBOs are involved in sexual and HIV/AIDS education, care and support programmes. In a number of countries, religious norms and values have been praised for favouring care and support activities during the earliest stage of the pandemic (Chikantaka Hospital and the Salvation Army in Zambia²; the Protestant Hospital in Dabou in Ivory Coast, and the Catholic SIDA Service in Senegal). Jamra, an Islamic organisation in Senegal, began a very early prevention programme.

Religion has had a negative as well as a positive impact. When issues of sexuality, gender and HIV/AIDS juxtapose the interwoven issues of religious doctrines, ethics, morality and the official positions of religious hierarchies perspectives can be diametrically opposed. In many countries, HIV/AIDS strategies, such as condom promotion, faced tremendous obstacles from religious organisations. They failed to disentangle HIV/AIDS prevention from family planning. Some religious leaders propagated judgmental attitudes towards PLWHA, and religious leaders were slow to take action in much of the region. Thus, the response from the religious community has been uneven.

So how compatible are sound, effective HIV/AIDS prevention and care and support activities with religious ideologies in Sub-Saharan Africa? On the one hand, the primary prevention methods espoused by the major religions are in themselves a valid means to prevent HIV infection spreading. The care and support provided by FBOs had alleviated the suffering of many PLWHA both physically and spiritually. However, religious leaders often reach a deadlock with other stakeholders over condom use and mandatory testing before marriage. They may also have contributed to self-stigmatisation, which is common among followers who find themselves HIV positive.

Recognising the important role religious leaders and FBOs play in attitude and behaviour change and in care and support for PLWHA, KIT has conducted the present desk review on HIV/AIDS, Religion and FBOs with the support of the Directorate-General for International Cooperation (DGIS) of the Netherlands Ministry of Foreign Affairs. KIT aims to create a knowledge base while also developing a policy strategy and advocacy for effective participation by religious leaders and organisations.

This study aims to do the following:

- i) Synthesise existing documentation on FBOs and HIV/AIDS
- ii) Capture different religious principles and activities regarding HIV/AIDS prevention, care and treatment
- iii) Compile lessons learned from FBO involvement in the prevention and control of the pandemic.

The paper reviews the actual and potential role of FBOs in encouraging culturally-appropriate prevention education, in promoting quality pastoral care, and in fostering compassionate non-judgmental service provision to those living with HIV/AIDS.

Following a brief statement on religions, disease and HIV/AIDS control (Chapter 2), the paper provides a description of the methodology (Chapter 3) and an overview of the HIV/AIDS epidemic in Sub-Saharan Africa (Chapter 4). The paper's findings are presented under the following headings: an analysis of the driving principles of Christian and Muslim faiths in relation to control and prevention (Chapters 5 and 6), case studies from Senegal and Uganda (Chapter 7), a summary of FBOs' self-assessment of their HIV/AIDS related activities, and the lessons learned during implementation (Chapter 8). A concluding Chapter 9 identifies policy issues, and provides a set of recommendations for enhancing communication and moving the agenda forward.

2 Religion, disease and HIV/AIDS control

In Africa, it is said that: "Where there is a church, there are also a health post and a school."³ Churches have a long history of providing health care and improving literacy. In turn, Islamic teaching emphasises the health and well being of society as much as that of the individual. FBOs in developing countries not only provide spiritual guidance for their followers, they are also often the primary providers of a variety of local health and social services. Situated within communities and building on relationships of trust and respect, FBOs also have the ability to influence the attitudes and behaviours of their fellow community members.⁴

The world's religions reach out to virtually every community in the most remote corners of the earth.⁵ According to the director of Medical Assistance Programme (MAP) International, religion plays a central, integrating role in social and cultural life in most developing countries.⁶ In many countries, there are more religious leaders and FBO workers than health workers. They are in close and regular contact with all age groups in society and their voice is highly respected. In traditional communities, religious leaders are often more influential than local government officials, secular community leaders and health professionals.⁷

Whilst religious organisations have a wide reach, influence and capacity to mobilise communities to respond to HIV/AIDS, their responses have lagged behind the challenges and their policies have shied away from potential conflicts with theological constructs.⁸ From the start of the HIV/AIDS pandemic, the religious community has given conflicting messages. The opposition to condom use from most religious denominations hampered prevention efforts. Historical interpretations of leprosy or skin-diseases as the entry of an evil spirit reinforced stigma and discrimination.⁹ At first, many Christian and Islamic leaders interpreted HIV/AIDS as God's punishment of sinners and called for behaviour change or repentance. In general, this generated defensive behaviours, fatalism and self-stigmatisation among followers and other stakeholders.

Nevertheless, over time, many countries have realised impressive progress in the struggle against HIV/AIDS, and the case to be made for FBO involvement is strong. The contribution of FBOs and religious leaders to the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) supports the argument for FBO involvement.¹⁰ The donor community has become

increasingly active in funding FBOs, after years of hesitancy. In addition, UNAIDS has opened the policy dialogue to include all stakeholders in the fight against HIV/AIDS, including religious leaders. Since 1996, several regional and national conferences gathering religious leaders and FBOs have been organised throughout Africa with the support of UNAIDS and bilateral agencies.

The emerging trends from these conferences are that: 1) there could be a relative flexibility on HIV prevention without falling into “Relativism”, in which all ethical viewpoints are seen as equally good (often by critics), and 2) religious teaching and practice indicate clearly that stigma and discrimination against PLWHA is a sin and against the will of God.^{11,12} However, the growing number of individual statements favouring a pragmatic approach to HIV/AIDS prevention, care and support has to be balanced since the extent to which the wider religious community understands and shares this relative flexibility on prevention, and the stand against the stigma attached to AIDS, is not clear.

UNAIDS has heard religious leaders' statements and commitment to fight stigma and discrimination. It believes it is time to lay down its arms in the condom battle with the churches and concentrate more on what they can do to eradicate stigma and discrimination. As stated by Almedal, a UNAIDS senior staff, “would it not be a good programme if preachers address the stigma attached to AIDS and PLWHA 52 Sundays a year for three years? And it would not cost a cent, but might change something.”¹³

Finally, generally speaking, FBOs seem to be successful in fund raising. Most of their work in the area of HIV/AIDS prevention and care/support is supported by external religious secular donors, including individuals and faith-based international NGOs or agencies.

Bilateral and multilateral donors are increasingly interested in FBO work. At organisational level, and especially in remote areas, funding seems to be problematic for various reasons. The reasons include mutual distrust between political and religious leaders, and the belief that Churches and Mosques can always find their own resources. The situation is even more difficult for indigenous religious organisations, which often lack formal recognition and links to international religious organisations.

3 Methodology

The general framework for this desk review largely draws on the human rights-based approach to HIV/AIDS promoted by UNAIDS.¹⁴ The promotion and protection of human rights: reduces vulnerability to HIV infection by addressing its root causes; lessens the adverse impact on those infected and affected by HIV; and, empowers individuals and communities to respond to the pandemic.

The review addresses the following questions:

- 1) What principles do religious leaders use to legitimise support for HIV/AIDS prevention?
- 2) What principles do FBOs rely on to ensure respect, protection and fulfillment of the human rights of people living with HIV/AIDS?
- 3) What do FBOs contribute to creating social and economic conditions that enable individuals and communities to exercise prevention, treatment and care options when they are available?

This review heavily relies on conference reports and descriptive materials on FBO-related HIV/AIDS work. Originally, KIT had intended to review evaluation reports of FBO HIV/AIDS prevention and impact mitigation programmes. This proved impractical due to the limited number of such studies from Sub-Saharan Africa.

We are mainly concerned here with Christian and Muslim organisations. FBOs from the other major world religions are either not present or so few as not to be significant in the struggle against HIV/AIDS in the region. We were not able to find reports from animist or other indigenous religious organisations and further field research is needed to fill the gaps. In addition, the Christian churches are far more institutionally active than their Muslim counterparts. We do not attempt to explain that discrepancy here. However, the prevalence of Christian FBO sources inevitably gives the analysis of Christian involvement more depth.

Lastly, even among Christian denominations, the activities and views of the Roman Catholic Church are particularly well-documented, and therefore perhaps over represented in this review.

The materials described come from many sources:

- Dr. Georges Tiendrebeogo, a medical doctor, public health and training specialist at KIT and main author of this report, took advantage of country

visits during the UNAIDS Five Year Evaluation; the International Conferences on AIDS and STDs, and other assignments to collect documents and abstracts. He met with FBOs and religious leaders as well as international organisations contributing to FBO work in Africa, such as Cordaid and *Kerk in Actie*, The Netherlands, and Memisa, France.

- Michael Buykx contributed to Chapter 5 on the Christian perspectives. He has worked in Angola (Dioceses of Benguela and Lubango) in organising several Ecumenical Pastoral Congresses about AIDS for the Roman Catholic Church and various protestant churches. He was involved with the creation of an Ecumenical-AIDS board in Benguela, and launched the first website in Portuguese dedicated to AIDS and the churches.¹⁵
- A request for information on evaluation reports of FBO and AIDS programmes was launched through the Internet (see Annex 1) and many requests for information were made using different mailing lists, telephone interviews, and country visits. The review team received encouragement and expressions of interest in the study findings but little in the way of evaluation documentation. This might be due to difficult access to the Internet in developing countries, but it is also likely to be due to the lack of sound evaluation reports or because many programmes are just getting off the ground. The lack of responses limited the scope of the study and prevented us from presenting an exhaustive inventory of current FBO HIV/AIDS programme evaluation reports in Africa.

Given the sensitivity and importance of the issue, the gaps regarding information on animist or other indigenous religious organisations, funding sources, and the contribution of FBOs to the country overall HIV/AIDS coordination structures need to be addressed. KIT hopes to pursue further discussion on research, adoption, implementation and evaluation of FBO programmes. We would be grateful if you would contact us and, if possible, send a copy of any relevant documents for analysis and inclusion in future inventory publications.

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4 Basic facts for understanding the challenges of the HIV/AIDS epidemic

The AIDS pandemic claimed more than three million lives in 2002, and an estimated five million people acquired HIV in 2002. This brought to 42 million the number of people globally living with the virus.¹⁶

The threat that the AIDS pandemic represents hardly bears comparison with other diseases. According to UNAIDS/WHO estimates, malaria – another important threat – causes over one million deaths a year. It is important not to overlook the dynamics in this comparative picture. Already in 1954, millions of people were dying annually of malaria, especially children, while AIDS is still emerging as an epidemic, whose death toll rises every year. Cases have been reported in almost all areas of the world. Although HIV is a slow-acting virus that can take a decade or more to cause severe illness and death, it has already cost the lives of nearly 14 million adults and children. It has also brought other diseases in its wake. Tuberculosis, another infectious killer, is on the rise, largely driven by the HIV/AIDS epidemic.

Virtually every country in the world has seen new infections. However, more than 95% of all HIV-infected people now live in the developing world, which has likewise experienced 95% of all deaths to date from AIDS. Sub-Saharan Africa continues to dwarf by far the rest of the world on the AIDS balance sheet. It is now home to 29.4 million people living with HIV/AIDS. Approximately 3.5 million new infections occurred there in 2002, while the epidemic claimed the lives of an estimated 2.4 million Africans over the past year.

Another reason why AIDS demands a priority response is that the effects of the pandemic extend far beyond the simple number of deaths. Beside its potential psychosocial impacts, HIV selectively affects young adults, the productive members and the backbones of families, businesses and communities in developing nations.¹⁷ About half of new HIV infections are in people aged 15-24, the period in which most people start their sexual lives.

The bulk of new infections continue to be concentrated in eastern and especially in southern Africa. In general, western Africa is less affected by the epidemic but is far from immune. However, these figures are averages and the epidemic is not randomly distributed. Rather, the infection is clustered in families, occupations and geographical areas. While overall population figures on current estimates of HIV infection is estimated at one in every 40 men and women in Sub-Saharan Africa, in some communities, one in every four adults is infected.

With regard to the dynamic of the epidemic, it appears that in almost all countries the spread of the virus follows the same trend while the resulting prevalence depends more on the timing of introduction of the virus. For instance, in the countries most affected, such as Uganda, the first AIDS cases were diagnosed in early eighties, while in Senegal, which is less badly affected, the first AIDS case was reported in 1986. Other causes of the heterogeneity in sero-prevalence include biological factors, such as the characteristics of both HIV-1 and HIV-2 and their multiple genetic strains. HIV-1 is highly infectious and is particularly observed in southern, central and eastern Africa, and some countries in West Africa. HIV-2 is less infectious and is concentrated in West Africa (primarily in Guinea-Bissau) and in some parts of Central Africa. This may provide an explanation of the extent to which HIV/AIDS spreads in a given country. Nevertheless, today HIV-1 exists in almost every country.

Box 1: Ten Basic Facts about HIV/AIDS

1. AIDS attacks the body and discrimination undermines the mind. AIDS is caused by a virus and discrimination is caused by ignorance. Both can kill!
2. Sexual transmission is the dominant mode of HIV transmission.
3. You cannot tell by looking at people that they are HIV-infected, and most people who are infected with HIV do not know they are infected.
4. People with HIV infection are infectious to others in a limited number of known ways for the remainder of their lives.
5. The length of time from infection to experiencing symptoms and illness will vary from one person to another, but for most people for whom HAART is not accessible, it will be from 7 to 10 years.
6. HIV infection is not transmitted by close, everyday, familial and social contact.
7. The presence of a STI can facilitate the transmission of the virus during sexual intercourse.
8. There is no cure as yet for HIV infection.
9. HIV transmission via sexual intercourse, injecting drug use and blood, blood products, tissue or organ transplants in health settings can be prevented.
10. Once infected, a person may remain in good health and live an active and productive life for many years.

(adapted from Africa Consultants International training material, Senegal)¹⁸

The main channels for the spread of HIV are: unprotected sex, from an infected mother to her unborn child or during delivery or breastfeeding, and unsafe blood contacts. Sex, maternity and blood-related matters are taboo subjects in many societies, and thus not discussed openly. Environmental conditions, religious practices, and culture play protective or facilitating roles in the spread of the virus. This report mainly deals with HIV infection through sexual contact, since most FBOs do not take a specific position on infection through blood contact. Infection due to drug use is dealt with tangentially since it is not a highly significant factor in the region.

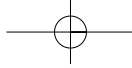
HIV does not discriminate according to gender, wealth, race and age. However, communities face challenges which impact on individual and collective vulnerability to the spread of HIV. These include: i) marriage instability, both

traditional or common-law unions; ii) high levels of unemployment, poverty and the related paid sexual activity, which is often related to food or other material needs; iii) high levels of mobility, especially related to work-seeking, conflict or family events, and people living or posted far from their communities of origin, which decreases the level of social control; iv) factors such as male domination, polygamy, widow inheritance, early marriage, female genital mutilation, resistance to condom use, and the low status of women, which may be based on cultural, social and/or religious influences; v) high levels of secrecy, social stigma and denial surrounding HIV/AIDS – the spread of HIV thrives under these conditions; and, vi) use of drugs and alcohol, which may increase susceptibility to HIV infection through the sharing of needles with HIV-infected individuals and may increase risky sexual behaviour when under the influence of drugs and/or alcohol.¹⁹

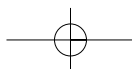
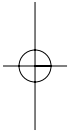
Not much is known about the extent of the epidemic in religious communities, but it should be recalled that religious leaders and religious workers are not immune to HIV infection themselves. Vulnerability factors include: i) relative wealth, mobility, high levels of respect, and status within the community; ii) single men and women serve as religious leaders world-wide (due to religious doctrine or personal choice); and, iii) high levels of stress and feelings of incapacity to deal with the epidemic may lead to unsafe sexual behaviour, drug or alcohol use.²⁰ To respond to the epidemic, and in line with public health and human rights-based approaches, Fr. Kelly²¹ repeatedly advocates the following measures:

- While there is no infection: by providing knowledge that will inform self-protection; fostering the development of a personally held, constructive value system; inculcating skills that facilitate self-protection; promoting behaviour that will lower infection risks; and enhancing capacity to help others to protect themselves against risk;
- When infection has occurred: by strengthening the ability to cope with personal and/or family infection; promoting care for those infected; helping young people stand up for the human rights that are threatened by their personal or family HIV/AIDS condition; and reducing stigma, silence, shame, discrimination;
- When AIDS has brought death: by helping in coping with grief and loss, in the reorganisation of life after the death of family members, and in the assertion of personal rights.

Research shows evidence that effective prevention programmes are those which: i) promote the acquisition of specific skills and the development of social norms for healthy behaviours; ii) focus on sexual health rather than narrow conceptions of disease prevention; iii) take an interest in listening to the problems which young people themselves identify, whether or not related to HIV infection; iv) emphasise clear behavioural values and norms; and, v) provide services, structural and environmental circumstances which are enabling and supportive of such behavioural change.



Least effective programmes are those which: i) promote abstinence only, rather than providing a range of options; ii) focus only on technological intervention, e.g., use of condoms, which dodge the more difficult issues of how to discourage early teenage sexual activity; iii) tend to suggest or imply that people should make their own decisions rather than giving clear guidance; or, iv) restrict discussion to adult concerns rather than considering those of young people as well. Such approaches rarely work well because they do not address the reality in which people live, and therefore are lacking in interest for them.²²



5 Christian perspectives

The role of Christian FBOs in preventing the spread of HIV/AIDS (section 5.2) has predominantly been characterised by the deadlock over condom use. Christian organisations for the most part do not promote condom use, and non-Christian stakeholders have questioned the efficacy of the church's emphasis on abstinence and fidelity. In contrast, care and support seems to be dealt with effectively by Christian networks of volunteers, hospitals and health centres. It will be discussed in section 5.3.

5.1 Christian churches in Africa

Sub-Saharan Africa is the most Christian of all continents after Latin America. Roman Catholic and many Protestant Churches were founded there in the era of colonialism and missionary work. While these missions have served some colonial purposes, they have also provided the local community with a church, a school and health facilities.

Recently-founded independent African churches, and some theological movements within the older churches, are engaged in a process known as "inculturation".²³ Put simply, Africans are adapting Christian theology to their own context, synthesising Christian teachings with African values and culture. In the process, they are rejecting aspects of liturgy, art (see Box 2) and theological tradition considered Western or colonial. The justification for "inculturation" is that even before the Gospel preached by Jesus Christ in present-day Israel arrived in Africa, it had been adapted to the Greek civilization of Europe by the Apostles.²⁴ Similarly, in the fight against HIV/AIDS, religious and political leaders link Christian teaching to their own African culture and tradition. The Bishops of Cameroon write: "The Church calls on men and women of goodwill to put all hands on deck to wage an all-out war against this pandemic, by taking part in public sensitisation, information and education activities, without hesitating to fall back on our cultural and spiritual values."²⁵

Consequently, people can no longer simply blame religious leaders outside Africa for unpopular messages. Since the Second Vatican Council, regional conferences of bishops have taken an important initiative and a certain amount of liberty in teaching the doctrine of the Catholic Church. To reconcile the Christian view on marriage with the African cultural context might constitute one of the most difficult issues: "As a matter of fact, nothing in Africa has more resisted Western Christianisation than marriage."²⁶

5.2 Christian churches' perspectives on HIV/AIDS prevention

5.2.1 ETHICAL AND MORAL TEACHING

Christianity is defined as a religion of love: Divine love for humankind, reflected in mutual love of human beings. This love may be celebrated in the gift of sexual intimacy by a couple. But whereas modern attitudes towards sexual pleasure tend to detach it from procreation and a lasting mutual commitment, the churches emphasise the importance of marriage in which responsibility, faithfulness, and exclusive intimacy are considered essential.²⁷ All Christian denominations see the exclusiveness of sexual intimacy as an essential value of the Gospel.

Many Church denominations ban the use of condoms. The Catholic Church took a strong position against condom use in 1965 when Pope Paul VI spoke out on family planning issues. He said that sexual contacts, reserved for married couples, should not be barred from transmitting life by condoms. The emotional upheaval over his encyclical *Humanae Vitae*²⁸ continues to resonate in the era of AIDS. However, in relation to AIDS, the condom issue is quite different. The Churches – Catholic and Protestant alike – are aware that sex before or outside marriage is common practice but consider it contrary to their doctrine and interpretation of the Gospel. Use of a condom is perceived as a moral issue directly related to the view of the Churches on marriage and sexuality.

The churches will not change their position on condom use completely, although there is some recognition that sexual contacts may transmit a deadly virus rather than life. In this case, the commandment: "Thou shall not kill" prevails, especially in the situation of a discordant couple.

The Churches also claim to be misunderstood in some aspects. They say that they are not so much objecting to the use of a condom as its wholesale propaganda and promotion.²⁹ They are especially opposed to the more extreme slogans. For example, the slogan "No limits on sex, provided it is safe" carries a "two-in-one" message. It is the first part that provokes indignation of the churches. Their view is that sexual love requires a couple to accept all the responsibilities of marriage, including the responsibility not to transmit death. The ban on condoms by the Catholic Church is detrimental to HIV/AIDS prevention campaigns aimed at reducing unsafe sexual practices. However, this doctrine does not necessarily render churches unfit to promote HIV/AIDS prevention.

Christian FBOs have highlighted the importance of targeting women in preventing the spread of the disease. Many women and girls are forced to accept sexual contacts due to poverty or gender inequality. At a SECAM meeting in October 2003, national and regional secretaries general and partners proposed a plan of action against AIDS. They drafted an online working document focussing on gender issues in order to protect girls, young people and women from their vulnerability to HIV infection.³⁰

Box 2: The Fleet of Hope

An example of a Christian prevention campaign initiative is the so-called, "Fleet of Hope". It was developed in Tanzania by Father Bernard Joinet, a professor of psychology at Dar-es-Salaam University. He had been distressed to see how quickly the epidemic was spreading while the various stakeholders sent out conflicting messages on prevention. He therefore elaborated a means of harmonising campaign messages based on visual images that are inspired by Noah's Ark. The approach is based on two main assumptions:

1. People are more sensitive to emotional imagery and pictures than to theory and factual text.
2. A national government has a different responsibility than the various groups in society.

Fr. Joinet's images compare the AIDS pandemic to a flood from which the only escape is to climb on board the Fleet of Hope, an inseparable combination of three boats, the Fidelity, the Abstinence and the Condom. It is explained that whereas the government or the UN and NGOs have a responsibility to get people on board, no matter onto which boat, groups like Churches, tribes or families may urge their members to climb onto a specific boat, according to their common shared values. However, the Abstinence is not only for monks, nor is the Condom only for poor sex workers. Everyone may at some determined moment have to change from one boat to another to avoid the risk of drowning. A typical example is that of the "condomizing womaniser" who runs out of stock: he can either drown or board the Abstinence until the pharmacy opens the following morning.

This prevention tool has been used by churches in many African countries. In Burkina Faso, it has been translated into French and adapted into the basis of a group discussion game with the help of a tapestry and some cartoon characters. In the Benguela Diocese, Angola, it has been translated into Portuguese and posted on the Fleet of Hope website <http://www.fleetofhope.tk>. A French association *Flottille de l'espoir*³¹ disseminates worldwide posters and instructions on how to play the game. A major advantage of the Fleet of Hope approach is that it opens up possibilities to talk about sexual options in an indirect way.³²

The Church and secular services do not operate in isolation. As the Fleet of Hope example shows, FBOs do find ways to stimulate safe sex practices. Similarly, most secular HIV/AIDS prevention campaigns no longer limit their message to promoting condoms. The other two main prevention strategies – abstinence, and fidelity to one partner – are neither easy nor popular. But the Churches have a comparative advantage in preaching them. Given the social context and value system of the Churches, these strategies can be promoted with credibility.

A growing trend exists in some Churches to allow the use of condoms as the "lesser evil", if sexual contact will put one or other partner at risk of mortal danger.³³ A married couple has the right to celebrate their love sexually, but this puts one partner in danger if the other is HIV-positive. The Church accepts that everyone has the right to defend his or her own life. This would inevitably imply the use of condoms.

The practice is not entirely unchallenged within the Church, as some fear that allowing exceptions may be used to promote family planning.^{34, 35} However, if "the risk of mortal danger" can be accepted in relation to HIV infection, it should be accepted as a means to protecting a women from the risk of dying in childbirth.

Otherwise, the implication seems to be that the latter is ignored or not regarded sufficiently seriously. Abbé Alexandre Mbengue, the director of a major priest seminary in Senegal, is quite clear on this matter. He says that the “*Loi de la Gradualité*” has to be applied if abstinence is not an option for two married people: using a condom is preferred to transgressing the commandment: “Thou shall not kill”.³⁶ The Senegalese bishops’ conference saw no difficulty in quoting this and concluded positively that: “The use of condom could be a lesser evil.”³⁷

Bishop Kevin Dowling from the heavily HIV-infected mining district of the Rustenburg Diocese in South Africa, is the initiator of the AIDS Office of the Southern African Catholic Bishops’ Conference. He goes even further: “We live in a world where many people choose not to live according to the values espoused by the church. And especially in our southern African region, there are so many poor people, women and girl children whose socio-economic and cultural situation takes away their options and choices. In those situations, I believe that people living with HIV must be invited and challenged to use a condom in order to prevent the transmission of potential death to another person, or to protect themselves from infection, especially in abusive and destructive relationships.”³⁸ Bishop Dowling represents a growing minority opinion among Christian theologians. There is an increasing awareness of the vulnerability of women, many of whom are not able to negotiate their sexual relations.

The churches also play an important role in education, managing schools, and organising training sessions. The final resolution of the second “Colloquium on AIDS and Religion” in Senegal states: “It is necessary to intensify the effort in literacy in order to promulgate information on HIV/AIDS. It is necessary to intensify collaboration between the various social structures of the Church: Health, Education, Caritas, Women empowerment.”³⁹ Father Emílio Sumbelelo of the Diocese of Benguela, Angola stresses the importance of church schools, where education and role models help young people in their choices.⁴⁰

In other instances, Christian values can have a negative impact on AIDS prevention in schools. An Action AIDS report on schools in Kenya states: “Teachers exercise a self-imposed veto on sections of the curriculum that deal with any practices they feel will offend local beliefs. In Kenya particularly, Catholicism has a big effect on the way HIV is taught and teachers view this as having a negative impact”.⁴¹

This apprehension over causing offence leads teachers to skip HIV altogether, or to address it in a technical way, leaving out issues of sexuality, human values and stigma. The proposed plan of action for the PAN-African synod of Catholic bishops about AIDS may help them to overcome that fear.⁴²

5.3 Christian churches’ perspectives on HIV/AIDS impact mitigation

5.3.1 CHRISTIAN CHURCHES AND HIV/AIDS MEDICAL AND SOCIAL CARE AND SUPPORT

A strong current of helping others runs through Christian doctrine, from Jesus Christ’s unconditional love for lepers⁴³ to the “works of mercy” concept, which

led the church to care for orphans, the sick and the poor in the Middle Ages. Today, Christian churches assume a large role in providing health care. In many African villages and towns, the mission hospital or dispensary represents a welcome presence of the church.

Even when the moral issues created by the prevention campaigns initially led some church leaders to remain silent on the AIDS pandemic – or even to oppose action undertaken by others – the response of their medical staff to the explosion of patients was more than adequate.

Home-based care has emerged as an important aspect of Christian care for PLWHA. The move was necessitated by the magnitude of the crisis, in which hospitals were running out of space. The inner cohesion of a congregation or parish combined with medical know-how, trained staff and external networks is a strong asset of the churches. Volunteers for Christian FBO home-based care tend to be more motivated than their secular colleagues. This may be due to the shared value system of the caregivers. Liebowitz coined the theory of “the social capital of FBOs”. He argues that since in many religious institutions members regularly engage themselves in activities that build trust and community, the members are more likely to use these religious institutions to accomplish social goals.⁴⁴

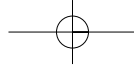
Box 3: Ndola Home-Based Care

The Ndola Catholic Diocese in the north of Zambia runs a groundbreaking programme of home-based care for AIDS patients who are very ill. It operates in the poorest neighbourhoods, where every day is a struggle to find food. Some 700 volunteers, co-ordinated by Ndola Diocese, offer basic health care, home visits and friendship to people at home. British photographer Don McCullin, who visited Ndola, said: “I was deeply moved by these people. If I was lying in one of these darkened rooms, if I heard their singing, at least I would think I hadn’t been forgotten”.

The Ndola Diocese initiated the home-based care programme for AIDS and TB control in 1991. It has 7,000 registered clients in 23 townships (some 450,000 people), which are served by 750 community volunteers and 34 professional nurses.

To overcome stigmatisation right from the start, the churches train people to visit anyone they know to be sick in their neighbourhood. In a second stage, these volunteer “visitors” focus on AIDS patients, providing nursing, care and material assistance, such as food or schooling for children. The visitors rely on professionals for instruction, provision of medicines and commodities, and a referral network.⁴⁵

In addition to care and support for people living with HIV/AIDS, Churches provide services for children orphaned by the disease. The explosion in the number of AIDS orphans has gone far beyond the capacity of the Church orphanages. Catholic AIDS Action (CAA) in Namibia trains volunteers to include care for orphans in their home-based care programmes. They provide material support so that the children can stay in their own communities. They also provide psychological support, especially in cases of child abuse or neglect.



By December 2001, CAA had registered 9,922 orphans, of whom 5,645 had received material assistance from the programme.⁴⁶

5.3.2 CHRISTIAN CHURCHES AND HIV/AIDS PASTORAL CARE AND SUPPORT

In the early stages of the pandemic, many pastors avoided getting involved with people living with HIV/AIDS. That is no longer possible. Today, every pastor in Africa must assist many people dying from AIDS. Each community is confronted with heavy losses in the workforce within agricultural production, education⁴⁷ and other sectors. Institutions of the Church are no exception.

Some pastors have been recruited as HIV/AIDS counsellors. For counselling to succeed, the recipient must have confidence in the counsellor. Many people in Africa already have a trusting relationship with their pastor, making them potential recruits and the natural allies of counsellors. If conscience prevents a pastor from presenting all the options, she or he may refer the person to a trained counsellor. But a professional HIV/AIDS counsellor would be severely hampered in his or her work if the person being counselled were under the influence of a misinformed local Church leader. Catholic AIDS Action in Namibia provides voluntary counselling and testing precisely because it recognises the need and its trusted role and potential to influence in a positive way.⁴⁸

5.3.3 CHRISTIAN CHURCHES FIGHTING STIGMA AND DISCRIMINATION

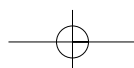
Theological debate

In the first phase of the pandemic, Christian Church leaders contributed to the suffering of People living with HIV/AIDS (PLWHA) either by remaining silent or by relating their condition to sin. FBOs at the UNGASS conference 2001 made the following statement: "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."⁴⁹

It is in theological debate that these issues can be properly addressed. Father Robert Vitillo of Caritas International strongly urges theologians: "To link HIV/AIDS discrimination issues with other struggles for justice and with necessary condemnations of discrimination in other areas of social life. The proof of such a need lies in the fact that the very members of society who are most subjected to other structural injustices in society are the most vulnerable to the spread of the HIV/AIDS virus. Thus we see that the pandemic is most disseminated among the poorest and most marginalised in society."⁵⁰

This is in line with the human rights-based approach to HIV/AIDS of the UNHCR, which explains the relationship between HIV/AIDS and loss of human rights as threefold: i) Increased vulnerability; ii) Discrimination and stigma; and, iii) Impeding an effective response.

Examples of negative stigma attached to the disease are rife. In Uganda, in 2002, a man was thrown out of a public minibus for refusing a seat to an



apparently AIDS-infected woman, while in South Africa a few years earlier a woman was stoned to death for declaring herself HIV-positive.⁵¹

Fortunately, there are also many positive examples: “I recall specifically the medical director of a well-respected Catholic hospital who steadfastly refused to admit patients suffering with AIDS. After attending a Caritas sponsored HIV/AIDS seminar and after being confronted with this policy, on both medical and ethical grounds, he not only reversed his previous decisions but also began a comprehensive HIV/AIDS training programme for his entire staff.”⁵²

MAP has launched an HIV/AIDS theological initiative. They have hosted culturally-sensitive HIV/AIDS conferences for Baptists, Lutherans, Catholics, Anglicans, the African Inland Church and a wide range of African independent churches. The goal is to incorporate HIV/AIDS training into the curriculum of four Anglican theological institutions in South Africa, Zambia, Tanzania and Kenya.⁵³

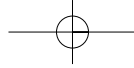
The ecumenical advocacy alliance defines the number one goal in its HIV/AIDS campaign as: “The dignity and rights of people living with HIV/AIDS and for an attitude of care and solidarity that rejects all forms of stigmatisation and discrimination.”⁵⁴

The fight against stigma is very important as highlighted in the aforementioned plan of action announced at the SECAM conference. A preparatory document by the secretaries general of the regional bishop conferences and various partner organisations states: “Stigma and discrimination in the Church and society are still major factors contributing to the spread of HIV/AIDS. Stigma and discrimination also constitute the major obstacles to effective HIV prevention and care. ... We recognise that it is the children and women who carry the burden of care, isolation, vulnerability, stigma, discrimination, shame, poverty and desperation.”⁵⁵

Community involvement

Some Churches in Africa have managed to help fight the stigma faced by many HIV patients. The best and clearest examples have emerged when people who have openly declared their HIV positive status in their religious communities have been subsequently supported instead of being discriminated against. Whenever the ambience in such a community is safe and tolerant, it contributes much towards acceptance of PLWHA, and towards mitigating the epidemic as well.⁵⁶

Bishop Dennis H. de Jong from Ndola Diocese, Zambia, received the 2001 Africa Prize for Leadership awarded by the Hunger Project for fighting stigma. The project, apart from assistance to AIDS patients and orphans, includes student-led HIV-prevention drama groups, workplace programmes focusing on HIV prevention and care, and training workshops for HIV-positive people to become motivators for others to go public about their HIV/AIDS status.⁵⁷



Catholic AIDS Action in Namibia explicitly aims at training pastors, not only by informing them but also by encouraging participatory training. Often they are unaware of how much they use discriminatory language, and therefore increase stigma, nor of how important their role is in the fight against the pandemic.⁵⁸

Catholic AIDS Action fights against stigma and discrimination of people living with HIV. Joint activities are held regularly with the AIDS Law Unit of the Legal Assistance Centre and Lironga Eparu, the newly launched national organisation of People living with HIV/AIDS in Namibia.⁵⁹ Through its programme of spiritual support, Catholic AIDS Action seeks to reduce stigma and promote an environment of acceptance and positive living. It also works closely with other church denominations to provide training, support, outreach and annual conferences on “Living Positively with HIV/AIDS”. The programme’s services are provided in English, Oshivambo, and Afrikaans.

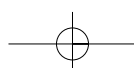
Box 4: Canon of the Anglican Church of Uganda declares himself HIV positive

An important stigma fighter is Gideon Byamugisha of the Anglican Church of Uganda. He addressed the ecumenical advocacy alliance HIV/AIDS strategy group on the launch of its campaign on HIV/AIDS World AIDS Day, 1 December 2001.

“My own church continues to take up its part in this campaign by challenging the stigma that is usually attached to HIV/AIDS. In a few days I will be made a Canon of the Anglican Church. You may ask, ‘What does this have to do with HIV/AIDS and stigma?’ The answer is simple yet painful...you see I am living with HIV. (...) I can testify that my church cares. She did not throw me out when I disclosed that I was HIV positive way back in 1992. Instead, she supported me in the task of developing an HIV prevention and AIDS care programme that integrates issues of sex, sexuality, and sexuality in worship in Christian literature and in ministry with children, young people and parents. As church, we have worked together (albeit in a small way) in: i) extending subsidised HIV counselling and testing services to those wishing to know their HIV status; ii) initiating post-test HIV support clubs for continuous counselling, social and spiritual support to those living with HIV/AIDS; iii) training and commissioning Good Samaritan home care teams among children, youths, and adults in the church; and, iv) starting health units where there are none, and strengthening those that lack medicines and equipment.”⁶⁰

Canon Byamugisha subsequently developed AIDS liturgy to span the church year and keep HIV/AIDS and those infected and/or affected by it in the prayers of the church. And he mobilised church leaders.

“Christian church leaders need to be met where they already have strengths – in using the Bible – before training about research and statistics.”⁶¹



6 Islamic perspectives

The word “Islam” means peace and submission, and Muslims seek to achieve peace by submitting to the will of God.⁶² Islam is one of the world’s major religions with over one billion followers worldwide and 270 million in about 51 African countries.⁶³ In contrast to the Catholic faith, no central authority can unify Islam’s prescriptions.⁶⁴ There are a limited number of practical examples to support the discussion in this chapter.

For the purposed of this review, we will focus on the moral values embodied by Islam, which can be a strong force in the struggle against HIV/AIDS. The following section reviews Islamic values and principles relevant to HIV/AIDS prevention. Section 6.2 deals with and care and support.

6.1 Islamic values and strategies for HIV/AIDS prevention

The following Islamic principles, values and teachings provide highlights for the theological foundations of Islam-based sexual health and HIV/AIDS prevention strategies. They also attempt to explain why some current preventive measures have not succeeded in curbing the pandemic.

First of all, promiscuity is forbidden in Islam. According to Rajput, Prophet Mohammed alluded to this fact 1,400 years ago when he said: “If fornication and all kinds of sinful sexual intercourse become rampant and openly practised without inhibition in any group or nation, Allah will punish them with new epidemics (*ta’un*) and new diseases, which were not known to their forefathers and earliest generations.”⁶⁵ Accordingly, many Muslims believe that the AIDS pandemic is God’s retribution for homosexual activity, extra-marital sex, and drugs.⁶⁶ The media is also implicated in the crisis, for promoting “free sex” while neglecting morality and fidelity.⁶⁷

A prevalent belief among Muslims is that the only answer to the HIV/AIDS pandemic is a radical change in sexual behaviour and a return to ethical values that reinstate the primacy of the family. The Prophet predicts a cure for AIDS saying: “God has not created a disease without creating its medical cure”. However, even with cure, the Prophet believes that another epidemic will surely befall society if it does not abandon immoral sexual practices.⁶⁸

Islamic law, the *Shari`a*, governs various aspects of human behaviour. Imams and activists combating HIV/AIDS refer to various aspects of the *Shari`a* in

their prevention efforts. For instance, Islamic law calls for adulterers to be punished. Prostitution is banned, and those who run sex businesses must be punished. Islam also strongly prohibits two kinds of sexual relations, even between spouses: vaginal intercourse during menstruation (*Qur'an* 02:222), and anal intercourse at all times.⁶⁹

On the other hand, Islam honours the pleasure of sex as a gift from God. It is considered a source of his pleasure and a reward if practised in the sanctioned manner. Sexual desires should be channelled through marriage, which is considered an act of worship.⁷⁰ Islam encourages early marriage whereas premarital sex and extramarital sex are deplored.

While Islam encourages couples to have children, a childless marriage is equally valid. But Muslims are allowed to explore appropriate medical help. Artificial insemination and in-vitro fertilisation are permissible provided that only the husband's sperm and the wife's eggs are used. Most importantly in the context of HIV/AIDS prevention, condoms are accepted as a means of family planning.⁷¹

Islam encourages sexual and family life education within the family setting. Such teaching should be balanced, including physical, psychological, social and spiritual aspects of sexuality. Washing one's private parts after intercourse and male circumcision are also part of Islamic tradition.

Another aspect of Islam that helps clergymen in the fight against HIV/AIDS is the position of women. While the religion acknowledges different roles for women and men due to their physical differences, in many areas it strongly advocates treatment of men and women on equal terms. Under Islam, women have the right to financial independence, to own and inherit property, to refuse marriage or to divorce, and to use her own name.⁷²

Finally, the intake of alcohol and drugs is strictly prohibited, since their effect is to dissolve moral restraints. This has obviously positive implications for HIV/AIDS prevention, both in controlling sexuality, and in stopping the possible spread of the disease through shared needles.

6.2 Islamic values and strategies for HIV/AIDS care and support

Islamic law mandates that individuals actively care for others. The Muslim community must do this through indulgence and correction. A good Muslim should put his or her personal tribulation in the broader context of the good of the community.⁷³ People dealing with HIV/AIDS can use communal bonds in dealing with stigma. In addition, there is a strong current of mercy in Islam, which applies to anyone in distress, even sinners and criminals. Hence, men having sex with men should be able to expect compassionate care when they are taken ill, even though gay sex is condemned.

The *Qur'an* also enjoins believers to visit the sick or bereaved. The Prophet said: "Allah, the Lord of Honour and Glory, will say on the Day of Judgement:

'O son of Adam! I was sick and you did not visit me!' The man will submit and say: 'My Lord! How is it that I visit You and You are the Sustainer of the Universe?' And God will reply: 'Didn't you know that my servant so and so was sick and you did not bother to visit him? Didn't you realise that if you had visited him you would have found Me with him?''⁷⁴

Every Muslim with the means to do so must give alms (*Zakah*).⁷⁵ Indeed, this is one of the five pillars of the faith. Alms can take many forms, so faith-based organisations involved in HIV/AIDS care and support benefit from this Islamic prescription. The price people pay for accepting alms and care is that they are pitied, which affects their self-esteem and self-image. Having to accept charity may be as feared as other types of stigma and discrimination. There is a belief in Islam, similar to that of some Christians, that HIV/AIDS is the mark of a sinner. Because HIV is mainly transmitted through sex, many believe those infected must have contravened the law. More broadly, some theologians interpret AIDS as God's punishment for a humanity that does not respect His laws.⁷⁶

These aforementioned beliefs underpin the Friday sermons and personal counselling of many Imams in Sub-Saharan Africa. In this way, theologians attempt to affect Muslim behaviour toward PLWHA and toward the disease. However, unlike the Christians, there are no formal Muslim health care institutions or support groups for PLWHA in most countries. In progressive countries, such as Senegal, mosques and Muslim organisations have linked up with Christian health care services to enable PLWHA in their communities to have access to care. Box 7 describes the teachings of an Islamic organisation in Uganda. Most Muslim activities, even those concerned with care and support for PLWHA, are most concerned with influencing behaviour.

Box 5: Reduction of HIV/AIDS stigma and promotion of safe disclosure: The Muslim Community perspective

(from Dr Magid Kagimu, Chairman of IMAU and convener of the 1st International Muslim Consultation)⁷⁷

The Islamic Medical Association of Uganda (IMAU) convened the 1st International Muslim Leaders Consultation on HIV/AIDS in Kampala, Uganda, in November 2001, with the support of USAID.

There are many Islamic teachings that support the reduction of stigma in general, which could be applied to the HIV/AIDS situation. For example, there is a verse in the *Qur'an*, which discourages people from defaming and laughing at each other.

“O you who believe: Let not some men among you laugh at others. It may be that the latter are better than the former. Nor some women laugh at others. It may be the latter are better than the former. Nor defame, nor be sarcastic to each other by using offensive nicknames. Ill seeming is a name connoting wickedness to be used of one after he has believed. And those who do not desist are indeed wrong doers.” *Qur'an* 49:11.

Stigma in the context of AIDS is either verbal or non-verbal defaming and degrading of a person with HIV/AIDS. Despite the misfortune a person with HIV/AIDS may have, he or she may be better than many others without such a problem. Indeed there are many PLWHA who have given great service to their families and communities. For example, many PLWHA have disclosed their status and taught their communities about AIDS prevention, care and support. They have done a very great service. The AIDS virus cannot be seen, but PLWHA are the ones who make us see the virus. They give AIDS a human face, which helps everyone understand the problem much more. This is why the Islamic teaching discourages defaming others. No one can be sure of the actual value of another person. It is better to assume the other person is of high value. Safe disclosure starts with the individual affected by HIV/AIDS. The main question we all face when confronted with a calamity is: “Why me?” Islamic teachings help us to address this question. This verse from the Holy *Qur'an* gives guidance on this matter:

“You who believe, seek help with patient perseverance and prayer for God is with those who patiently persevere. And say not of those who are slain in the way of God that they are dead. No, they are living but you do not perceive it. Be sure we shall test you with something of fear and hunger, some loss in goods, lives and the fruits of your toil. But give glad tidings to those who patiently persevere. Those who say when afflicted with calamity that to God we belong and to Him is our return. They are the ones on whom descend blessings from their Lord and mercy, and they are the ones that receive guidance.” *Qur'an* 2:153-157)

The individual affected by HIV/AIDS must be patient and accept that whatever has happened is beyond his or her power. God controls it. Then, he or she should patiently seek help from God. Once the individual has reached that stage of acceptance, then he or she can feel more secure to disclose their status. But safe disclosure requires a supportive environment that will not defame or degrade the individual. This is the environment recommended in the first verse mentioned above. We therefore concluded during the Muslim Leaders Consultation that, if we encourage our communities to utilise the guidance in these verses and apply them practically to the HIV/AIDS situation, we shall reduce stigma and encourage safe disclosure. This is what we call the Islamic Approach to HIV/AIDS. It means using Islamic teachings to support our AIDS prevention, care and support initiatives. We will continue consulting each other on HIV/AIDS issues and encourage our communities to utilise Islamic guidance in their fight against AIDS.

7 Evidence of FBO contributions to the fight against AIDS: Case studies

This section presents the findings of two selected country success stories: Uganda by Green and Senegal by Lagarde.^{78, 79}

7.1 Uganda

Uganda has had the most dramatic decline in HIV infection rates of any country in the region. At the same time, a number of FBOs became active in HIV/AIDS prevention early on. Can a correlation be made?

In 1987, the major religious organisations in Uganda (Catholic, Anglican, Muslim) got involved in AIDS prevention with funding from the WHO Global Programme on AIDS channelled through the Ministry of Health. By 1992, USAID had also decided to allocate funds to these FBOs. The money was given on the FBOs' own terms: for the promotion of fidelity and abstinence, rather than condoms. This approach was strongly supported by President Museveni, who is credited with being the most activist African head of state in addressing the AIDS crisis.

Beginning in 1993, Uganda recorded a downward trend in HIV infection rates. That trend continued throughout the nineties. Green believes this is in part due to behaviour change brought about by FBO and government campaigns. The number of reported sexual partners has reduced, the reported age at which young people become sexually active has gone up, and more people report abstaining from sex completely. These trends are stronger than the increase in condom use.

By the mid-1990s, about 7% of women and 10% of men aged 15-49 were reporting complete and sustained abstinence for HIV prevention. By 2000, according to the most recent Demographic Health Survey (DHS) and to Ugandan Ministry of Health surveys, reported abstinence in the past year was up to 25%-30% (most of this reflects youth delaying sexual debut).

Impact studies have corroborated these trends. A UNAIDS Best Practice Case Study of the IMAU shows that AIDS prevention activities carried out through religious leaders have had significant direct impact on particular populations targeted.⁸⁰ The Anglican Church of Uganda has also implemented special prevention programmes aimed at youth, which are carried out in Sunday schools and primary schools. The areas targeted for behaviour change by the FBOs – abstinence and fidelity – were the ones most likely to be found in surveys and studies.

As behaviour has continued to change and as HIV infection has continued to decline, the number of religious leaders and groups involved in AIDS prevention has expanded under district MoH AIDS prevention activities funded by the World Bank. As a result, there is now a high level of involvement on the part of religious organisations and leaders. By 1995, only two years into the first FBO project, there were over 2,745 trainers and peer educators as well as 5,629 community volunteers in the Muslim IMAU project. They had reached 193,955 households and had counselled or sensitised 1,059,439 sexually active people, according to the external evaluation of the USAID-funded project that supported the first FBOs. In the Anglican CHUSA project, 96 diocesan trainers and 5,702 community health educators were trained, and they sensitised 736,218 members of the community by 1995. There was also a Catholic-run project.

In 1998, an average of 150 religious leaders (ministers, imams, deacons, elders) were being trained in each of Uganda's 45 districts per year, resulting in the training of some 6,750 religious leaders in HIV/AIDS annually. Training here refers to education about AIDS and about what the religious leaders could do to help prevent it.

In conclusion, Greens finds the evidence suggestive that FBOs, in combination with government and NGO programmes, have had an impact on the overall decline in infection rates.

7.2 Senegal

Senegal is another country widely recognised as a success story. According to UNAIDS reports, in Dakar, the major urban area in Senegal, HIV-1 prevalence among antenatal women was 1% or less for all years up to 1998. Prevalence rates range from zero to 0.8% outside Dakar.⁸¹ The Senegalese two-round behavioural survey reports evidence of behavioural change in partner reduction and a rise in age of sexual debut.⁸² However, attribution of the cause of these successes is an issue in Senegal. FBOs in this country have been active since early on in the pandemic, but Senegal also boasts a very active National AIDS Control Programme, and an array of development NGOs, Community-based organisations (CBOs), and youth and women's organisations involved in the response.

Green reports that a conservative Muslim organisation, Jamra, approached the national AIDS programme in 1989 to discuss prevention strategies. A survey conducted by Africa Consultants International (ACI) concluded that religious leaders wanted more information about HIV/AIDS. Educational materials were designed to meet their needs, and training sessions for decision makers and religious leaders were widely implemented. AIDS became a regular topic in Friday sermons in mosques throughout Senegal, and Jamra and senior religious figures addressed the issue on television and radio. A colloquium on AIDS and Islam was organised in 1995.

A Catholic NGO, SIDA Service, also became involved in prevention as well as counselling and psychosocial support. In 1996, a meeting on AIDS prevention was organised for Christian leaders with the support of USAID/AIDSCAP. Every bishop in Senegal attended and consensus was reached that AIDS prevention was an important national priority (see Box 9). The following year, with the support of UNAIDS, Senegal hosted the First International Colloquium on AIDS and Religion held in Dakar in late 1997. It was attended by some 250 people from 33 countries, including Muslim, Christian and Buddhist religious leaders and the ministers of health of five African countries. The impact on Senegalese religious leaders of all faiths seems to have been to empower them "to act freely in the promotion of prevention strategies".

Notwithstanding the intense activity in Senegal, it remains difficult to isolate the impact of FBOs. In the search for evidence of the effects of religion on AIDS risk-taking and protective behaviours, Lagarde conducted a study aimed at describing the association between religion and STIs/AIDS Senegal. The study concluded that, despite initiatives aimed at involving religious leaders in AIDS prevention, religion was non-significantly associated with AIDS awareness in this area. Moreover, the study suggests that religion was negatively linked with preventative behaviours. Lagarde concluded that religion has the ability to modulate preventative behaviours and suggested the need to intensify the efforts to involve religious leaders.

Green reports that indeed religious leaders propagated negative images of people infected by HIV thereby contributing to the stigma. But he goes on to cite evidence that FBOs and religious leaders now acknowledge the importance of dispelling myths about the disease, such as the common belief that AIDS is a curse or punishment from God.

Another problem with analysing the effectiveness of these campaigns in Senegal, according to Green, is that sexual behaviour there is conservative by general Sub-Saharan African standards. Pre-existing norms and values, rather than the impact of any interventions, may have kept infection rates low. Furthermore, widespread male circumcision among Senegalese men helps prevent heterosexual transmission of HIV. It may even be that the presence of HIV-2 limits the spread of HIV-1. But these considerations fail to explain why HIV-1 infection rates have risen in Senegal's neighbouring countries, which share many of the traits mentioned above. In terms of HIV/AIDS, Senegal is unique in West Africa.

7.3 Conclusion

Green notes that both Senegal and Uganda stand out in Africa as countries where governments supported AIDS prevention efforts boldly and strongly at a relatively early stage. There is agreement in both countries that this support has made a major difference and has allowed prevention programmes to have maximum impact. It is probable that one of the factors inhibiting a strong government response to AIDS elsewhere in Africa is the fear of a negative

reaction from religious authorities. This strengthens the argument for involving religious leaders and FBOs as early as possible.

Box 6: Process, the response of SIDA Service in Senegal⁸³

Background

In Senegal, individuals, decision makers and communities are becoming aware of the scale of the HIV/AIDS epidemic and are getting involved. People are talking about HIV more openly and responding to the challenges of the epidemic by launching new initiatives. One such community-based initiative is SIDA Service, the brainchild of a nun from Saint Thomas de Villeneuve who felt a need for guidance among youths.

SIDA Service has evolved considerably over time. The activities have been maintained and strengthened by a volunteer base of parents, physicians, teachers, church members, social workers, lawyers and students. HIV prevention information was introduced in schools and a partner support system was established for people living with HIV. Activities have spread from urban to rural areas and have involved the clergy, Church networks, national stakeholders in HIV prevention and networks of people living with HIV/AIDS.

Process

None of these achievements would have been possible without the commitment of the nun and the volunteers, and the benevolence of the church leaders. The multi-disciplinary approach and use of planning tools developed by the UNDP HIV and Development Regional Project for Sub-Saharan Africa has facilitated the continued training of group members.

In its quest to attain a more coherent plan of action, group members undertook a survey to assess the community's level of understanding of the epidemic. Results led to the organisation of a programming seminar in April 1993. HIV prevention strategies were devised in keeping with the teachings of the church.

SIDA Service participated in the HIV and Development Workshop organised by the UNDP Regional Project in Saly Portugal in August-September 1993. A SIDA volunteer also went to the Inter-country Consultation of the African Network on Ethics, Law and HIV in Dakar in June-July 1994. SIDA Service now has three representatives in the Senegalese Network on Ethics, Law and HIV and has adopted all its recommendations.

Results

SIDA Service created tools, which are currently used to train the agents of 72 privately-owned Catholic health centres and schools throughout Senegal. Health workers develop action plans for safety and good nursing practices and support to people with HIV/AIDS. In all dioceses, schools and affiliated youth, women and catechist groups are involved in HIV/AIDS-related activities with the support of SIDA Service. The organisation has since organised two national symposia on AIDS and Religion: the Christian Response. It also runs a Health Promotion Centre, which provides voluntary counselling and testing (VCT) – the first in Senegal outside a hospital – alongside primary health care services and routine laboratory tests. All this is supported by over 200 volunteers within a network of private and public hospitals and development partners, such as the Memisa, French overseas cooperation, USAID/AIDSCAP and the Catholic Relief Service.

8 Christian FBOs' self-assessment of their HIV/AIDS related work

The following is a summary of Christian organisations' statements. Materials are adapted from "Christian Connections for International Health".⁸⁴ Sections 8.1 and 8.2 present FBOs' accounts of their prevention activities and opportunities for improvement. Sections 8.3 and 8.4 deal with statements by FBOs on their care and support activities.

8.1 HIV infection prevention

FBOs can play a central role in the prevention and control of HIV/AIDS. Together with communities and families, they are on the front line of the response to AIDS. The church can be a trusted source of healing, and religious institutions are present at the community level. They are sustainable organisations, and often the ones who can reach remote areas. For example, in rural areas of Burkina Faso that are heavily affected by AIDS due to migration, Churches are well placed to lead the effort.⁸⁵ Similarly, Churches' health, educational and social workers in the Eastern Province of Cameroon are active in Pygmy communities. The government has had difficulty reaching this region.⁸⁶ FBO workers are committed and motivated by their faith. Traditional leaders can be used to bring a positive message on how to address HIV at the village level, thus reducing fear and stigma. This has been achieved in a pilot programme in The Gambia called "Hands on Care".

The Anti-STDs/AIDS Youth International (ASAYI) states that sexual and reproductive health education for youth is an emergency. The Integrated Action Against AIDS with Kenyan Churches' Programme acknowledges that although the level of awareness and knowledge regarding HIV/AIDS has greatly increased among target audiences, there is no corresponding increase in behaviour change. Changes in core values, though difficult to achieve, are possible. Cultural and religious values are the foundation on which behaviour is built. With prevention information everywhere, it is becoming clear that it is only a change in behaviour that will stop the spread of this disease.

Besides messages about abstinence and faithfulness, life-skills training have been lacking. Some organisations are now filling this gap. In Namibia, Catholic AIDS Action (CAA) has adapted the UNICEF and Namibia Ministry of Education life-skills education programme to target pre-adolescents. The Edu-AID project in South Africa states that their strategy changed significantly when they realised that they were not making a lasting impression. They

decided that they had to look at things that would have an impact on, and change, behaviour and attitudes. Issues such as personal values, sexuality, sexual orientation and self-worth needed to be addressed.

There is much that local communities in developing countries can achieve themselves in terms of human welfare without depending on outside assistance. As the Integrated Action against AIDS with Kenyan Churches says, churches have a wealth of human resources, which can enable them to reach a wide audience.

8.2 Opportunities and the way forward in HIV prevention

The International Family Health's experience of working with religious health organisations to promote integrated sexual and reproductive health provided the impetus to establish an alliance of religious health organisations in Africa to influence the discourse on HIV/AIDS in the context of religion, ethics and morality. The aim is to inform programmatic and policy change amongst religious hierarchies and religious health organisations through action research, cross-fertilisation, leadership development and advocacy. The Forum supports champions of change within religious health organisations to influence the development of appropriate HIV/AIDS services.

The Forum now covers eight African countries and 15 religious health organisations of various faiths. Such a forum has created an opportunity for religious health organisations to collectively raise awareness and understanding of sensitive issues around HIV/AIDS, so as to advocate for change. The partnerships have facilitated sharing of information, expertise and resources to strengthen the capacity of religious health organisations. The more progressive organisations have effectively influenced agenda setting in the more conservative ones.⁸⁷

Participation and networking play a vital role in effective project design and implementation. This has often led to the development of a common understanding and partnerships with priests, parishioners and the community at large. Imams and church leaders need to be sensitised before starting church programmes.

Committed and well-trained peer educators who are competent and realistic are needed. They should receive proper refresher training. Health districts should work closely with all NGOs and community-based organisations to provide support, supervision and offer technical assistance where it is needed.

National AIDS Control Programmes, donor agencies and international NGOs, including international FBO NGOs, should not define the problem on behalf of local faith-based organisations, religious leaders and programme implementers. Rather, they should strengthen local stakeholders' capacity to do so themselves using participatory tools and techniques and by improving the functioning of the various organisations and networks.

Facilitating church leaders to look at HIV/AIDS as a spiritual, economic, cultural and gender issue has led to a better understanding of the problem, which goes beyond the moral issues that churches have focussed on as the cause of the spread of HIV/AIDS.

Networking is very much needed at all levels. Typically, churches work in isolation from each other. It will be easier for the African Independent Churches to network with other agencies involved in HIV/AIDS programmes after these churches have understood AIDS in their own settings.

The Salvation Army experience is a lesson in facilitation, participation and ownership. When a project is "owned" by only a few people, or a few organisations, then future sustainability is jeopardised. It would be seen as yet another *expat* project. This can be avoided by moving at a slow enough pace to ensure that local churches become partners. There is a tradition of mistrust between governments and international agencies' representatives on the one hand and religious organisations on the other. South-South and North-South cooperation in a partnership context of mutual respect is needed. The Nigerian Fellowship of Christian Students Aid for AIDS and Design for the Family states that existing structures can either be stepping stones for success or stumbling blocks for the failure of projects, depending on how they are managed. Political will and Christian commitment are key motivating factors. The active involvement of policy makers and other key stakeholders and beneficiaries gives credibility at all levels.

Neutrality in an ecumenical approach to church-based interventions is key to success. Even though MAP training workshops equipped participants with knowledge on the efficacy of all scientifically proven protection methods, MAP did not prescribe any particular methods. The respective church organisations were left to make their own informed decisions. Opposition in any form should be used as an opportunity to pray and seek alternative strategies for implementation at all levels.

Research, monitoring and evaluation is still weak. Balanced, well-researched, well-documented information stimulates church leaders to address HIV/AIDS issues, especially when these leaders can tailor them to their own needs and philosophies. The Integrated Action Against AIDS with Kenyan Churches acknowledges that results of a baseline research have been instrumental in sensitising church leaders. When confronted with the reality of the situation, the leaders began to act decisively, and with urgency, to address policy issues.

The church should pay particular attention to the dilemma of the youth. Youth from one of Nairobi's slums identified a number of factors they perceive as causes of risky sexual behaviour and rapid spread of HIV/AIDS among young people in Kenya. Ranking highest on their list were boredom and peer pressure, followed by ignorance, feeling out of place in society, lack of skills, frustrations, drugs and a permissive and persuasive media. In 1995, one of Kenya's daily newspapers reported that 124,000 girls drop out of school annually because of pregnancy. Positive behaviours among youth, such as abstinence should be

promoted. This should not be done as a prescription but as a negotiated and complemented approach with other skills needed to consolidate abstinence practices among responsible human beings. The complementary services needed, with referrals if possible, would be access to condoms and ensuring that young people feel comfortable using them.

8.3 Perceived need for care and support

In the area of care and treatment, the cost associated with voluntary counselling and testing (VCT) limits the expansion of initiatives. Access to funding is often problematic. Stigma and discrimination towards PLWHA are still very high. In Botswana, the Tshepong Counselling Network found that people have a high threshold to cross in order to speak with someone about the illness and their fears about it. In addition, counselling is a new concept in this culture so it is not easy for someone to understand how sitting down and speaking with a stranger may help him or her. This is at the core of what makes HIV/AIDS so deadly in this society, the nature of transmission of the virus coupled with a reluctance to talk about it openly work together to greatly exacerbate the problem.

The project's surrounding environment is one of informal shack settlements without adequate sanitation, water or electricity supply. This leads to the rapid onset of the AIDS syndrome following HIV infection, and to an early death. To care for AIDS patients and families means more than providing nursing, medical and social intervention, it also means finding ways of providing for a quality of life, employment and skills that will help the sufferer gain admission to community life and/or provide for themselves.

St. Francis Hospice provides the following services as part of the Integrated Community Home-based Palliative Care Services in East Cape Townships for Terminally Ill Cancer and AIDS Patients, South Africa:

- i partnering "soup kitchens" and nourishment and food parcels;
- ii skills training for family members, relatives and friends;
- iii community talks;
- iv workshops for awareness campaigns for home-based care;
- v encompassing prevention elements and foster care for orphans; and,
- vi development of garden projects, quilting, sewing, and beading.

Community care is appreciated both by PLWHA and other chronically-ill patients. Home care can alleviate suffering and reduce stigma and isolation. The Hands On Care: HIV/AIDS Care Pilot Programme in The Gambia has provided medical and spiritual support through home visits to the terminally ill, including the elderly, invalid, people with cancer and people who are HIV positive.

A programme called "A New Robe" provided by the Swaziland Parish Nurse Programme, attributes its success to the following factors:

- i interventions integrate client's values, faith beliefs and cultural practices;

- ii interventions reflect consideration of the client's uniqueness, integrity and independence of opinion;
- iii interventions empower the client to use self-care abilities to promote wellness, prevent illness and cope with changes in health status;
- iv the strengthening of relationships with other denominations. Counselling services conducted with pastors and priests;
- v training volunteers, both male and female, who are church members and parishioners in caring for the terminally ill;
- vi the strengthening of relationships with personnel at clinics and other health facilities all over the country; and,
- vii the establishment of an all-inclusive approach to care of terminally ill.

It faces difficult challenges:

- i scattered homesteads mean nurses and care providers have to walk long distances to clients' homes;
- ii poverty, an underlying problem for most families coping with terminal illness, results in a lack of basic necessities, bedding, soap and food;
- iii the high expectations of families that Parish Nurses and care providers will be able to supply all their needs;
- iv lack of protective clothing gloves and overalls;
- v lack of medications, especially anti-retroviral drugs, to delay the occurrence of AIDS-related diseases;
- vi the programme does not have transport to get to all the parishes to support and monitor progress;
- vii lack of policy on the use anti-retroviral drugs by Ministry of Health and Social Welfare; and,
- viii a growing number of orphans being identified, who will need to be cared for, supported and educated during the next phase.

8.4 The way forward in care and support

- Work together with other churches to enable programmes to increase coverage to terminally ill people in the country.
- Encourage the training of nurses from other denominations to be Parish Nurses. Provide access to medication for pain, etc.
- Assist communities to start projects to secure finances to cater for orphans and the aged.
- Work with community leaders and other stakeholders for sustainability of the programme.
- Provide at least five food parcels for each parish for the most destitute families.
- Network with other agencies is possible.
- Keep up-to-date with news about AIDS.
- Encourage people with AIDS and their families to accept responsibility as much as possible. Sometimes financial help may be necessary.

For the most part, what the Church lacked was tools, affirmation and encouragement. Training, provision of awareness-raising and educational

materials, interaction and a communications hub were needed in order to enable them to more effectively engage in HIV/AIDS intervention.

Others needs include:

- i Maintaining and extending services to additional communities;
- ii Providing community and township day care services at each service base;
- iii 4-wheel drive ambulatory vehicle for patient transport;
- iv Volunteer training in communities;
- v Caring for HIV affected and infected children through their families; and,
- vi Improving contact with hospitals and clinics on referral procedures.

According to Mobilising for Life, World Relief, in Burkina Faso, funds alone are not an adequate solution, and can actually be harmful if they flatten a community's response rather than augment its capacity. Coordination and networking are essential components to enable the churches to share ideas and resources. Training of trainers allows a multiplier effect, and professional training should accompany the distribution of written tools. The church should cooperatively seek the means to provide compassionate care to those persons and families affected by HIV/AIDS. As the epidemic deepens, families will face ever-greater costs in health-related expenditures. The church can teach and offer models of compassionate care based and centred in family homes.

9 Discussion: where has religion taken us?

Sub-Saharan Africa is the area of the world worst affected by HIV/AIDS. Fortunately, many religious leaders have now abandoned the impulse to apportion blame, according to case studies, conference reports and observations in the field. Instead, they are developing policies and structures to combat the pandemic. Most FBOs in the region are more concerned with practical achievements than with religious principles. They seek action rather than rhetoric.

At the same time, religious principles are not always clear. Sometimes, they seem so general that they could serve as a panacea for almost anything. As yet, there is no unambiguous definition and interpretation of many of these principles for concrete policymaking and resource allocation. This begs several questions: What sets FBOs apart? What are their strengths, and what are their limitations? And how can the international aid community best support FBOs?

Most FBO programmes do not have integrated research and evaluation components. Few have been properly reviewed or evaluated, and where data exist, much has not been synthesised. This leaves FBO and religious leaders, as well as national planners, with little or no guidance as to what has or has not worked effectively in terms of content, adequacy in terms of meeting the challenge of the task, effects, process, cost and efficiency. With this desk review, KIT hopes to start a process to redress this shortcoming. In this concluding section, we present some of the discussions raised by the evaluations and reports reviewed.

9.1 What do FBOs contribute to the struggle against HIV/AIDS?

FBOs have displayed a number of strengths compared to government institutions and development NGOs. For example, they are clearly the most effective in service delivery in relation to care and support for people living with HIV/AIDS. Their limitations are manifested mostly in the areas of prevention (See 9.1.2), and in their lack of opportunities for participation in the design of national policies and strategies (See 9.2).

9.1.1 CARE AND SUPPORT: CARING AND HEALING COMMUNITIES

Care and support is the Christian FBOs' strongest contribution to the struggle against HIV/AIDS in Sub-Saharan Africa. The churches have a long history of providing health care in the region, and hence an extensive network of

institutions is already in place. FBO members demonstrate a strong commitment to supporting PLWHA in accordance with the Biblical example of Christ caring for the sick.

FBOs and Christian health care facilities face difficulties typical to most developing countries, e.g., disease pressure, overcrowding, workload, lack of funds, limited managerial capacities and qualified human resources. However, Churches seem to be successful in fund raising both inside and outside the global HIV/AIDS context. This contributes towards schools, health and VCT centres, orphanages and supports income generating activities.

Faith-based care and support services are at their best when they employ a bottom-up approach. Programmes and interventions are developed at sectoral or community levels, both by Muslim and Christian groups. In many instances, successful initiatives have been led by “change agents”, e.g., a nun, nurse, priest or school-going adolescent. They are later on supported by religious leaders.

Muslim FBOs are less active in providing care and support. This is unfortunate but it is changing. More could still be done to provide practical facilities, community-based support and care activities and to address fatalism and self-stigmatisation so as to empower followers to face the challenges rather than “coping out”.

The Churches have been responsive to the impact of the epidemic on individuals and affected families. Organising home-based care often necessitates cooperation between ecumenical and various religious groups, and highlights the international contacts between many churches, community and multi- and bilateral donor agencies. Catholic SIDA Service in Senegal and the Ndola home-based care programme in Zambia have provided inspiration for other programmes.

However, contacts between congregations themselves in various African countries remain rare. Although national and international funding seems to be available, allocation and fund raising at the local and individual organisational level is proving uncertain. This raises questions about the sustainability of most care and support initiatives in poor and remote settings.

FBOs offer a special advantage in care and support in their capacity for spiritual care. Theology profoundly influences people’s readiness to accept strategies for prevention, facing and reacting to HIV infection and the AIDS social catastrophe. Theology could serve as the motor for restoring hope and combating stigmatisation and discrimination rather than instilling helplessness, fatalism and “coping out” behaviours.

Spiritual and pastoral support meets the need of many PLWHA but, in contrast to the view of Church medical staff, it is generally not considered relevant by the international donor community. This creates an unnatural dichotomy in the

staff of the churches (and may occasionally explain “deviation of medical funds for church activities” in the eyes of the donor). It also deprives important opinion leaders of financial support for AIDS-related activities.

Another limitation for Christian care and support is the problem of stigmatisation. On the whole, religious groups have a reputation for responding to the issue of HIV/AIDS in negative terms. This can be due to religious leaders’ judgmental comments, resistance to condoms, and an obstructive stance towards policy development, particularly regarding drug use, commercial sex, and harm reduction approaches. The religious sector has been largely unwilling to engage in any way that could imply dilution of moral standards. As a result, people with HIV have experienced rejection by some religious people, congregations or institutions.

In both Christian and Islamic communities, more and more people are combating the stigma driven by moral and religious values, and positive attitudes are developing. Faith-based groups have been working in community-based care and prevention and they have had clear achievements in stigma reduction in entire communities. The fact that religious communities are usually interwoven into the wider community is a strength and major asset for sustaining a response, and for promoting mutual healthy accountability for care, support and change.

9.1.2 PREVENTION: MISSED OPPORTUNITIES

The strong points FBOs have demonstrated in prevention, including their considerable potential for outreach, are counterbalanced by two serious limitations among prominent Christian organisations. First, many churches or programmes have an official ban on condom use. Second, many Christian leaders condemn people, particularly women, who have sex before marriage, more than one relationship, or are earning a living through sex.

However, FBOs can have a comparative advantage in the area of prevention. UNAIDS reports that religious leaders and FBO members are in close and regular contact with all age groups in society and that their voices are highly respected. People involved with FBOs are usually highly committed and motivated, and are adept at motivating those with similar beliefs.⁸⁸

FBOs also usually reinforce existing value structures, or adapt their message to fit communal values or the needs of a target group. This is illustrated by the success of the “Fleet for Hope” campaign developed by Joinet, which offers options for different individual and contextual situations.⁸⁹ The “Fleet for Hope” could be further reproduced and made available to the various FBOs active in each corner of the world.

Although FBOs’ primary prevention strategy of promoting abstinence and fidelity may be having a positive effect, as we saw in Chapter 7, attribution is problematic. The point to be made is that religious leaders have a different time perspective and, in “hoping for the best”, they trust that overtime, and

incrementally, individuals will reach the ideal (abstinence and faithfulness). Meanwhile, secular public health decision makers, who are “planning for the worse”, wish that Church leaders would also adopt the practical HIV preventive means (condoms).

Clearly, abstinence from sexual activity until marriage or psychological and sexual maturity, and fidelity to a sero-negative partner, are the best strategies for preventing the sexual transmission of HIV/AIDS. But these strategies do not always work in the real world. They need to be complemented by various other programmes. An important element of such programmes is skills training, where people learn practical decision-making skills, refusal skills, and communication and negotiation skills for safe sex practices. Other important elements include income-generating activities, schooling for girls (this reduces their dependency on sex work and transactional sex), and community development initiatives to address gender relationships, double standards and other barriers that hinder safe sex practices.

Most FBO prevention programmes could be improved by focusing on knowledge, attitudes, personal risk perception, personal development and social norms, self-efficacy and skills. To some extents, Islam and Christian faiths do already address the social and psychological risk factors in relation to AIDS amongst youth. They could do more.

The fidelity strategy, being faithful to a known sero-negative sexual partner, is the preferred strategy with regard to the sexually-active population. However, this strategy is complicated by the fact that most people are “sero-ignorants”, that is, they do not know their own HIV status nor that of their partner. Fidelity programmes need to be accompanied by skills training similar to abstinence programmes.

Even more important to successful fidelity programmes are community development on sexual health issues and gender relationships. Both men and women often find it difficult to negotiate safe sex practices. In most cultures in Africa, men are expected to have multiple partners. In Islam, monogamy is promoted although polygamy – but not polyandry – is perceived as less hypocritical and is therefore tolerated. FBOs can play a role in reinforcing fidelity but have more difficulty in addressing the ongoing practice of multiple partners and the barriers to practising safe sex in marriage. Overall, government and NGO health services are in a better position than FBOs to promote dual contraception and negotiating safe sex through couple counselling programmes. These services would complement FBO natural family planning work.

FBOs often promote HIV testing before marriage. These practices can be an important aspect of enhancing abstinence and fidelity programmes, and even consistent condom use. However, such testing has limitations and could backfire. It may also cause conflict with the ethical and global agenda on HIV testing.

In general, the idea of promoting confidential, voluntary counselling and testing is attractive and could influence individual informed decision-making and behaviour change processes. However, a number of points need to be considered:

- i the test in itself does not protect, and test certificates can be forged or purchased. Window periods are not always taken into account introducing a false sense of security. Whatever the pros and cons, it is important to ensure that pre-test and post-test counselling covers all prevention strategies: abstinence, fidelity, and condoms;
- ii in certain communities and countries, the test is used for discriminatory purposes. The requirement of a pre-nuptial or pre-employment HIV negative test is a flagrant violation of human rights;
- iii for a policy on access to VCT to work well, it should be complemented with the provision of quality care, good home-based care and treatment programmes, initiatives to address stigmatisation and discrimination of people who tested positive, an assurance of confidentiality, action to reduce family and social rejection as well as fear and anxiety, and the improvement of living conditions. All these are measures that strengthen individual capacity to make “enlightened” decisions concerning behaviour and future; and finally,
- iv by definition, testing people before marriage makes confidentiality impossible. Testing must provide a benefit rather than engendering fear and stigmatisation. Here, FBOs can play an important role in developing a positive atmosphere around HIV testing.

Islamic religious leaders and FBOs also contribute to prevention by efforts to combat female genital mutilation. Among other negative consequences, this practice can lead to bleeding during sexual intercourse, which contributes to HIV transmission.

The major limitation of some FBOs working in prevention is their “ethical” refusal to promote condom use. This should be dealt with on a case-by-case basis in each community or denomination. In contrast to the strict refusal of the condom as a means of family planning, the acceptance of condom use as a means of HIV prevention varies greatly from place to place. Attitudes are highly dependent on local factors. Specifically, those working at the grassroots level often decide to advise condom use when they perceive the need to do so. This unofficial condom promotion may be quite common, and should be tacitly encouraged. In any event, condom policy should not inhibit secular institutions from working with FBOs. Indeed, there is a strong argument that values-based programmes and condom programmes work best when offered cooperatively.

In conclusion, while the work of FBOs in prevention is problematic, there are some useful entry points. First, FBOs can be effective in helping young people learn how to avoid STIs and HIV transmission before they become sexually active. Second, religious organisations have always focused on values. In the face of the HIV/AIDS pandemic, value education, with an appropriate focus, can be a powerful tool.

9.2 How can the international community best support FBOs?

The international donor community, as well as native secular agents in Sub-Saharan Africa, have often fallen short in their working relationships with, or support for, FBOs, and vice versa. Based on the findings in this desk review, we can make the following recommendations for improved cooperation.

First of all, further large-scale studies and research are needed to identify and map the strengths and shortcomings of FBOs, including indigenous and less represented religions, in the context of HIV/AIDS, and to document the effects/impacts of FBO prevention and support activities. Such research should fully involve the FBO and religious leaders themselves. A broader view on how FBOs' activities influence behaviours and lives of PLWHA in other continents could also be shared with their African counterparts.

It is also essential to continue to fill the gaps between FBO and secular organisations at national and international levels. This will help to break the isolation of FBOs and to further strengthen their capacity to respond effectively to HIV/AIDS. However, communication between secular and faith-based institutions can easily go wrong. Secular institutions should not fight the role FBOs aspire to, and governments and NGOs should communicate directly with religious organisations to help facilitate participation and relationships based on mutual respect and trust. The pandemic calls for action on a large scale, and all the stakeholders have a role to play. Programmes must complement each other rather than compete. It is thus important to involve religious and FBO leaders in country and global HIV/AIDS coordination mechanisms so as to enhance the transparency, collaboration and accountability of all stakeholders.

Secular leaders should attempt to understand religious leaders' perspectives. Religious organisations and leaders have sometimes obstructed response programmes. This often happens in a context of passionate defence of moral principle, but may be divorced from local reality. Yet, such moral stands can be expressions of solidarity and beliefs shared by the wider community. Further research into the influence of religious beliefs on behaviours and community participation could help understand opportunities and threats for improving strategy development. Articulation of religious values and norms can be part of the community identity rather than an imposed position. As with leadership in many other areas, religious leaders do not readily accept having views imposed on them. At every level of negotiation, the process should involve facilitation and participation. Perspectives easily shift when people become more closely involved in the lives of people with HIV/AIDS. Religious leaders need to see for themselves what the problems are and from where the short and long term solutions may emerge. The ban on condoms addressed a particular concern: respect and protection of life. While the ban on condoms is still valid, many FBO workers consider that respecting and protecting life can mean unofficially discussing condom use on a one-on-one basis. The decision to do so is based on a perceived need and the moral teachings of the person's faith rather than on any international or national strategy.

Regarding stigma and discrimination, religious leaders – and to a lesser extent FBO workers – are both part of the problem and part of the solution. On the one hand, religious teaching and beliefs may have led to discrimination, self-stigmatisation, fatalism, feelings of helplessness and maladapted coping behaviours; on the other hand, caring communities have played an important role in providing service delivery and social support.

For the most part, the positive stands taken by religious leaders are happening at random based on the pressure of the epidemic or its immediate effects on individuals or families. These reactions could be influenced by proper objective informative and understanding of the potential negative impacts on human well being and development. It is important for policymakers to give opinion leaders in the churches opportunities to gather correct and unbiased information about the individual and global aspects of HIV pandemics. This information should be based on evidence and developed with respect for the position and views of the churches.

9.3 Conclusions and recommendations

- The main priority is to create a better understanding between religious/FBO leaders and governmental policy makers at national and international levels. This would involve greater communication and professional discussion.
- FBO care and support activities need to be complemented by public health activities that support prevention.
- If FBO projects are to be improved and scaled up, international FBOs and the HIV/AIDS institutional agencies must show greater commitment to supporting local FBO initiatives.
- FBOs should be supported in their very effective work at the grassroots level, notwithstanding the rhetoric at a higher level. Policy should be devised to further support the people on the ground via FBO activities. For example, policy makers could facilitate travel expenses for FBO workers and support communication infrastructure to stimulate ongoing exchanges.
- Training is needed to ensure increased skilled human and financial resources for the treatment, care and support activities in which FBOs have demonstrated a strong commitment and potential. This would include support for skills training and initiating community development activities.
- More research is needed to document the influence of religion on behaviour change and to assess the effects and processes of FBO work.

9.3.1 INSTITUTIONAL AND POLICY MAKING ISSUES: HIV/AIDS PROGRAMMES, RELIGIOUS AND FBO LEADERS

- The extent to which mechanisms are in place for effective participation of FBOs in HIV/AIDS programmes should be reviewed. This includes reference to the national and global AIDS control programmes coordination, other institutional relationships, and co-ordination around FBOs' strategies and work.
- Secular stakeholders should facilitate contacts and discussion with religious leaders. Communication at the higher levels is important to keep religious leaders and FBO workers informed. At the national level, the Ministry of

Health or leading institution should identify its allies, initiate contact on a basis of mutual respect, and sustain the relationship. Governments should organise conferences and subsequent follow-up to keep religious leaders informed, and to increase their participation in areas where they have shown a comparative advantage.

- Religious leaders and FBOs should also actively seek information and exchange and avoid isolation. FBOs should pursue regional, national and international networks at every opportunity.
- Not all FBOs are in a position to promote condom use. They should work on their areas of comparative advantage to complement the work of other stakeholders. Religious leaders and FBO programme makers should promote alternative strategies in relation to perceived threats at the pastoral level.
- FBOs should be encouraged to give young people access to HIV/AIDS prevention services, along with expressing their message. In their own religion classes, FBOs should be supported in teaching young people how to negotiate sexual relations. Such life-saving skills are especially important for pre-adolescents who want to practice abstinence.

9.3.2 RESEARCH AGENDA

- Research could promote understanding of how religion influences sexual behaviour, service delivery, help-seeking behaviours and community participation in the context of the HIV/AIDS epidemic. Research on how religious principles, faith-based strategies (including Islamic and secular religions) and practices impact on PLWHA lives can elicit attribution and inform/improve project design and messages and strategies, and identify necessary complementary strategies by non-secular organisations.
- FBO programme makers should contribute to situational analysis and subsequent evaluations to help develop or review strategies. This process should include providing evidence of the effect and impact of programmes, e.g., on the effects of sex education on the timing of first sexual intercourse.
- National authorities and international agencies should explore with FBOs the development of behaviour change surveillance mechanisms to measure the effects of FBOs' work on sexual and reproductive health. Such reviews should also assess FBOs' need for any further information and technical assistance.
- The present study does not provide information on resource allocation and flows, participation of the religious leaders in country and international coordination, nor interfaith collaboration. Further research should look into these aspects. Some of the information is already available from government authorities, national religious institutions, international faith-based organisations, and donor agencies.

Annex 1: Request for information

Amsterdam, 13th, June 2002

Dear Colleague,

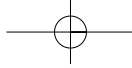
Wisdom suggests the need to broaden the response to HIV/AIDS and to open the policy dialogue as to intensify the involvement of religious leaders and faith-based organisations in HIV/AIDS Prevention and Impact Mitigation. Indeed, around the world, much social activity is organised around religious associations, which are active in many fields of human development, including health and education.

Recognising the important role of religious leaders and faith-based organisations in attitude and behaviour change communication, and care and support to people living with HIV/AIDS, the Royal Tropical Institute (KIT/Health) is undertaking a study on HIV/AIDS, religion and faith-based organisations that will ultimately create a knowledge base while also developing an adequate complement in policy analysis and advocacy for an effective involvement and participation of religious leaders and organisations.

The goal of this study is to capture different religious perspectives to and activities in HIV/AIDS prevention, care and treatment. This will help mobilise Faith-based organisations, promote quality pastoral care, encourage culturally appropriate prevention education, and foster provision of compassionate non-judgmental service to, and advocacy on behalf of, those infected and affected by HIV.

Given your experience or that of your organisation, the Royal Tropical Institute would much welcome your contribution. We are interested in the following documents or reports:

- Synthesis of activities
- Project reports or summaries (location, affiliation, target groups, scope of work, strategies, networks, etc)
- Evaluation reports, Lessons learned (Strengths, difficulties, opportunities) and ideas or plans for further actions
- Policy and strategy documents including the religious, ethical or pastoral guiding principles
- Conference reports

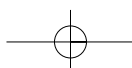
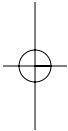


We welcome your recommendations on how to translate this knowledge base (strengths, weaknesses, opportunities and threats) into an advocacy tool for discussion with religious leaders, Faith-based organisations and Development partners.

We wish to mention that we do welcome any suggestions you may have for other contact organisations.

Please send all electronic documents to: g.tiendrebeego@kit.nl and all hard to:
Georges Tiendrebeego
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Mauritskade 63, Amsterdam, The Netherlands

With very best regards, Georges Tiendrebeego



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