Faith Communities Engage the HIV/AIDS Crisis

Lessons Learned and Paths Forward

A project of the Berkley Center for Religion, Peace, and World Affairs and the Edmund A. Walsh School of Foreign Service at Georgetown University

Supported by the Henry R. Luce Initiative on Religion and International Affairs
The Edmund A. Walsh School of Foreign Service

Founded in 1919 to educate students and prepare them for leadership roles in international affairs, the School of Foreign Service conducts an undergraduate program for over 1,300 students and graduate programs at the Master’s level for more than 700 students. Under the leadership of its Dean, Robert L. Galluci, the School houses more than a dozen regional and functional programs that offer courses, conduct research, host events, and contribute to the intellectual development of the field of international affairs. In 2007, Foreign Policy ranked the School’s graduate programs first in the nation.

The Berkley Center

The Berkley Center for Religion, Peace, and World Affairs, created within the Office of the President in March 2006, is part of a university-wide effort to build knowledge about religion’s role in world affairs and promote interreligious understanding in the service of peace. Through research, teaching, and outreach activities, the Center explores the intersection of religion with four global challenges: diplomacy and transnational relations, democracy and human rights, global development, and interreligious dialogue. Thomas Banchoff, Associate Professor in the Department of Government and the School of Foreign Service, is the Center’s first director.

The Luce/SFS Program on Religion and International Affairs

Together with the Mortara Center for International Studies, the Berkley Center is implementing a grant from the Henry Luce Foundation’s Initiative on Religion and International Affairs to the Edmund A. Walsh School of Foreign Service. The Luce/SFS Program on Religion and International Affairs convenes symposia and seminars that bring together scholars and policy experts around emergent issues. The program is organized around two main themes: the religious sources of foreign policy in the US and around the world, and the nexus between religion and global development. Topics covered in 2006–07 included the role of evangelicals in US foreign policy, and links between religion, migration, and foreign policy in the United States and Europe.

This publication is made possible through a grant from the Henry R. Luce Initiative on Religion and International Affairs
Religious communities are critical players in the world of global development, but we know relatively little about their activities. The Luce/SFS Project on Religion and Global Development is devoted to closing that knowledge gap. It explores the role of religious groups and ideas in donor and developing countries and points to areas for greater religious-secular cooperation in the development field. The project supports faculty and student research and publications, development-related courses, and an on-line databases that captures the activities of religious actors engaged in development activities worldwide.

This report is the first in a series designed to illuminate the little-understood role that religious actors play in global development. This Religious Literacy series provides an overview of the activities of religious actors around a particular issue area, in this case, the HIV/AIDS crisis. Subsequent reports will examine topics including children, shelter, and education. Each report is designed to highlight the nature of the global challenge, faith-inspired responses across traditions, interfaith and religious-secular collaborations at the national and international levels, best practices, and lessons learned. The series as a whole will deepen our knowledge of faith-based engagement in development issues, provide an overview of challenges and opportunities, and point the way forward.
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## Abbreviations and Glossary

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADRA</td>
<td>Adventist Development and Relief Agency</td>
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<tr>
<td>AEE</td>
<td>Africa Evangelistic Enterprise</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ANERELA</td>
<td>African Network of HIV-Affected Religious Leaders Living With or Personally Affected by HIV and AIDS</td>
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<td>ARHAP</td>
<td>African Religious Health Assets Programme</td>
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<tr>
<td>CAA</td>
<td>Catholic AIDS Action</td>
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<tr>
<td>CBO</td>
<td>Community-based organization</td>
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<tr>
<td>CGJR</td>
<td>Center for Global Justice and Reconciliation</td>
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<tr>
<td>DFID</td>
<td>Department for International Development (Great Britain)</td>
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<tr>
<td>DREAM</td>
<td>Drug Resource Enhancement against AIDS and Malnutrition</td>
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<tr>
<td>FBO</td>
<td>Faith-based organization</td>
</tr>
<tr>
<td>GFAMT</td>
<td>Global Fund to Fight AIDS, Malaria and Tuberculosis</td>
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<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>MAP</td>
<td>Multi-country AIDS Project</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and vulnerable children</td>
</tr>
<tr>
<td>PACANet</td>
<td>Pan African Christian AIDS Network</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People Living with HIV and AIDS</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
</tr>
<tr>
<td>RCBs</td>
<td>Religious coordinating bodies</td>
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<tr>
<td>TAP</td>
<td>Treatment Acceleration Program</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>URI</td>
<td>United Religions Initiative</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WCRP</td>
<td>World Conference of Religions for Peace (Religions for Peace)</td>
</tr>
<tr>
<td>WEF</td>
<td>World Economic Forum</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>World Bank Group</td>
<td>includes International Bank for Reconstruction and Development (IBRD), International Development Association (IDA), International Finance Corporation (IFC)</td>
</tr>
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</table>
Faith institutions and leaders have been intricately part of the HIV/AIDS pandemic and global challenge almost from the start. They are deeply active in countless communities, caring for people and families affected by HIV/AIDS, providing medical services, and coping with the disruption of communities and development, especially in the poorest affected countries. Faith roles have many facets, some positive and some far less so. The caring and advocacy of an extraordinarily diverse range of faith actors for those affected with HIV/AIDS is a vital element in the response to the pandemic, too little recognized among global and national leaders. Perhaps better known, unfortunately, are the tensions that faith perspectives sometimes introduce into dialogue on issues of abstinence, condom use, and stigma associated with HIV/AIDS.

This report reviews the work of faith-inspired leaders and communities, in both global- and country-specific efforts to combat HIV/AIDS. It is directed both to practitioners and to academics, to those from faith-inspired communities interested in deepening their engagement with HIV/AIDS and to secular development workers interested in exploring further contacts with faith communities in their work on HIV/AIDS. It is part of a Berkley Center series that explores development issues from the perspective of faith institutions. The report is a living document and is linked to the Berkley Center website and database so that it is a “gateway” to information and networks that will be updated continuously in the future.
Part I presents a brief portrait of the global HIV/AIDS pandemic, introducing statistical issues, trends, sources of information, and dynamics. It focuses on significant issues which have changed the face of the pandemic, including its impact on development and welfare in the most affected countries, the feminization of HIV/AIDS, its devastating effect on children, and its special challenge in conflict situations.

Part II summarizes what is known about the very disparate roles of different faith institutions and traditions. The diversity of responses reflects both the extraordinary global diversity of religions and the complexity of their roles in their work on HIV/AIDS. This report gives an idea of the range of work and its significance. There is no global mapping of faith-based organizations work on HIV/AIDS and little reliable and comprehensive national data. UNAIDS estimates that one of every five organizations engaged in HIV/AIDS programming are faith-based groups. HIV/AIDS interventions by faith-based organizations cover the full gamut from prevention, to counseling and support, to palliative and home based care, to moral and political advocacy. The paths that have led faith institutions towards their present engagement on HIV/AIDS are varied, and this explains in part the fissures and differing approaches towards HIV/AIDS among faith communities. Faith-inspired institutions with long experience in health care have been drawn into work on HIV/AIDS initially through their medical missions. Other faith communities have come more indirectly to work with HIV/AIDS, such as through work with children or with women affected by violence.

Part III explores in more detail the faith aspects of responses to HIV/AIDS, including how different religious traditions have approached the issue. While there are strong common threads among religions, notably the call to care and compassion, there are also wide differences.

Part IV explores seven issues (among a much larger number of topics on which active international reflection is taking place) with particular relevance for faith-inspired HIV/AIDS work: (a) abstinence and the condom issue; (b) prevention versus treatment debates; (c) approaches to male circumcision; (d) social justice and gender issues; (e) addressing issues for marginalized groups; (f) alternative approaches to support for the care of AIDS orphans and vulnerable children; and (g) combating stigma and discrimination.

Part V introduces global HIV/AIDS programming and financing institutions and discusses the roles of faith institutions in this context.

Part VI highlights major issues in the journey ahead, with a focus on areas where research and information sharing and dialogue on live issues have particular importance.
The HIV/AIDS pandemic has passed the quarter century mark as a known disease and major topic on the global agenda. Growing stealthily at first, barely seen and barely acknowledged, it rapidly created a terrible and, in many respects, unprecedented crisis in many communities and many countries. It affects all regions of the world but is by far the most devastating in Africa.

Faith institutions and leaders have been intricately part of the HIV/AIDS pandemic and global challenge almost from the start. Faith communities are deeply engaged in combating HIV/AIDS in every corner of the world, with an array of interventions spanning the full spectrum from awareness and prevention to care and support. HIV/AIDS is a disease that remains incurable and fatal and that exacts a terrible toll of suffering for the millions who witness its devastation. HIV/AIDS, however, has treacherous features that extend well beyond its medical aspects; the stigma and denial that surround this disease of intimacy have contributed to its rapid spread. It is a disease of poverty, most severe in poor communities. It spreads rapidly in situations of the worst social crisis, notably military conflicts. It is thus one of the central, multisector challenges for international development that extends far beyond health and doctors. Here, the world of faith plays critical roles, both remarkably positive and highly negative. Faith communities and leaders are a central part of the continuing challenge for communities, large and small, global to family, as they come to terms with practical and ethical, material, and existential facets of this scourge. They have sometimes been at the forefront, as educators, advocates, and caregivers. However, faith leaders and communities have often been part of the insidious social norms that have contributed to spread of the disease and in important ways their roles have hindered efforts to prevent HIV/AIDS.

Thus a first and important faith role involves the complex ethical challenges that HIV/AIDS presents and the difficult debates within societies and institutions about how to approach it. Should the focus be on changing the behaviors that contribute to HIV/AIDS (is that possible? Desirable? How? With what assurance?)? Or should it, instead, be on accepting the actual behaviors and working to limit suffering of all, and especially those with the least ability to respond—unborn children, young wives, young people everywhere? Who should have priority in receiving care when resources are constrained? How can communities cope with the burdens of the pandemic? Faith communities have special roles in addressing these ethical issues.
Religious institutions also have extensive material roles. An important part of the story of faith involvement, as major providers of services, is not well known and too little appreciated within many global and national institutions. Faith communities and institutions organize and deliver an extraordinary array of programs that respond to the pandemic, from prevention efforts, treatment provision, and above all care and support to communities and individuals. The poor understanding of this work results in part from its decentralization and wide variety but also from poor communications among the different worlds involved. A series of knotty controversies and discordance about issues specifically related to HIV/AIDS have stymied dialogue and cooperation.

There is finally the social, advocacy dimension. HIV/AIDS is a complex, dynamic disease and problem. It has evolved and mutated on many different levels—epidemiologically, socially, culturally, and economically—faster than the capability of the global community to keep pace. International attention has focused sharply on the pandemic, especially within the past five years, and its high profile has led to extraordinary resource commitments and bold international programs. All indications point to a long haul continuation of the pandemic, with the best scenarios representing containment. Despite heavy investments in research and vaccine development, an effective vaccine or cure is unlikely to be widely available in the foreseeable future. Extraordinary developments in treatment options, unimaginable a decade ago, have made it possible for a rapidly growing number of people, even those with few financial resources, to have access to care. Nonetheless, the harsh reality is that, outside the United States and Europe, prevention is not working well and only a small fraction of people living with AIDS are receiving life-saving treatments. A (very) few countries have seen some decline in prevalence rates; a significant number have seen some leveling off in the growth of infection, but still at unacceptably high levels. But in too many countries, infection rates still continue to mount, causing untold suffering and placing an ever increasing burden on already fragile health infrastructure and social safety nets—both formal and informal.

This report reviews the work of faith-inspired leaders and communities, in both global and country specific efforts, to combat HIV/AIDS. It is the first in a series of documents prepared by the Berkley Center that take stock of the joint approaches of faith and development institutions to critical issues on the global development agenda. It explores what have been the determining factors in engagement to date and what directions it might take in the future. It is directed both to practitioners and to academics, to those from faith-inspired communities interested in deepening their engagement with HIV/AIDS and to secular development workers interested in exploring further contacts with faith communities in their work on HIV/AIDS.

The report has six parts. It begins with an overview of the current status of the global pandemic (with a more detailed regional analysis in Appendix 1). Part II summarizes what we know about what faith-based organizations are doing (a “mapping” exercise). Part III looks at special features of faith engagement in the fight against HIV/AIDS (including specific issues particular to specific traditions) and explores some strengths and weaknesses of faith-based organizations. Part IV explores trends and emerging issues. Part V looks specifically to technical and capacity issues including financing considerations. Part VI presents some ideas on the path ahead.

This study is intended as a contribution to a structured examination of and dialogue about the subject. It responds to a particular irony and difficulty. Far too little is presently known about the engagement and contributions of faith institutions, yet tens of thousands of pages and materials are available that describe the efforts of faith-based organizations to help prevent the spread of HIV/AIDS and alleviate the suffering of those afflicted with the disease. This report aims to help navigate this information, highlighting examples of success as well as failure, of hope as well as dilemmas, and in doing so suggests areas where future study would be useful. The paper largely reflects reviews of available literature and the experience of the study team in describing the broad landscape of major faith communities’ engagement in a range of HIV/AIDS interventions.
An important feature of the review is its link to the Berkley Center’s website, where relevant materials are gathered in a dynamic database. The bibliography (Appendix 2) and organization review (see Appendix 3 on the Berkley Center website) represent a window into the vast array of resources available on faith-inspired work on HIV/AIDS; Appendix 4, on the Berkley Center website, gives pointers to relevant work of the development community which faith communities can use. The intent is to add materials to the Berkley Center development database with HIV/AIDS as a priority.

The effort to “put faith communities on the HIV/AIDS map” is a shared endeavor and several institutions are working towards similar ends. Eight related efforts deserve special note. The Ecumenical Advocacy Alliance (EAA) published a comprehensive review of faith approaches to HIV/AIDS in early 2007 which stands out for its care and wealth of information. Father Vitillo of Caritas Internationalis is working to bring together Catholic Church endeavors for HIV/AIDS; given the large role of Catholic Church institutions on HIV/AIDS, this deserves special attention. Tearfund (a UK-based institution) has undertaken a series of reviews focused on links involving funding channels. WHO has supported a pioneering mapping exercise of religious health assets in two pilot countries, Zambia and Lesotho. UNAIDS, the United Nations collaborative venture to coordinate work on HIV/AIDS, has an office devoted to faith initiatives which is developing networking tools. Georgetown University, under the leadership of its president, John DeGioia, is undertaking an initiative to utilize the university’s resources to strengthen HIV/AIDS programs. A Washington, DC-area organization, Christian Connections in International Health (CCIH), has several years of experience in documenting different Christian inspired HIV/AIDS programs and promotes coordination between them. Finally, the British Department for International Development (DFID) is developing a specific faith “portal” as part of a broader effort to gather information on HIV/AIDS and make it available through the internet.

In undertaking this initiative, the Berkley Center aims to engage with others as partners in the common effort to promote more effective links between faith and development partners. These efforts focus on establishing a solid factual base, identifying, exploring, and amplifying issues, and supporting dialogue among different parties with a view to learning from experience and addressing areas of significant disagreement. The issue of coordination is a central concern within the development community and applies with particular force to HIV/AIDS. Thus, there is a high premium on networking, sharing information, and collaboration.

I. The HIV/AIDS Global Pandemic: A Portrait

The HIV/AIDS pandemic is often described first in numbers, to give an overall picture of impact and trends, and above all to convey the enormity of the effects and its dynamic. As statistics by themselves can be mind-numbing, masking the human impact and character of the disease, many try to inject a human face and the epic drama of the situation through photographs, stories, and comparators (for example, contrasting daily HIV/AIDS deaths with hypothetical losses from comparable jumbo jet crashes). Conveying the magnitude and horror of the pandemic is essential both for understanding and as part of the effort to awaken the conscience of the world.

Figure 1: This cartoon contrasts the extraordinarily generous world response to the tsunami catastrophe in December, 2004 to the longstanding and continuing suffering caused by HIV/AIDS, especially in Africa. Its implication is that both HIV/AIDS and Africa tend to be neglected in global debates and aid flows, a contrast vividly evoked with the tsunami response. Many continue to refer with frustration to HIV/AIDS as a “silent tsunami.”
This report focuses on the links between religion and HIV/AIDS. Here, data is especially bad though, in a few countries, disaggregation of data by religious group is becoming increasingly feasible. (Uganda, for example, is a case where specialists speak with considerable confidence about differences in prevalence rates for Christian and Muslim populations.) The impact of religious teachings on behavior is not well known and the specifics of faith-run HIV/AIDS programs and their performance are, in general and across many faith groups, poorly understood.

Information about the extraordinary range of responses to the HIV/AIDS pandemic, by governments, international bodies, communities, individuals, civil society organizations, private sector actors, etc., also comes in a rather piecemeal form and data is even more tenuous when judging results is concerned. Again, small studies are extrapolated to a macro level. The data on financing flows and arrangements should theoretically be more accessible but in practice the arrangements tend to be highly complex and reliable information in a clear, usable form is difficult to obtain.

This section gives a brief statistical portrait for essential background, with notes on places and trends also aimed to bring home the import of the story. Appendix 1 provides much fuller information, especially region by region.

**Box 2** shows the current key statistical indicators often used to summarize the state of the pandemic (these are UNAIDS estimates from the end of 2006).

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**BOX 1**

**Canon Gideon Byamugisha at the United Nations, June, 2006**

I must confess to you that quite often I grow weary and frightened when I imagine how future generations will look back to this 25th anniversary of the suffering and death caused by AIDS. Of course, our grandchildren will see that there were aspects of the response where we made real progress in those 25 years—we learned what it takes to prevent transmission of the virus, we learned what works to help people who are positive to live longer and productive lives, we learned how to help children who are orphaned, and we learned what responses are most effective in providing care and support to individuals and communities that are affected. But the greatest and most obvious gaps that survivors, will wonder about—and be angry about—are the missed opportunities, the lack of political will and the lack of total commitment by those of us in leadership positions to use all that we knew and all that we had to fight the pandemic. They will surely ask “What went wrong?” “What prevented us from transforming the knowledge and the resources we had, into focused will and targeted action?” “Who were the world leaders at that time?”

But we still have the opportunity to escape the harsh pen of history. To do this, we need your political will. We need your total commitment. You are our political leaders. It is your job to provide the needed leadership—in your nations’ capitals and your local communities.

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**BOX 2**

Basic HIV/AIDS Data: A Stark Portrait

**39.5 MILLION:** number of people living with HIV/AIDS (PLWHA) worldwide

**17.7 MILLION:** number of infected women

**2.3 MILLION:** number of infected children

**2.6 MILLION:** increase from 2004 to 2006

**4.3 MILLION:** number of new HIV/AIDS infections in 2006 (400,000 more than in 2004)

**40 PERCENT:** number of newly infected that were young adults aged 15–24

**2.9 MILLION:** approximate number of deaths worldwide attributed to AIDS-related illness in 2006—about 8,000 a day

*Source: UNAIDS, 2006 Epidemic Update, 1, 3.*
Poverty, along with gender disparities and cultural practices, drives the epidemic in most parts of the developing world. Precarious life situations make people more vulnerable to risky behaviors and curtail their capacity to seek treatment and help. Low educational levels are an important factor also. Economic crises increase vulnerability. Conflict situations often accelerate the spread of the disease and also curtail or interrupt programs to combat the pandemic. It is against this backdrop of rapid and profound economic and social change that HIV/AIDS, along with several other infectious diseases, has come upon the world scene, severely challenging the international health communities to find ways to care and treat infected and affected people.

The geography of the pandemic is complex and dynamic, with wide differences by region and often by community.

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**FIVE SIGNIFICANT ASPECTS OF THE FIGURES ON HIV**

1. **UNAIDS**, the interagency United Nations agency designed to mobilize and coordinate global efforts to combat HIV/AIDS, is widely if not universally seen as the most authoritative source of data and its estimates and projections often serve as a reference point (most data is prepared by the WHO).

2. HIV/AIDS data includes many uncertainties because (a) most (80-90%) of people who are HIV positive or have AIDS do not know it. (b) many HIV/AIDS deaths are reported under other categories (partly from shame, partly because the proximate cause of death is indeed another disease); and (c) the data comes from multiple sources (government estimates, scientists’ estimates, surveys) and the various estimates are used to paint an overall picture. There is a constant drumbeat of different estimates from various surveys, the results of which are projected at national and international levels. People may extrapolate good or bad news from slender and preliminary data.

3. The data can become politicized, as governments may wish to downplay or (less often) over portray their AIDS situation (witness recent debates in India). The sharp increases in funding for HIV/AIDS complicates the picture, both because money tends to go where the disease is worst and because financiers of all kinds want to know the impact of their funding on the disease and people and communities affected by it. Different groups emphasize certain findings that appear to be hoped for evidence that can confirm or deny their approach to the pandemic (the most prominent example is data on effectiveness of abstinence programs).

4. Because HIV/AIDS is dynamic, with changes occurring continually, the data and especially projections are subject to wide variations and uncertainty. Further, the epidemic is very different from country to country, so estimation methods must also differ. Testing pregnant women does not tell us much where the epidemic is mostly among drug users or gay men, and it can be difficult to come up with a “representative” sample of such populations. Estimation methods have changed over the years, and in many countries population-based surveys (e.g. DHS’s) give a much fuller picture of the epidemic. These may differ from earlier estimates, which creates scope for all kinds of misinterpretation. That said, the pandemic is stabilizing in much of the world and is better known and studied than many other diseases of poverty.

5. The data that is most needed for program design is particularly difficult to obtain in any society, given the behaviors that are causal factors for HIV/AIDS (examples of such data are information about numbers of sexual partners, age of first sexual experience, sexual practices).

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Sometimes I develop feelings and I ask myself: what if my mother passes away? Who will look after me? Our relatives have not played any significant role even when my mum is sick, so I feel insecure and always think about it.


The source of the quote is a female OVC (Orphaned or Vulnerable Child) in Uganda, as reported by World Vision International. This quote reflects the emotional and social challenges faced by children affected by HIV/AIDS, highlighting the role and lack of support from relatives in managing their care and well-being.
TABLE 1

Regional HIV and AIDS statistics and features, 2006

<table>
<thead>
<tr>
<th>Region</th>
<th>Adults and children living with HIV</th>
<th>Adults and children newly infected with HIV</th>
<th>Adult (15-49) prevalence (%)</th>
<th>Adult and child deaths due to AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>24.7 million [21.8–27.7 million]</td>
<td>2.8 million [2.4–3.2 million]</td>
<td>5.9% [5.2%–6.7%]</td>
<td>2.1 million [1.8–2.4 million]</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>460,000 [270,000–760,000]</td>
<td>68,000 [41,000–220,000]</td>
<td>0.2% [0.1%–0.3%]</td>
<td>36,000 [20,000–60,000]</td>
</tr>
<tr>
<td>South and South-East Asia</td>
<td>7.8 million [5.2–12.0 million]</td>
<td>860,000 [550,000–2.3 million]</td>
<td>0.6% [0.4%–1.0%]</td>
<td>590,000 [390,000–850,000]</td>
</tr>
<tr>
<td>East Asia</td>
<td>750,000 [460,000–1.2 million]</td>
<td>100,000 [56,000–300,000]</td>
<td>0.1% [&lt;0.2%]</td>
<td>43,000 [26,000–64,000]</td>
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<tr>
<td>Latin America</td>
<td>1.7 million [1.3–2.5 million]</td>
<td>140,000 [100,000–410,000]</td>
<td>0.5% [0.4%–1.2%]</td>
<td>65,000 [51,000–84,000]</td>
</tr>
<tr>
<td>Caribbean</td>
<td>250,000 [190,000–320,000]</td>
<td>27,000 [20,000–41,000]</td>
<td>1.2% [0.9%–1.7%]</td>
<td>19,000 [14,000–25,000]</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>1.7 million [1.2–2.6 million]</td>
<td>270,000 [170,000–820,000]</td>
<td>0.9% [0.6%–1.4%]</td>
<td>84,000 [58,000–120,000]</td>
</tr>
<tr>
<td>Western and Central Europe</td>
<td>740,000 [580,000–970,000]</td>
<td>22,000 [18,000–33,000]</td>
<td>0.3% [0.2%–0.4%]</td>
<td>12,000 [&lt;15,000]</td>
</tr>
<tr>
<td>North America</td>
<td>1.4 million [880,000–2.2 million]</td>
<td>43,000 [34,000–65,000]</td>
<td>0.8% [0.6%–1.1%]</td>
<td>18,000 [11,000–26,000]</td>
</tr>
<tr>
<td>Oceania</td>
<td>81,000 [50,000–170,000]</td>
<td>7,100 [3,400–54,000]</td>
<td>0.4% [0.2%–0.9%]</td>
<td>4000 [2,300–6,600]</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>39.5 million [34.1–47.1 million]</strong></td>
<td><strong>4.3 million [3.6–6.6 million]</strong></td>
<td><strong>1.0% [0.9%–1.2%]</strong></td>
<td><strong>2.9 million [2.5–3.5 million]</strong></td>
</tr>
</tbody>
</table>

Sub-Saharan Africa continues to be disproportionately hit by the pandemic, whose epicenter is in southern Africa. The most striking recent increases in prevalence rates, however, have been in East Asia, Eastern Europe, and Central Asia. Sub-Saharan Africa’s epidemics are, for the most part, generalized; that is, they affect the entire population, while in Asia, Eastern Europe, and Latin America those infected are highly concentrated within specific population groups engaging in risky behaviors, such as sex workers, men having sex with men, injecting drug users, the military, and prison inmates.

Table 1 summarizes the information in tabular form. Boxes 2 and 3 provide a sense of how the pandemic looks at a country level, as each country has its own special features and pain.

An enormous amount of information is available about HIV/AIDS and different actors will need quite different resources. For those working on aspects of the disease, technical medical information is needed, while those with programs in need of funding or seeking to coordinate delivery of services will need to navigate the different organizations that provide financing. Appendix 2 provides a summary “orientation” to the vast information resources that largely serve international HIV/AIDS programs.

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We have felt the anguish of Africa. Nearly 10,000 people are newly infected each day. We have been inspired by the courage and dignity of people living with HIV/AIDS. We have confessed our silence as the church and [to] our actions that have contributed to the spread of the disease and [to] death.

—Rev. Dr. Sam Kobia, World Council of Churches (WCC)

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**Box 3**

**Lesotho: A Brief Overview**

Since its first reported case in 1986, HIV/AIDS prevalence in Lesotho has escalated dramatically, and today, the country has one of the world’s most severe epidemics. Some one quarter of adult Basothos are infected, with rates skewing toward women (25.7%), and among young people aged 15-24 (14% for young women vs. 6% for young men). Lesotho currently ranks among the world’s top five countries in key HIV/AIDS indicators: overall prevalence rates, adult mortality, declining life expectancy, and HIV-related deaths among children under five. Although Lesotho’s epidemic is classified as “mature and stable” it clearly presents a crisis situation in terms of mortality, increasing incidence, increasing mother to child transmission, and a very high incidence of related diseases such as TB and other sexually transmitted infections.

The drivers of Lesotho’s epidemic have profound implications for religious leaders and organizations:

- Cultural factors: multiple sexual partners and low condom use; significant gender inequality along with gender-based violence and unequal legal status of women; intergenerational sex, by both men and women; early age of sexual debut; inadequate education and communication with youth, especially parent to child;
- Socio-economic factors: poverty, unemployment and food insecurity; binge drinking and dagga smoking; high labor mobility which works to break down family structures;
- Beliefs and behaviors: poorly devised communication messages, especially radio/television over remote and difficult mountainous terrain; lack of vocal leadership from any quarter—government, civil society, faith communities and secular NGOs; significant denial implying that AIDS is a “foreign disease” and myths surrounding condom use.


Despite the emerging will to foster partnerships with faith-based organizations across a variety of HIV/AIDS interventions, there is a general lack of understanding and knowledge about what faith organizations (of many kinds) are doing, how they operate, and perhaps most important, what is/are their comparative advantage/s in responding to HIV/AIDS. Despite the increasing calls for greater collaboration in fighting HIV/AIDS, there is still a great untapped potential in mining this well-recognized resource of faith-based initiatives and networks. In large measure the explanation for this gap between rhetoric and reality lies in insufficient understanding of how faith-based organizations operate, the nature and scope of their activities, and the constraints—practical and ideological—that impede collaboration.

Categories of Organizations

A useful first step is to clarify what is meant by a faith organization. Faith organizations cover a broad spectrum of institutions and entities influenced by or with some ties to religious communities. These vary widely by

BOX 4

Zambia: A Brief Overview

Zambia’s HIV/AIDS epidemic is considered “mature and generalized,” with an adult prevalence rate of 17%. After the first reported case in 1984, the rate of infections increased dramatically. Today, Zambia stands out among the hardest hit countries by the AIDS epidemic, with an estimated 11 million people living with HIV/AIDS, of which 52% are women. Infection rates vary by geographic location: urban rates are twice those of rural rates—23% vs. 11%; within the country, regional rates vary from 8% to 22%. HIV/AIDS has reduced life expectancy in Zambia from 51 to 40 years; with more than half of Zambia’s population living on less than US$2 per day, the AIDS epidemic is wreaking havoc with economic development, poverty reduction and efforts to increase sustainable livelihoods. Zambia’s orphan population, 750,000 a few years ago, is fast reaching the 1 million mark.

Typical of many other African countries, the drivers of Zambia’s epidemic can be summarized as follows:

(a) Gender differences: Women and girls are 1.4 times as likely than men to be infected; Young women 15–24 years are four times as likely to be HIV positive as young men of the same age (12.5% vs. 4%); AIDS cases peak among women 20–29 and among men 30–39, suggesting significant transmission from older men to younger women; deteriorating economic circumstances has forced many young women into transactional sex to provide for their families; prevention of mother to child transmission is a significant issue with close to a 40% rate of infection of infants born to HIV positive mothers.

(b) Interaction of HIV/AIDS, malaria and TB

- Malaria is endemic throughout Zambia, with an estimated 3.5 million cases and 50,000 deaths per year;
- High rates of HIV infections have correlated positively with high rates of TB infection; Zambia is sixth worldwide in TB incidence and among HIV patients, TB prevalence is 54%;
- The combination of HIV, malaria, and TB is putting a severe strain on an already fragile health infrastructure;

(c) Environmental concerns

- Safe water and other environmental issues present severe challenges to health service delivery;
- Poor roads and general lack of transport severely limit access to health care.

Very briefly, the topography suggests three types of organizations: large international faith-based organizations, more local (often grassroots, community-based) organizations, and finally, interfaith initiatives and groups. The roles, actual and potential, of traditional healers, which fall in a somewhat different category, deserve note as they often help set social norms and the response of those affected to medical interventions. Appendix 3 (on Berkley Center website) provides brief introductions on many faith-inspired organizations involved in HIV/AIDS education and medical care.

Several large, multinational faith-inspired organizations are well known and their work in many areas, including HIV/AIDS, is well documented: Catholic Relief Services (CRS), World Council of Churches (WCC), World Vision International, Christian Children’s Fund, Caritas, Family Health International, The Aga Kahn Foundation, and the Lutheran World Federation, are a few examples. These organizations are generally quite sophisticated and are characterized by high level expertise and capacity (in technical, administrative and financial areas) and they can often command significant resources. Such groups will typically mobilize international funding for a large proportion of their programs. Information about the activities of such organizations is generally readily obtainable through publications, websites, etc. Many of these groups exercise political influence in efforts to shape public policies.

Far more numerous, but much less well known or understood, are the multitudes of local faith-based groups, which operate within regional, national, or grassroots local circumstances. Semi-secular faith-based organizations are common in South Asia. A large and increasing number of these organizations are involved in a wide spectrum of HIV/AIDS interventions, with growing recognition from many governments of their important role. This type of organization generally depends largely on locally mobilized funding and exhibits fairly simple institutional structures, with limited administrative and financial capacity. However, they often have a wealth of on-the-ground experience and understanding of the communities they serve. To realize their potential, however, these faith-based groups generally need to overcome weak administrative, financial, and technical capacities and relatively poor coordination among themselves, with donors and government, and with other civil society actors. Improved coordination could make their activities more long term, programmatic, and thereby more sustainable than they currently are. Volunteers generally represent a significant portion of the personnel of such groups, a “two-edged sword” since volunteers will often exhibit a profound commitment to their work but sometimes do not have commensurate skills and capacity. Leadership of these groups can be individual clergy or laypersons associated with the congregation or other group.

Interfaith organizations are playing expanding roles in HIV/AIDS, both through direct program management and supporting networking and information exchange. Interfaith work has growing importance and special contributions in today’s world. While tension and strife are often cited between major faith communities, it is important to recognize that the strength and breadth of dialogue among major world faiths has been growing in the past 50 years or so. While the dialogue often springs from efforts at conflict resolution, especially in areas where religion has been viewed as a contributing factor in conflicts, it has broadened and evolved towards efforts to address major social issues. Interfaith alliances can be either ecumenical, such as the World Council of Churches, or among different religions, such as the World Conference on Religions for Peace. These groups offer special credibility especially in communities where inter-community strife is an issue or where there are other civil society actors.

I hope for a day when every church engages in open dialogue on issues of sexuality and gender difference. I hope for a day when every synagogue will mobilize as advocates for a global response to fight AIDS, when every temple will fully welcome people living with HIV, when every mosque is a place where young people will learn about the facts of HIV and AIDS. When that will have happened, I am convinced that nothing will stop our success in fighting against AIDS.

—Peter Piot, Executive Director UNAIDS
Interfaith Pre-Conference Session, 2004 International AIDS Conference, Bangkok, Thailand
concerns about proselytizing; interfaith organizations reinforce the message that the basis for faith-run services is “need not creed.”

Finally, traditional medicine and practitioners have significant importance for health in general and HIV/AIDS in various parts of the world. Traditional healers practice in communities and settings that hold particular spiritual meaning for them. Since these practices are linked to indigenous spiritual beliefs, traditional practitioners can be considered faith-based in important respects. Despite significant advances in health over the past decade, many people in poor communities in developing countries still have no access to modern health facilities. In practice, they rely to a large extent on traditional practitioners for health care or advice, and they often represent first-line care for a significant share of the population. The relationship of traditional and modern medicine is quite complex, with the two worlds working in tandem or in contradiction, depending on the setting. Similarly, the relationship between traditional healers and major religions is also quite complex, with some religious groups shunning traditional healers and demanding exclusive adherence of their followers, while traditional religions/healers may be more inclusive and syncretic. Even in areas where there are modern health practitioners, many people seek out traditional healers for complementary treatment. In the case of people living with HIV/AIDS, traditional medicine can sometimes provide a means of palliative care and nutrition support.

On the other hand, some traditional practices by these healers, such as skin-cutting and blood-sharing, are potential vectors for the spread of HIV. More important, some traditional healers advertise their ability to cure AIDS, whereas what they offer are herbal treatments or nutritional supplements that treat opportunistic infections or improve nutritional conditions, providing tangible, but still temporary, improvements in AIDS patients’ appearance and conditions. In Mozambique for example, there have been recent troubling instances where traditional healers have been allowed to advertise their “cure for AIDS” in periodicals and on television.

In South Africa, a cauldron of the epidemic with some 5.5 million people infected and a country where the history of HIV/AIDS has been marked by political denial at the highest levels, the use of a herbal concoction, called ubhejane, is promoted as a “cure” not only by local herbalists, but by high level government officials. Recently the President of Gambia announced he had discovered a cure for AIDS and he would be offering these services “on Thursdays.”

Thus, like some other faith communities, traditional healers are a “double-edged sword.” Their potential lies in their large numbers, their presence in most rural areas, and their deep connections with people. They are often well trusted by families and are regarded as keepers of wisdom. Traditional healers are often very much grounded in the social and cultural traditions of areas in which they practice. The challenge is to recognize their role, maximize their positive contribution, and eliminate harmful practices. Some health ministries have initiated efforts to collaborate with the world of traditional healers; various donor reviews have argued for increased study of and collaboration with traditional medicine as a potential source of palliative care for people living with AIDS. As such, USAID, UNAIDS, and others now consider traditional healers a worthy constituency to include in HIV/AIDS consultations and selected interventions.

A final and important facet of the faith-inspired response to the HIV/AIDS pandemic is at the individual level, where many people are inspired by their faith to respond. Individuals engage in countless ways: leaders are moved to act, inspired by scripture or the prophetic voices of faith leaders; individuals and companies contribute human, financial and technical resources. Many attribute their concern and their actions at least in part to the teachings of their faith traditions and the example and inspiration of religious leaders (even as they may shun people living with HIV/AIDS for similar reasons). Such people are often the foot soldiers in the trenches delivering medical care and education on a daily basis around the globe.

“Mapping” Faith-inspired Work on HIV and AIDS
There is no overall global mapping of faith-based organizations’ HIV/AIDS activities, and solid and reliable national data is rare. However, despite the lack of precise data, the numbers and reach of faith-based groups engaged in a variety of HIV/AIDS interventions is indisputable. UNAIDS estimates that one in five organizations
engaged in HIV/AIDS programming are faith-based. The range of HIV/AIDS interventions by faith-based organizations is wide, and covers the full gamut from prevention, to counseling and support, to palliative and home-based care. Similarly, the size and scope of activities runs the full span from micro interventions (largely undertaken by small local congregations or groups) to large-scale sustainable activities (mainly undertaken by the larger, international groups). Often working in parallel with government services, and sometimes filling in where government services do not exist, faith-based groups provide support in the areas of medical care, education, social welfare, justice, and peace.

The paths that have led faith institutions towards their present engagement on HIV/AIDS are varied, and this explains in part the fissures and differing approaches towards HIV/AIDS among faith communities.

A significant trend is that faith-inspired institutions with long experience in health care have been drawn into work on HIV/AIDS initially through their already established medical missions. This has complicated the picture because HIV/AIDS work is combined with much broader work on health. Many faith-based organizations have a long history, dating to centuries-old missionary experiences, in providing health care throughout the developing world. For example, many faith-based organizations have long experience in home-based care, counseling, and programs for orphans and vulnerable children that predate the HIV/AIDS epidemic and reflects a longer history of congregations caring for their communities. Nurses and doctors in religious outposts and mission hospitals and clinics were among the very first to recognize symptoms of HIV/AIDS, before the disease was formally identified and named. Today, faith-based organizations are known in many countries to be very active in home-based care (the backbone of many national treatment programs in poor communities), supporting orphans and vulnerable children, and working with people living with HIV and AIDS, particularly through mitigation programs, programs to prevent mother to child transmission, and voluntary counseling and testing services.

Often, faith communities came to work with HIV/AIDS indirectly. Stories abound of faith communities who, from their initial encounter with HIV/AIDS, saw the pandemic in terms of a moral problem or a health issue to be dealt with through government health structures, but compassion drew them into directly providing care and advocacy. Two prominent examples are the Coptic Church in Kenya, whose perspective on the HIV/AIDS pandemic shifted markedly as community members were increasingly affected, and the case of Kay and Rick Warren. Kay Warren tells the story of reading a magazine article about HIV/AIDS orphans which changed her life and made her and her husband ardent champions for HIV/AIDS (see Box 5). Some faith groups and leaders have become more directly engaged in HIV/AIDS as they came to appreciate the enormous challenges presented by the pandemic, or as secular leaders sought their support (India is a case in point).

**Interview with Kay Warren in Newsweek, December 1, 2006**

**When and why did you first start focusing on AIDS?**

Kay Warren: It was about four years ago. I was reading a magazine that had a story on AIDS in Africa. I can’t say why it caught my attention but it did. And as I sat down to read, I was quickly horrified by all the pictures that showed men and women dying, and emaciated children, too. I remember covering my face with my fingers, trying to block out the pictures and focus on the words. I remember it said that 12 million children had been orphaned in Africa due to AIDS, and it just rocked me. I dropped the magazine and—here I was sitting in my nice comfortable living room—and I thought, ‘Do I even know one orphan? Do I even know one person with AIDS?’ I didn’t.

I had a real intense internal dialogue over the next few weeks. I realized that I could either forget about it, pretend I hadn’t even read it, or I could let my heart get involved and make a conscious decision to say yes. And in that moment, it felt as though my heart was put through a wood chipper, shattered into a million pieces. I began to cry. I cried for days and, honestly, hardly a day goes by that I don’t cry about it. I became a seriously disturbed woman, I couldn’t think of anything else.
The intense and global focus of faith institutions, particularly within the interfaith institutions and global institutions, is relatively recent (the last 3-5 years). The divisions among faith communities about the proper approach to the pandemic, and the discomfort of many faith leaders in dealing with the link of HIV/AIDS to sexuality, partly explains the long and costly delay in coming to terms with HIV/AIDS. In many institutions, that has already changed or is changing rapidly; today faith leaders are among the most powerful and persistent advocates for HIV/AIDS action.

Areas of Engagement

A recent global survey of 77 faith-based organizations working in HIV/AIDS was undertaken by a coalition of international faith-based organizations. Of these, 42 came from Africa (10 from West and Central Africa, 14 from East Africa, 18 from Southern Africa) 17 from Asia, 9 from Europe, 4 from North America and one from South America. The annual budgets of these organizations range from quite small (2 organizations with annual budgets of less than $10,000) to reasonably large (13 with annual budgets of more than $500,000), with some 15 in the middle at $100-250,000. Although a fairly small sample, this survey provides some useful information. Factors which influenced their access to resources are described below. They are described below, providing a useful indication of the field (numbers do not sum to 100% given multiple activities of each organizations):

- advocacy, prevention, and education (38%);
- home-based care programs (23%);
- care and support of orphans and vulnerable children and support for people living with AIDS (20%);
- prevention of mother to child transmission or voluntary counseling and testing programs (14%).

Interestingly, only a small percentage (7%) were engaged in training programs for church leaders or congregations. Not surprisingly, antiretroviral treatment programs represented a minor share of total activities, since the treatments are so new. Although this survey covers a limited population, it would seem to be fairly reflective of the scope and distribution of most faith-based organizations’ activities in the realm of HIV and AIDS.

A joint study by the African Religious Health Assets Program and the World Health Organization, “Appreciating Assets: The Contribution of Religion to Universal Access in Africa,” interviewed hundreds of community, religious leaders, and organizations in Lesotho and Zambia to ascertain the scope of faith-based engagement in HIV/AIDS and assess their contribution. In both Lesotho and Zambia, some 434 sites were mapped, of which more than three-fourths were working in partnership with other organizations, such as health and education providers and development agencies. The study highlighted the range of activities which, for various reasons, faith-based interventions were not fully apparent and thus counted in traditional studies. Less precise mapping exercises thus tend to underestimate the range and reach of faith-based activities.

Although it stresses the vital importance of analyzing religious institutions in a highly localized context, the “Appreciating Assets” report nevertheless highlights several broad findings that are applicable more broadly to religious responses to HIV/AIDS in Africa:

- Religious responses are far more prevalent and extensive than generally recognized and they are having an impact at community levels;
- Religious responses span the continuum of prevention, care and support, treatment and rights; they are usually

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**Box 6**

Andrea Riccardi, Founder of the Community of Sant’Egidio, on AIDS in Africa

So, what impressions did I have of Africa? First of all, that of a world turned upside down by AIDS. In this world of war, in Mozambique, there was something of a miracle after the war, because the peace was real and it was a peace of the people. People were not killing each other anymore, and there was a true process of reconciliation.... But they know they’ve been forgotten, and AIDS, along with wars, is the fundamental point of this neglect...

The battle for Africa [has] just begun, in all the senses we’ve already discussed … AIDS, peace, the development of a true African church, a real African church, of the people.
holistic in nature, addressing emotional and spiritual as well as physical needs; support for orphans and vulnerable children is especially important;
• Prevention messages focus on sexuality with uneven effectiveness;
• Religious responses do not always conform to the norms of public health strategies;
• There is a remarkable lack of information about the nature, scale, and scope of religious activities in HIV/AIDS, especially at the local and community levels;
• Similarly, there is little knowledge about how they interface with public programs and it seems likely that there is a frequent lack of alignment of services between these two sources;
• Religious activities both contribute to stigma and discrimination and support programs to combat them;
• In an African setting, there is a complex blending of multiple religious and cultural practices which needs to be acknowledged, especially concerning sexual practices and in relation to beliefs and behaviors stemming from traditional religions and practices.

A recent review by UNICEF examined some 50 faith-based organizations’ HIV/AIDS related activities in eight countries in South Asia. While by no means a complete picture of faith-based interventions in South Asia, the survey presents a representative picture of the size of these programs—spanning from independently run to those working in partnership with governments or large international NGOs—and those working on diverse programs—from destigmatization to education prevention to care and support of people living with AIDS. Interestingly, training and communication appears to feature much more prominently in the activities of the groups in this region than was the case in the UNICEF survey. In few of the countries have there been any systematic efforts to reach out and engage faith groups in HIV/AIDS activities, despite the fact that all of the countries have comprehensive national programs. Most of the faith-based organizations have initiated program activities primarily from a tradition of providing welfare and charitable services to poor and marginalized populations. As the epidemic has spread, these programs have become more developmental- than charity-based in their approach. In growing instances, Christian organizations are striving to work jointly with each other. For example, the National Council of Churches in India established a coordinating office, The National Christian Council for Combating HIV/AIDS, in 2003.

In other countries with state sanctioned religions, faith-based organizations have had a natural place in their national AIDS responses. The Imam Training Academy, established by the Islamic Foundation of Bangladesh, introduced reproductive health and HIV/AIDS education in its curriculum for imams and has trained more than 40,000 imams. In Bhutan, HIV/AIDS training and advocacy is now embedded in the government-sponsored Religion and Health programs, and trains religious leaders and groups in HIV/AIDS prevention.

The size and scope of faith-based programs ranges from very small to very large networks reaching millions of people. The Christian AIDS Network Alliance (CANA) in India has a membership of over 350 organizations working on prevention, advocacy, training, action research, and economic empowerment for members. At the other end of the scale is the Buddhist Child Home in Nepal which houses 21 abandoned or displaced children and provides training on HIV/AIDS issues, among other support services.

A large proportion of faith-based groups working in South Asia are Christian, some affiliated with international groups, although their services are reportedly non-sectarian. Some examples are the Catholic Relief Services, the Salvation Army, Caritas, and World Vision. The activities of these groups include advocacy, prevention, training and sensitization of religious leaders, support for women and children and efforts to address stigma and discrimination. The Catholic Bishop’s Conference of India and the Christian Medical Association both have huge networks which provide sexual health education in schools, home-based care for AIDS patients and their families, and antenatal clinics. The Emmanuel Hospitals Association, established in 1994, operates 25 projects in 12 of the poorest states of north and northeast India. Its staff of 1500 trained doctors, nurses, and project officers, offers a diverse range of HIV/AIDS services, including outreach to commercial sex workers and injecting drug users, focusing on holistic care within a context of Christian values. Other services include peer groups for girls, antenatal clinics, non-formal education, literacy, and HIV/AIDS education programs.

The majority of surveyed organizations place a strong
focus on advocacy, training, and communication. The Emmanuel Hospital Association, the Christian Medical Association, the Catholic Bishops Conference, and the National Council of Churches all have programs on prevention and education, aimed at adherents, pastors, school children, and people living with AIDS. The Synodical Board of Health Services, Caritas, World Vision and the Salvation Army are all supporting various communication and advocacy efforts, including radio talk shows and rallies. In Bangladesh, the Imam Training Academy and the Islamic Research Cell (affiliated with Family Planning Association) are supporting training for imams, youth outreach, equal rights for women, and appropriate use of condoms (mostly within the context of marriage).

A common theme which runs through much of the literature is that the work of many faith-based organizations, although ubiquitous, often goes unreported. Analogous to domestic housework, (which seldom appears in any collection of data on countries’ gross national production but which provides bedrock services by any conception of economic activity), social services offered by faith-based communities and organizations, especially at the

| Box 7 | Mozambique, Faith, and HIV/AIDS |

Like other multilateral institutions, the World Bank has acknowledged the role of faith groups in HIV/AIDS work. In the report “Faith Leaders and Institutions in Mozambique’s HIV/AIDS Strategy,” authors Lucy Kough and Marisa Van Saanen of the Bank’s Development Dialogue on Values and Ethics explore what faith groups are doing and how they could be more effectively engaged in the fight against Mozambique’s pandemic. Still recovering from brutal and protracted civil war and abrupt independence, the country now faces a 16% adult seroprevalence rate that continues to rise. Life expectancy is predicted to fall below 40 years in the coming decades. Mozambique is religiously diverse; this has generally not been a source of tension. It retains a strong Catholic character (a legacy of its Portuguese colonizers), along with other Protestant Christian and syncretic Christian Zionist elements. Significant parts of the population practice African traditional religion and there is also an active Muslim community.

Currently HIV/AIDS efforts in Mozambique are coordinated through a National AIDS Council known as Conselho Nacional de Combate ao HIV/SIDA (CNCS). Practically, this body oversees all non-medical AIDS work while the Ministry of Health takes responsibility for all clinical interventions, including voluntary counseling and testing. The CNCS also distributes funds from the World Bank, Global Fund, and other donors. A series of National Strategic Plans have guided national HIV/AIDS policy since 2000 and they are framed to combat HIV/AIDS while increasing the country’s meager number of health workers and building infrastructure that is not dependent on foreign technical assistance. Faith institutions play a major role within the country’s formal health system (operating two hospitals and a medical school), while less formal groups represent a significant portion of NGOs offering care and support services to those affected by HIV/AIDS. These faith-based groups, however, have experienced difficulties in navigating what they contend is an overly cumbersome CNCS grant process and consequently they are still not well connected to the national HIV/AIDS effort. This disconnect highlights the capacity issues that often plague small FBOs in Mozambique, as well as the lack of coordination between various aspects of the HIV/AIDS effort, both along faith-based/secular lines and between prevention, treatment, and mitigation programs, for instance. Another obstacle is the sometimes harmful practices and claims of traditional healers, though their connections and presence in rural areas could make them a crucial first line of intervention. One faith-based effort which has had considerable success, especially in the area of ARV provision, is the Sant’Egidio DREAM project (see Box 12). The report offers recommendations for improving FBO capacity and strengthening linkages among the various sectors of Mozambique’s national HIV/AIDS effort.
local level, are centrally important but can remain largely invisible to official assessments of HIV/AIDS activities.

III. Special Roles of Faith-based Leaders and Organizations in the Fight Against HIV/AIDS

The most recent UNAIDS report on the global AIDS epidemic (December 2006) paid special tribute to the role of non-governmental organizations in combating the HIV/AIDS epidemic. It states, quite unequivocally, that the motivation and persistence of public actors in civil society was the main driving force which instigated early efforts to address HIV/AIDS and will eventually provide the foundation of most countries’ HIV/AIDS strategies and programs. Such public advocates remain at the forefront of prevention, care and mitigation, and counseling and support initiatives in many countries, especially in the developing world and for otherwise marginalized and isolated groups within the population. Moreover, advocacy efforts by civil society organizations have been among the most potent forces in global campaigns leading, for example, to the dramatic declines in the prices of antiretroviral treatments and thus the expansion of access to these life saving drugs for poor people in resource scarce environments.

Within the overall rubric of civil society organizations, faith-based groups have a special place and vital, multiple roles to play in many aspects of the battle against HIV/AIDS. But what makes them a special group within civil society? What justifies special outreach efforts by governments and donors toward faith groups?

In a broad sense, there is increasing recognition of the value of enhancing partnerships between the worlds of faith and development as a reflection of the key role that faith-based organizations play in many areas of development, poverty alleviation, and social service delivery. In the first place, they are significant actors; in many African countries, faith-based organizations have long traditions of providing basic social services. Often building on their missionary experience, today, faith-based organizations are thought to provide something close to 50% of health and education services across the developing world. The Vatican claims that it delivers some 25% of worldwide health services, and 25% of worldwide HIV/AIDS care. UNAIDS cites other data: the Christian Health Associations in Africa, working in parallel with government ministries of health, provide about 40% of health care in Lesotho, 45% in Zimbabwe, 48% in Tanzania, 47% in Liberia, 40% in Kenya, and 30% in Zambia. While the absolute precision of these data may be debatable, it is certain that faith institutions constitute a cardinally important constituency across a broad range of social service delivery. In remote areas, especially in conflict and post-conflict countries, this is frequently the only source of such social services. In addition, they have “staying power.” Faith organizations are often seen to be on the ground for the long term—they are “of the soil”—whereas the turnover of many secular groups will tend to be much more frequent.

Secondly, faith leaders and organizations exercise profound influence in communities and households on a wide array of issues—spiritual and practical. More than 70% of the world’s population identify themselves with a particular faith community. This affiliation often bears heavily on their perceptions of the world, themselves, and their communities. This is especially relevant in many parts of the developing world, e.g., Africa.
Latin America, and South East Asia, where pastors, imams and Buddhist monks have a profound impact on daily lives. No other institutions have comparable understanding or access to communities through well developed grassroots delivery networks. Their wide-spread networks offer great scope in expanding delivery of both communication and education messages as well as physical commodities. Faith institutions, especially at the local level, are well grounded and deeply conversant with local culture. Because they inspire levels of trust and confidence unmatched by governments, donors, or secular non-governmental groups, they have the capacity to mobilize communities to action.

Among all the development challenges where there is untapped potential for partnership between development and faith communities, none has greater immediate significance than HIV/AIDS. Above all, faith institutions see the dramatic human significance of the HIV/AIDS pandemic and, in partnership with government and other donors, are driven to act in bold new ways. Despite the differences in their beliefs and teachings, adherents of the five major world religions—Christians, Muslims, Hindus, Buddhists, and Jews—all incorporate within their core values basic tenets subscribing to humanity, the sanctity of life and the duties of social justice, compassion, and treating others with dignity. These values serve as a solid foundation for critical elements of a broad set of interventions to address HIV/AIDS and the care and treatment of people living with the disease.

And thus, governments and international agencies are increasingly acknowledging their importance as partners in fighting HIV/AIDS. People’s faith and religious beliefs play a key determining role in their behavior patterns and in overcoming fatalistic beliefs. It has been suggested that such influence may be central in cases where it is necessary to surmount people’s disbelief that they can take preventive action to safeguard their own health against HIV/AIDS. The potential for faith leaders to encourage a sense of responsibility and empowering people toward more awareness of how to protect both themselves and others is huge, but not yet fulfilled.

The breadth and depth of experience across a range of social service areas—health care, home based care, and support for orphans and vulnerable children—have already been highlighted. In many other areas related to care and counseling, faith groups are particularly well placed to play a special role because of their moral authority, their reach, and the trust they inspire in local people. Their ability to engage in HIV/AIDS prevention, to mobilize communities and individuals toward behavior change, is perhaps the most recognized role of faith groups. Among HIV/AIDS activities of faith-based organizations are community education to combat stigma and care for those living with the disease. Faith groups are able to inspire hope and confidence in people already afflicted with the disease, encouraging them to more life sustaining behaviors and a more productive life. Equally, again reflecting their moral authority, faith leaders and groups have the capacity to mobilize and educate communities to combat stigma and to advocate to governments for the human rights of AIDS patients.

On the other hand, it must be recognized that the influence of faith leaders and communities can present a

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**BOX 8**

**Religious Health Assets**

We are not suggesting that public health practitioners must themselves be religious or that to engage with these [faith-based] assets they need to be “believers” in one of the multitude of religious expressions found in Africa. What we are suggesting is that if they are to take seriously the on-the-ground key factors that have a significant impact upon people’s perceptions of health and wellbeing, then there needs to be a greater willingness to seriously engage with this religiously informed healthworld.* It is clear that the concept of health promotion is one that is inherently linked to the notion of healthworld* and without a greater appreciation of the assets held by religious entities in Africa, health promotion is likely to be a contested part of the HIV/AIDS continuum.

* Healthworld is defined to refer to people’s conception of health as a holistic combination of physical and spiritual wellbeing of the entire person within their particular social, cultural environment.

significant hindrance to confronting HIV/AIDS. Most faith leaders and groups now acknowledge that in many instances, religion has been used to foster stigma, exclusion, and marginalization related to HIV/AIDS. The issue of stigma is discussed in greater detail later in this document; suffice it to note here that faith hierarchies, leaders, and communities have in the past often been promoters of stigma associated with HIV and AIDS, partly because of their difficulty in confronting aspects of human sexuality and partly because they often assume a link between AIDS and what they regard as sinful activities. Indeed, many religious leaders acknowledge that their initial reticence and slow response encouraged silence and denial that accentuated stigma and discrimination. Certainly this picture is changing—in many cases, markedly in recent years—but it would be unrealistic to assume that this stigmatizing is no longer the case.

While faith-based groups, in general, are not primarily engaged in clinical, medical activities, the activities where they are heavily involved—including the full range of preventive activities, education, counseling, testing, and combating stigma—have profound linkages with treatment efforts. It is widely recognized that an effective programmatic approach to HIV/AIDS involves a comprehensive strategy in which all elements play essential and interlinking roles. However, as will be discussed subsequently, many, if not most, faith-based groups need education and training themselves, in technical and programmatic issues related to HIV and AIDS, in order to fully exploit this unique potential.

The role of faith-based organizations in conflict zones is an especially vital one. The very conditions that define a complex conflict situation—namely, social instability, poverty, and powerlessness—are also the conditions that can foster the spread of HIV/AIDS along with other sexually transmitted diseases. Annual mortality from

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**BOX 9**

**Faith Roles in Addressing HIV/AIDS in Uganda**

Uganda has long been regarded by the international community as an excellent example of a successful campaign against HIV/AIDS. In her report “Conquering Slim: Uganda’s War on HIV/AIDS,” Lucy Keough outlines the efforts behind this remarkable phenomenon. The report particularly emphasizes the integral role faith groups played within the broader national strategy. Both the Catholic and Anglican communities have long served as formal healthcare providers, and they expanded their efforts in response to HIV/AIDS. Islam, though practiced by a minority of Ugandans, was a base from which medical professionals and imams worked to spread the message of prevention and care. Religious leaders also helped people “personalize risk” and employ successful behavior change strategies, which the report considers a result of the trust and access they receive at the grassroots level. In a concluding analysis of future challenges, the report highlights the work faith groups can still do to combat stigma and discrimination, along with the need for better coordination and funding streams among the numerous small faith- and community-based organizations dedicated to HIV/AIDS work.

HIV/AIDS work was an integral part of the effort to support successful economic growth after years of decline in Uganda. Reforms (including the abolition of user fees) dramatically increased access to the general healthcare systems, and the potential decimation of the army by HIV quickly prompted the government to adopt HIV/AIDS as a major policy focus. Leaders encouraged open discussion on the issue, exhorting citizens with a triple emphasis on safe sex, abstinence, and faithfulness. The wide availability of condoms also contributed to the country’s success in reducing their seroprevalence rates; in Uganda for example, infections decreased from 30% in 1986 to 6% in 2002, and condom availability and use (as well as higher age of sexual debut and a lowering of the number of sexual partners) was thought to be an important component of the overall program.


AIDS has long exceeded annual mortality from conflict. However, the presence of conflict, exacerbates the precariousness of living standards and access to social services and thus further increases vulnerability to HIV/AIDS. Social norms governing behavior and social institutions tend to break down during conflicts, and families and communities are fragmented. Displacements further contribute to a fertile landscape for the spread of HIV. Porous borders mean that refugees returning home from neighboring countries bring disease with them. Similarly, demobilized soldiers, including child soldiers, can introduce infection to the household and community. Conflicts especially play havoc with human rights, including those in which HIV/AIDS flourish. The result most often is that women and children are left at increased risk. The use of rape as a tool of war has been well documented, e.g., in Eastern Europe and Africa. Studies in Sudan showed that one in four single mothers were forced into selling sex as a basic survival coping strategy. In Sierra Leone, at the height of the conflict, HIV prevalence among female sex workers was over 70%. The legacy of Rwanda’s genocide is a generation of war orphans which the government and NGOs are struggling to protect from rampant sexual abuse.

Faith-based organizations, unlike many of their secular counterparts, usually remain working in conflict areas, and are often the sole source of health, education, and HIV/AIDS services. Here, they have a potentially pivotal role to play, building on their community ties and experience across a range of rehabilitation, remediation, and social services. Too little is known about their activities in the area of HIV/AIDS under conflict and post conflict situations. This would seem to be an area meriting further study and exploration.

Two constraints often plague small FBOs across a wide spectrum: capacity limitations and a marked lack of coordination, both along faith-based/secular lines and among various aspects of HIV/AIDS interventions, for example among prevention, treatment, and mitigation programs. A further obstacle is the sometimes harmful practices and claims of traditional healers, though their connections and presence in rural areas in some situations make them a crucial first line of intervention.

**Advocacy: The Prophetic Voice**

The passion, witness, and ethical arguments that many faith leaders bring as advocates for action on HIV/AIDS are illustrated in several of the boxes and quotations in the report. An excellent example is Rabbi David Saperstein’s speech on the topic (Box 10).

**Special Features and Approaches of Different Faith Traditions to HIV/AIDS**

Very different faith traditions share some important common ground as they have approached the HIV/AIDS pandemic. The focus on care and compassion stands out, and some contend that this quality distinguishes faith run services and programs in HIV/AIDS from comparable services provided by secular counterparts. There are also important differences, in philosophy, theology, organization, and institutional ethos that differentiate faiths on HIV/AIDS, as on other topics. The faith tradition, whether it inspires a community group, a global organization, or a hospital, often has implications for organizational and institutional features, including financial stewardship and governance issues which are discussed subsequently.

**Most major faiths share a profound commitment to compassion and care which can often outweigh their tendency toward retribution for “sinful behavior.”**

Most religions have teachings that can be an impetus to encourage acceptance and care of people living with AIDS. Both Islam and Christianity strongly endorse care for the sick without discrimination. Many faith-based organizations have strong principles on which to build and consolidate care and support for the sick, bereaved, and orphaned. In many cases, they also have a solid foundation of previous health care work from before the AIDS pandemic, in key areas such as home care delivery and support to families affected by disease.

It is beyond this report’s scope to explore the specific organization and significant differences in approach among different faith traditions. The 2006 EAA report, “Scaling up Effective Partnerships: A Guide to Working with Faith-based Organisations in the Response to HIV and AIDS” has broken much ground on this topic. That report offers a detailed review and practical guide to approaching different faith traditions and institutions in the HIV/AIDS context. What is presented here is a brief synopsis of how each of the five major world religions approaches HIV/AIDS issues, highlighting some links among basic precepts in their teachings and scriptures.
A. Christianity
With some 2.1 billion believers and followers—roughly 33% of the global population—and a majority in two-thirds of the world’s countries, Christianity is the largest world religion today. For that and historic reasons, Christian communities have been among the most severely affected by HIV/AIDS. Christianity is characterized by wide diversity among different segments and denominations and this remarkable diversity extends to approaches to HIV/AIDS.

With the relatively defined hierarchies of many Christian denominations, tracking of decision making, policies, programs, including those relating to HIV/AIDS is relatively more feasible than for other faiths.

Christian Values Related to HIV/AIDS. The Christian faith is based on the life, death, and resurrection of Jesus Christ. Christian values, though difficult to generalize across the diversity of churches, begin with a simple understanding that God loves all human beings whatever their shortcomings. Five commonly found Christian values—justice, solidarity with the oppressed, compassion, equality of all persons, and respect for human dignity—fit this frame logically and for many imply a special obligation toward care for the poor and the marginalized. Today, in every country around the world, there are literally millions of Christians working in response to the HIV/AIDS crisis.

Many Christian denominations tend towards social conservatism, especially in the area of “family values,” and confront issues such as sexuality and injecting drug use with difficulty. The Roman Catholic and Orthodox Churches have deeply rooted beliefs in ‘natural law,’ and thus they oppose abortion, homosexuality, the death penalty, and artificial birth control methods, including condom use. Interestingly, individual bishops and priests have often found compelling reasons to “make space” for condom use, such as in the case of AIDS discordant couples (one partner is HIV+ and the other is not). In some countries, the Catholic stance on condom usage is viewed as not responding to existing realities and this reportedly has caused some of their other HIV/AIDS activities to be somewhat discredited. Protestant denominations as a whole have had fewer problems than Catholic and Orthodox Christians in promoting condom use as part of a comprehensive HIV/AIDS prevention strategy.

There are countless, remarkable programs to fight HIV/AIDS being undertaken by virtually every Christian denomination throughout the world. Many of these are discussed elsewhere in this report.

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**BOX 10**

**Rabbi David Saperstein, on AIDS Day 2003, Washington DC**

As we remember the thousands of people who lost their lives today, we remember the Biblical mandate of Leviticus 19: You shall not stand idly by the blood of your neighbor. Often, we think of this as a metaphor, teaching that we must help those in need. Here, thinking about the AIDS pandemic, we are also speaking quite directly, quite literally, of our neighbor’s blood.

Today—this very day—8500 people worldwide will die from AIDS. They will die because we are busy, because we have other priorities, because of bigotry; they will die because they are far away in Africa; they will die most of all because we just don’t care enough. Think of it: on every death certificate—8500 new ones today, and again tomorrow, and again the next day—on 8500 death certificates, let the cause of death be accurately reported: cause of death—independence. One day, perhaps we will be fortunate enough to have children or grandchildren who will with puzzled expressions ask: did you not know? Or, may God help us: is it that you did not care? How will we answer them? How will the leaders of the nations of the world, whose failure to respond adequately means more pain, more suffering, more death, more orphans—how will they answer? No, we—and they—must not, we dare not stand idly by.

And so, today, on this 16th annual World AIDS Day, we stand here together, religious leaders from diverse faith traditions, to call on our nation, including the Congress and President Bush, to take up the challenge of his words, ‘Seldom has history offered a greater opportunity to do so much for so many.’
B. Islam
The Islamic faith shares the story of Abraham with Christianity and Judaism and, like those two faiths, is a monotheistic religion. The Muslim world, over one billion strong—making it the second largest world religion—is focused in some 50 countries with 40% or higher Muslim populations, spanning three continents and hundreds of different cultures: Albania, Turkey, Africa, the Persian Gulf, Malaysia, and Indonesia, to name a few. While Muslims share common religious beliefs, it is clear that their social, economic, and cultural traditions differ markedly. Most Muslims are not Arab and most live outside the Middle East: 400 million in Indonesia, Malaysia and Bangladesh alone, 20% in Sub-Saharan Africa and about 30% in South Asia. The world’s largest Muslim community is in Indonesia. There are also significant Muslim populations in China, Europe, Central Asia and Russia. Most Muslims are either Sunni (85%) or Shiite (14%), an early division centered on different views of Muhammad’s rightful successor. Other important currents within Islam include Sufism (with strong mystical practices), Wahhabism (a very conservative, fundamentalist Sunni following in Saudi Arabia), Ismailis (a sub-sect of Shi'ism under the leadership of the Aga Khan, considered to be the most liberal and very involved in economic development issues). All share the five pillars of faith: testimony of faith, prayer, payment of Zakat (an income tax for the poor), fasting, and the duty for a pilgrimage to Mecca.

Islamic Values Related to HIV/AIDS. The Islamic response to HIV/AIDS is inherently complex. For Muslims, compassion is based on the belief that each person is a carrier of the divine spirit infused in his or her being at the time of creation. In the positive sense, Islam provides to all—even the humblest peasant or peddler—a dignity and courtesy rarely equaled in other societies. Within the Muslim code, it is explicit that brotherly and sisterly love extends to all, including those that are living with HIV/AIDS.

On the other hand, Islamic law contains clear punishments for prohibited acts (haram). While this is true in other major religions, in the case of Islam, it is often more extreme, with physical punishment exacted publicly for transgressions against Sharia law: stoning, cutting off of limbs, decapitation. But there is much debate about how one interprets such teachings in the context of HIV/AIDS. In some cases people become infected by taking actions that put them at risk of infection. In other cases, risk factors associated with HIV/AIDS are out of the individual’s control. Is it reasonable then to judge all people with HIV similarly, and to what extent are acts of judgment then contributing to stigmatization? These questions complicate the response of the Muslim world to HIV/AIDS.

HIV and AIDS in the Muslim World. There is considerable debate around whether there is a positive correlation between low HIV prevalence rates and religious adherence to the Muslim faith. Some studies13 have suggested this to be the case, due supposedly to near universal circumcision, low consumption of alcohol (associated with risky sexual behavior) and Islamic ritual cleansing, especially following intercourse. Other tendencies/practices such as aversion to condom use and the practice of polygyny may contribute to higher risks of HIV/AIDS. Few Muslim countries have launched comprehensive HIV/AIDS campaigns, as many Muslim leaders suggest that the risky behaviors that spread AIDS—premarital sex, adultery, prostitution, homosexuality, and injecting drug use—are not common in Muslim populations. This type of view has contributed to a persistent and pervasive high degree of denial in many Muslim countries/communities and a view that AIDS is “someone else’s problem.” Denial of risk and lack of testing/treatment facilities increase the likelihood of the virus’s spreading from high risk groups to the general population, in other words, from a targeted to a generalized epidemic.

A recent study by the National Bureau of Asian Research (NBR)14 has suggested that two factors, common through much of the Muslim world, work together to prevent a concerted effort to confront the disease. First, with few exceptions, is the fusion of religion and state, where the Quran serves not only as religious text, but also as a basis for law and an arbiter of social behavior. Second, and closely related, is the fact that few Muslim countries exhibit participatory forms of government, opting instead for more authoritarian systems. Taken together, NBR suggests that this helps to explain why Muslim countries have been slow to address the growing HIV/AIDS crisis.

NBR thus suggests that HIV represents a looming
potential crisis for many Muslim countries, where efforts to surveil and monitor HIV often lag behind other similar countries and where stigma is profound. In Iran, it has been documented that some 60% of people diagnosed as HIV positive commit suicide within a year of receiving the diagnosis. The social, economic, and political repercussions of any dramatic increases in HIV and AIDS in these often politically and socially fragile environments could be profound.

Two unlikely, albeit limited, success stories are Iran and Bangladesh. Iran has been forthcoming about the extent of the disease and the urgency of arresting its further expansion. Iran has passed laws to protect the rights of infected people and to reduce AIDS-related stigma—workers can no longer be fired for being HIV positive, nor can medical practitioners refuse to treat infected patients. HIV education programs are now included in many public school health curricula and prevention information is given to couples applying for a marriage license. Drug treatment programs are being strengthened and there is even a needle exchange program in selected neighborhoods of Tehran.

Bangladesh, where knowledge about AIDS and how it is transmitted is generally low, has also instituted a number of innovative measures. These include outreach programs to high risk segments of its population: commercial sex workers, and gay and bisexual men, as well as efforts to increase condom distribution within these groups. Among the broader population (especially youth), which according to the NBR study often exhibits more permissive sexual behaviors, mosques and imams have been enlisted in programs to educate and spread awareness and to promote safe sexual practices. Thousands of religious leaders, including some females, have been trained to deliver educational and prevention messages discouraging prostitution and homosexual activity but also promoting condom use within families to protect women and unborn children.

C. Buddhism

Buddhism, a religious tradition and a life philosophy born on the Indian subcontinent, is vibrant in many parts of the world and especially across Asia. There are approximately 360 million Buddhists in the world today, mainly in Thailand, Laos, Cambodia, Myanmar, Bhutan, Sri Lanka, China, Vietnam, and Taiwan. Buddhist teaching stresses five precepts to guide one’s life: refraining from taking life, not taking that which is not freely given, avoiding sexual misconduct, refraining from incorrect speech (lying, harsh language, slander), and avoiding intoxicants which lead to loss of mindfulness. These principles are guides, not strict mandates.

Values related to HIV/AIDS. Buddhists believe that the world always has been and always will be filled with disease, suffering, sin, and stigma; thus, Buddhists are called to show compassion and care for those suffering the effects of HIV and AIDS. The greatest number of Buddhists living with AIDS is in Thailand. Most Thais view the work of Buddhist monks with AIDS patients to be in line with traditional Buddhist practices and beliefs, namely to earn merit through working with the suffering. Temples have provided shelter to people living with AIDS when many had no other alternative; the most notable example is the Wat Phra Baht Nam Phu, a temple in northern Thailand which has been converted to a hospice by Dr. Alongkot Dikkapanyo, a Buddhist monk. Two factors might be considered possible constraints to the capacity of Buddhists monks and nuns to work effectively in HIV/AIDS. First, the educational level of many monks, especially in rural areas, is quite low, which means that they themselves require considerable education about technical and epidemiological aspects of the disease. Second, both monks and nuns are generally quite conservative, reticent to discuss sensitive issues such as sexuality, and they can be quite removed from everyday life. Many Buddhist nuns are in fact quite elderly and have joined the nunnery in order to “prepare themselves for the next life.” As such, it may difficult for many of them to connect with young people facing the challenges of peer pressures and emerging sexuality.

As the temples became overwhelmed with providing shelter and hospice care to AIDS patients, the question arose whether Buddhist monks should become involved in other aspects of AIDS work. Overcoming some initial resistance (for example, from some temple committees), Thai monks have established the Monk Network on AIDS in Thailand. With support from the Global Fund, the Network has set up the Community Center for Healing, Caring and Sharing in the temple which works with the community to provide care and support to AIDS patients, their families, and their communities.
Another remarkable program, Sangha Metta, built on the Buddhist tradition of teaching, recognizes that a fundamental constraint to providing care and support and to addressing stigma associated with AIDS is ignorance about the disease and how it spreads. Sangha Metta focuses on training monks and nuns with basic knowledge and skills to work with communities to devise locally appropriate prevention and care responses. Sangha Metta has trained thousands of monks and nuns in areas such as awareness-raising, prevention education, participatory management to better enable partnerships with communities, encouraging tolerance and compassion for people living with AIDS, and providing direct spiritual and financial assistance to families affected by the disease. Sangha Metta began in northern Thailand, but has since spread to neighboring countries.

D. Hinduism

Hinduism, the oldest living religion in the world today, has roots going back many thousands of years; it has given rise to other world religions including Buddhism, Jainism and Sikhism. Its followers believe in one God with other gods and goddesses as facets or manifestations of the Supreme God. Of approximately 1 billion Hindus living around the world, roughly 90% reside in India. Other significant Hindu populations are found in Bangladesh, with 12 million, and Nepal, with 19 million, 4 million in Indonesia, Pakistan, with 2 million, Malaysia with 1.5 million, and 1.4 million in Sri Lanka. Despite some diversity within different sects, there are unifying principles and values that provide guidelines to Hindus, most important among which are truth, purity, compassion, and selflessness.

Values Related to HIV/AIDS. Until recently, Hinduism did not figure prominently in international discussions of the work of faith-based organizations in the fight against HIV/AIDS. Perhaps this reflected the difficulty global organizations experienced trying to locate representative religious leaders within the great diversity of Hinduism. More likely, it reflected the fact that, through the late 1990’s, HIV/AIDS prevalence in Hindu populations was relatively low and thus created a degree of complacency.

More recently, India has become a significant flashpoint for the epidemic. Although India’s prevalence rate remains below 1%, more than 5 million Indians are thought to be infected and there is real concern that the risk factors and cultural norms that have served to spread infection rates in other countries exist in India and that infection rates may therefore spiral to levels similar to other hard hit countries. Thus, efforts are currently underway by government and donors to mobilize all segments of Indian society to mount a comprehensive assault on the disease. Within the faith-based community questions have arisen regarding who are the Hindu leaders and in what capacity should they and related organizations work to address HIV/AIDS? Do religious leaders and the caste system contribute to the strong stigmatization of people living with HIV/AIDS that exists in India? Or has the Hindu faith, in fact, inspired prevention, care, and treatment programs in places and ways that government and other non-government organizations cannot? Within this framework, Hindu religious leaders are becoming more active and engaged.

E. Judaism

Today there are roughly 15 million Jewish adherents concentrated in Israel/Palestine, but also found in the United States, Canada, the United Kingdom, Europe, and South America. Diversity within the Jewish faith is first among orthodox, conservative and reform movements, reflecting respective differences in approaches to modernity and how much effort the faith should make to adapt to modern circumstances. The second major difference is historically geographic, between Sephardic Jews (who are descendants of Jews from the Iberian Peninsula, recently including those of Arabic or Persian backgrounds who use the Sephardic liturgy) and Ashkenazi Jews (descendants of Eastern European Jews). Judaism developed a framework for religion, society, and culture—a framework which provides guidance on core and current issues relating to all aspects of life. At the

—Swami Agnivesh
heart of Jewish teaching is the understanding of an all encompassing, all powerful and loving God. Through the Torah, Judaism also provided a new world view of social justice as a prerequisite for political stability, and affirms that every human being by virtue of his or her humanity is a child of God and therefore has rights that even kings must respect.

**Jewish Values Related to HIV/AIDS.** The Jewish response to HIV/AIDS comes from a sense of responsibility that obligates Jews to reach out to all people—Jews and non-Jews alike—who are suffering. As early as 1985 a “Summons to Action” on HIV/AIDS was issued by the Union for Reform Judaism in the United States. In 1991, a United Synagogue Resolution on AIDS called for congregations to provide acceptance, comfort, counseling and sympathetic and empathetic listening as a form of protection against discrimination. According to most Jewish scholars, the value of life is preeminent and any danger to life suggests a mandate for preventive medicine. However, it has been debated whether this translates into the validation of education to prevent HIV infection or the use of condoms. The Jewish faith values human life above all and calls adherents “to protect the body,” to “save lives,” and to “visit the sick.” Because the Jewish moral code as conveyed through the commandments has placed constraints on sexual behavior outside of marriage, Judaism has had to contend with how to address certain aspects of HIV/AIDS—particularly the sexual activities of non-married persons, both heterosexual and homosexual, that result in HIV infections. Nevertheless, the Jewish code of compassion permits a forgiving and loving response to those infected with the disease.

Thus, at the core of each of the five major world religions are basic principles of care, compassion, and love which provide a solid context in which to situate HIV/AIDS interventions consistent with the respective overall core values of each.

**What distinguishes the services and programs of HIV/AIDS interventions provided by faith-based organizations from their secular counterparts?**

Several factors help to answer this question. Most broadly, religious organizations almost always take a quite holistic view (as opposed to looking to a specific sector—health—or discipline) in their prevention, care, mitigation and treatment programs. Religious organizations tend to combine religion, health, and wellbeing into a single concept, which acknowledges the complex ways in which people base their health seeking strategies on social and cultural norms and values. Such an approach may differ markedly from the concepts of policy makers and the public health community. This complex, somewhat subjective observation suggests an important thread that runs through much commentary about the distinguishing characteristics of faith roles on HIV/AIDS. Some assert that “The failure to recognize this may threaten the work of WHO and other donors.”

The services provided by religious groups are usually perceived as comprising both tangible and non-tangible components. Tangible services include compassionate care, material support, and health services, while non-tangibles include moral support, comfort, spiritual encouragement, and hope. It is this combination which distinguishes them. Moreover, religious messages, which incorporate communal ties and spiritual guidance along with medical advice, fit within a broader context and framework of values and beliefs. They therefore often carry more weight than a purely secular message focused exclusively on HIV/AIDS awareness raising.

Religious entities depend extensively on volunteer networks to provide their services, a factor which implies higher degrees of altruism and commitment than in government or secular NGO counterpart organizations. A 2004 research study in Uganda sponsored by the World Bank (inter alia), “Working for God,” demonstrated that faith-run health services staffed with qualified medical staff working for below market wages, are more likely to provide pro-poor services and services with a public good element, and charge lower prices for services, than for-profit facilities, with little or no difference in the observable quality of care. Although government services have better facilities, the quality of their services was judged inferior to both for-profit and not-for-profit organizations. These findings are consistent with the view that faith-based, not-for-profit organizations are driven, at least partly, by religious and values-based concerns and that these preferences matter qualitatively. These findings suggest that “working for God” matters.

Faith-based organizations have a special impact in
remote rural areas, since, in many countries, government services and most non-governmental organizations tend to be concentrated in urban and peri-urban areas. In Uganda in the early 1990’s, for example, as the country began to mount its national AIDS campaign, in many rural areas faith leaders were the first trainees/educators to teach communities about HIV/AIDS. At the grassroots level, religious institutions are a present and permanent fixture of daily life, and it is this associational infrastructure, coexisting with the spirit of volunteerism and commitment, that gives faith-based organizations particular credibility. In Senegal, as well as in Uganda, faith groups were seen as key partners in a broader national strategy aimed at mobilizing people from all segments of society, but with a unique convening, convincing, and influencing capacity. Religious organizations built strong networks of social capital that involved community members in a participatory and diverse approach to HIV/AIDS prevention and control. An essential element in the success of each of these two countries was the non-confrontational framework of the national discussion and debate. This provided an open and safe climate which allowed the participation of activists from diverse quarters without asking them to disavow their basic core values. In both countries, this was an extraordinary feat which reflected strong political leadership and commitment at the highest levels but which also signaled great courage, commitment, and leadership on the part of religious leaders who engaged in the debate despite significant initial reservations.

Faith-based groups not only have a ready audience of adherents, they are also already engaged deeply in health and education. Such venues offer faith-based communities the opportunity to promote messages and education relating to prevention, reduction in risky behaviors, positive living, and reduction of stigma. For example, they can influence curricula development in schools and communications efforts in clinics.

The strength and credibility of faith-based organizations will clearly affect their influence and ability to mobilize/educate the community as well as to affect individual behavior change. The more deeply involved the religion is in daily life, the greater its ability to influence behavior. In general, Christian Pentecostal and evangelical groups and Muslim groups would fit into this category; these are among the fastest growing religions across Africa. They also in many instances tend to be among the more socially-conservative groups.

Many faith-based groups, like many governments, have been attracted to an approach to HIV/AIDS prevention, first articulated in Uganda, that has come to be known as the ABC model—Abstinence, Be faithful, prudent use of Condoms (usually within marriage). For some, the ABC approach has been the bedrock of a strategy to combat HIV/AIDS, and this has generated considerable controversy and concern. While aspects of this approach are incontrovertibly effective in reducing the spread of HIV/AIDS, the current consensus is that it does not go far enough. By itself, it is incomplete, as it stigmatizes and fails to take account of the many gender disparities which make women and children particularly vulnerable to infection. To be effective, abstinence and fidelity must be practiced by both partners, yet this is frequently not the case, especially in societies where gender disparities are significant. Gender norms allow men to have more sexual partners than women or encourage older men to have sex with much younger women. Even if women want their partners to use condoms or to abstain from sex altogether, they often lack the power to make their partners do so for fear of violence or other repercussions. At the root of these and other trends are gender inequality and the poverty that often accompanies it.

The ABC model can be judgmental and moralizing in its approach and stigmatizing for anyone using (or seen to be buying) condoms, since it presumes that a person who is HIV positive failed to practice “A” and “B.” It does not recognize the role of voluntary counseling and testing, which has been shown to play a central role in all aspects of anti-AIDS programs. The ABC model assumes only one transmission mode, namely illicit sexual activity of some sort. It does not address the situation, now shown to be common in many parts of the developing world, where faithful, married women are at great risk. Marriage and women’s own fidelity do not insure against HIV infection; in fact, in growing numbers women are becoming infected by their partners. Nor does ABC address the need to prevent mother to child transmission, to ensure care and support of orphans and vulnerable children, and to guarantee a safe blood supply. It ignores many aspects of care and mitigation—for example, the importance of nutrition and treatment of
opportunistic infections—that are critical to improving the quality of life and prolonging life. Overall, when seen as an exclusive and encompassing approach, the ABC model fails to recognize the interconnectedness of all elements of a complete HIV/AIDS program, one that includes all elements of prevention, care and mitigation and treatment, all of which have close links to one another and thus to the success of any program.

IV. Trends and Emerging Issues

The HIV/AIDS pandemic has presented the global community with an extraordinary range of medical, scientific, ethical, social, financial, and organizational challenges. Many, though not all, of these issues engage faith communities. To underscore the range and nature of the debates, Table 2 summarizes the classification of issues by UNAIDS and underscores the complexity of the issues involved and their wide reach.

This section highlights and discusses seven issues which have particular impact on the way faith-based organizations engage with various aspects of prevention, care, and treatment of HIV/AIDS: debates about abstinence, often focusing on the role of condoms; prevention versus treatment debates; approaches to male circumcision; social justice, and gender issues; HIV/AIDS care for marginalized groups; alternative approaches to support for the care of AIDS orphans and vulnerable children; and combating stigma and discrimination. The major issues around scaling up of programs; capacity to support/engage in care and treatment programs; and compatibility with programs/protocols of government-sponsored programs are addressed in the following section.

(a) Abstinence and Condoms: To use or not to use; priority?

While the “mainstream” HIV/AIDS programs and global communities accept that widespread availability of condoms and promotion of condom use are major elements in successful HIV/AIDS prevention strategies, a focus on condoms is contentious for some religious communities because it contradicts the core recommended strategy of abstinence before marriage and faithfulness within marriage. Debates about the pros and cons of condom promotion and their place in an overall HIV/AIDS strategy have thus taken on a highly visible and polarizing role.

Widespread social marketing of condoms, promotion of condom use among sexually active populations, and development of a female condom are seen by many HIV/AIDS specialists as central elements of successful...
HIV/AIDS prevention strategies (notably in Thailand). The polar opposite view sees condom promotion as encouraging immorality by sanctioning and even promoting promiscuous sexual behavior. The perceptions magnify the realities so some religious leaders (who advocate abstinence and fidelity) interpret the dominant HIV/AIDS strategies as unduly focused on condoms, while some secular activists perceive religious leaders as curtailing discussion of a critical instrument that can save lives.18

The realities of positions and programs are more complex and nuanced. Appreciation of the complexities and diversity of approach could help shed light and promote dialogue. A review of stated and unstated positions from several faith communities underscores the diversity of views on the matter. Implicit questions include the following: Are all religious leaders against condoms? Are religious people less likely to “need” condoms? Do religious messages about abstinence work? Does condom promotion correlate with increased sexual activity outside marriage?

An illustrative study conducted in rural Senegal concluded with some observations that highlight the subtlety of factors at work:

- Religious men were more likely to have heard of condoms.
- Women who considered religion to be very important

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### TABLE 2

**UNAIDS Classification of Issues for HIV/AIDS**

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<thead>
<tr>
<th>Prevention, treatment and care</th>
<th>Affected communities</th>
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<tr>
<td>Access to care and support</td>
<td>Children</td>
</tr>
<tr>
<td>Access to treatment</td>
<td>Greater involvement of people living with</td>
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<tr>
<td>Antiretroviral therapy</td>
<td>or affected by HIV/AIDS</td>
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<td>Blood safety</td>
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were not more likely to have heard of condoms, but were more likely to agree that they were forbidden by religion.

- Christian men were more likely than Muslim men to cite AIDS spontaneously as a major health problem and mention an intention to change behavior to protect themselves against infection.
- Muslim men were more likely than Christian men to report that they had already changed their behavior to faithfulness in order to protect themselves against HIV/AIDS.¹⁹

The most sensitive and important debates involve the position of the Catholic Church on birth control and the opposition of the Church hierarchy to condom use for any purpose. The Catholic Church position is paradoxical, as it is admired for its leading role in support and care, even as it is widely criticized for its unwillingness to countenance or even debate condom use. In addition to its policy stance against condoms as immoral, some Catholic Church leaders have gone a step further, with individuals fostering rumors that suggest that condoms are even ineffective. As an illustration, there was an international outcry in 2003 when Brazilian Cardinal Alfonso López Trujillo claimed that promoting condoms was dangerous business because they have “tiny holes” through which the HIV virus can easily pass and a dangerously high failure rate—anywhere from 5–30%.²⁰

There are complex nuances and active discussion within Catholic hierarchies and communities about the topic of condom use. Pope John Paul II never made a direct statement against condom use; rather, he emphasized the prevention approaches of sexual abstinence outside marriage and mutual, life-long fidelity within marriage, in keeping with the Catholic Church’s teaching on legitimate and responsible exercise of sexuality in all circumstances, not just with regard to HIV prevention. Nonetheless, with the Papal transition in 2005, HIV/AIDS activists were hopeful that the Catholic Church’s stance on condoms would be modified. In early 2006, the Vatican took the unprecedented step of commissioning a comprehensive review of Church policy on condoms by the Pontifical Council for Health and Pastoral Care. The report had not been finalized as of this writing, though the President of the Pontifical Council of Health Care, Cardinal Lozano Barragan, spoke to the press about this “study”—but with no indication on its possible results or conclusions. Thus there is considerable discussion and speculation on possible outcomes. One thread which might support authorization of condom use is that in the interests of preventing the evil of knowingly spreading disease and misery and possibly causing death, the Church could accept the lesser evil of contraception. Based on a “non-physicalist” view of contraception, contraception is not about a physical barrier, but rather the motivation to use condoms of the sexually active persons. In other words, using condoms with the sole intention of protecting oneself or one’s partner from HIV/AIDS is disease control, not contraception. There are practical consequences to the

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**Pope Benedict XVI**

*Ecclesia in Africa, 116*

Family life has always been a unifying characteristic of African society. In fact, it is within the ‘domestic Church,’ built on the solid cultural pillar and noble values of the African tradition of the family,” that children first learn of the centrality of the Eucharist in Christian life (cf. *Ecclesia in Africa*, 92). It is of great concern that the fabric of African life, its very source of hope and stability, is threatened by divorce, abortion, prostitution, human trafficking and a contraceptive mentality, all of which contribute to a breakdown in sexual morality. Brother Bishops, I share your deep concern over the devastation caused by AIDS and related diseases. I especially pray for the widows, the orphans, the young mothers and all those whose lives have been shattered by this cruel epidemic. I urge you to continue your efforts to fight this virus which not only kills but seriously threatens the economic and social stability of the Continent. The Catholic Church has always been at the forefront both in prevention and in treatment of this illness. The traditional teaching of the Church has proven to be the only failsafe way to prevent the spread of HIV/AIDS. For this reason, the companionship, joy, happiness and peace which Christian marriage and fidelity provide, and the safeguard which chastity gives, must be continuously presented to the faithful, particularly the young.

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³³
“lesser evil” approach. How would congregations interpret this? “Some doubt if it is wise for church leaders to speak openly about condoms as a ‘lesser evil’ since the world may hear it as a blanket authorization for irresponsible sexual activity.”

Another nuance is the well known and established fact that many Catholic medical practitioners either dispense condoms directly or provide accurate information about their use, referring patients elsewhere to procure them.

Protestant views on the permissibility of condom use vary widely. That said, Protestant Evangelicals are among the staunchest supporters of the US Government PEPFAR earmark for “abstinence only” prevention programs.

Approaches to condom use in other religions are far more nuanced. In Morocco, for example, Muslim imams provide accurate information about disease and benefits of condom use in mosques themselves and forthright discussions of sexuality and prevention methods are widely reported. However, many associated issues including pressure to produce children, financial pressure to enter into relationships (early marriage), and male violence and force used to extract female compliance are less forthrightly approached.

In Sub-Saharan Africa condom use is generally modest or low. Data are difficult to verify, but it would seem that consistent condom use is infrequent, especially in marriage or long term relationships. In Rakai, Uganda, a 2001 study showed that 29% of all men and 13% of married men reported any condom use within the previous year but consistent use is only 6% with any partners. Among HIV-discordant couples, only 6.3% reported occasional condom use and only 1.2% report consistent use. Such low level usage took place in the context of near universal knowledge of the preventative effects of condom use, intense social marketing, free supplies of condoms, and free voluntary counseling and testing facilities available locally. This reflects to some degree stigma attached to perception of linkage between condom use and infidelity; it also reflects a culture which places a high value on fertility.

Most experts agree that condoms can play a vital role in a country’s overall efforts to combat HIV/AIDS. Two landmark conferences in Senegal offer excellent examples of faith leadership and interfaith work with condom use as a central element. The first was convened in 1995, between the Islamic NGO, Jamra, and Family Health International (FHI) and the second in 1996 by the National HIV/AIDS Control Program (NACP), SIDA-Service (Catholic), and FHI, which became a forum for inter-religious debates on educating youth, combating stigma, and the care of AIDS patients. Neither Muslim nor Christian leaders condemned condom use in Senegal. Muslims underlined values such as fidelity and abstinence before marriage; they recommended condom use after marriage if one partner was infected. Nor did the Christian leaders condemn condom use as it was considered the lesser of two evils against the commandment “thou shalt not kill.” This tolerance and open discussion played an important, though not exclusive role, in the substantial increase in condom use in Senegal in the latter 1990’s.

A renowned Islamic scholar said during a 1995 meeting: “the Islamic religion has no official position with regard to condoms because Islam prescribes principles. If condom use is aimed at preserving the couple’s life, then Islam subscribes perfectly to the principle for the well-being of mankind…. . Condom as a means of protection is therefore accepted by Islam.” In the 1996 meeting, the Catholic Archbishop of Dakar stated, “The church does not impose on anybody how to fight against this pandemic. Condom use in cases where one has no choice is the least of the evils compared to imposing death on a third party.”

(b) Prevention versus Treatment
A prominent feature of the HIV/AIDS pandemic and the international response is rapid changes in technical realities that force substantial changes in approach, often in an environment of very imperfect information. A prime example is the shifting ground in long-standing debates about whether to emphasize prevention or to focus on care of the sick and others affected by the disease. With the improvement of life-saving medication and dramatic price declines in what seemed until quite recently the prohibitive costs of HIV/AIDS treatment, the debates must change. At a simplistic level, the contemporary wisdom is that both prevention and care are essential and the inter-linkages between them are significant. Nonetheless, debates continue about program priorities and resource allocation; many involve faith communities.
This broad debate within the HIV/AIDS community can pit advocates of a focus on prevention strategies (including both the abstinence/be faithful elements and education/safe sex sides) against those who press for treatment of those dying of AIDS as at least an equal priority. Faith institutions and leaders fall on both sides of the divide, using many different arguments. Put simply, advocates of prevention argue that the absolute priority is to prevent the spread of the disease which is entirely preventable, and that this is both more cost effective and more principled than devoting the preponderance of available resources to care. Advocates of treatment argue that the sick, who include some 2.6 million children, have a right to treatment and can-

**Box 12**

**Demonstrating that Treatment Can Work:**

The Community of Sant’Egidio and the Treatment Acceleration Program

The Community of Sant’Egidio has pressed hard both to implement a program initiated in Mozambique based on providing high standards of care, and to gain global acceptance that all people should have a right to such care, no matter what their country’s income level. Sant’Egidio is among the most passionate of all institutions and in helping to change the terms of the debate about prevention and care.

Against criticisms from sceptics who claimed that the costs of treatment were too high, Mozambique’s health infrastructure too poor, and poverty too deep to allow such a program to work, Sant’Egidio led an excellent technical program notable for its community involvement and, among others, convinced World Bank financiers of its merits. Sant’Egidio thus was the inspiration for an ongoing Treatment Acceleration Program supported by the World Bank which aims to assess the merits of alternative distribution and monitoring mechanisms for antiretroviral treatments in three countries (Burkina Faso and Ghana along with Mozambique).

The “DREAM” program (Drug Resource Enhancement against AIDS and Malnutrition) aims to provide HAART to people affected by HIV/AIDS across sub-Saharan Africa. The program focuses on preventing mother to child transmission (PMTCT) and providing ARV tri-therapy and nutritional support to affected people. It is grounded in a community-based system of health education and counselling, especially through HIV+ “activists,” and helps to build a backbone of health services, based on molecular biology laboratories, health centers, and day-hospitals. The DREAM program offers nutritional support, ARV therapy, and community engagement, all entirely free of charge. It works to break down indifference, fear, and stigma. The PMTCT interventions make it possible for HIV positive mothers to give birth to healthy babies and allow the mothers also to live healthy lives with the benefit of HAART; this has convinced a significant number of mothers to enter the program despite heavy obstacles.

DREAM has demonstrated a highly effective preventive strategy, which makes far more people aware of their HIV positive status as they agree to testing. It also significantly lowers the reservoir of the virus by treating infected people. “Home care” services (provided to the sickest patients, or to children needing administration of treatment in syrups) and a program that reaches more people in remote rural areas through scattered health points further contribute to DREAM’s successful prevention efforts.

The program is grounded in the sustained, stable, and continuing involvement with the Community of Sant’Egidio which has guaranteed its material and moral support on a long term basis. The Community raises the financial resources and provides or mobilizes specialist knowledge, which is progressively shared with or assumed by local personnel. The scaling up has allowed the program to negotiate substantially lower costs on lab reagents and ARV drugs, improving considerably the cost/benefit ratio. Because Sant’Egidio relies heavily on volunteers, high expatriate personnel costs do not weigh heavily on the program budget.
not simply be left to die. They counter that no public health issue in history has been addressed through prevention alone and that ethical principles thus dictate an approach that cares for those affected by the pandemic as a priority.

There is no simple answer but instead many thorny practical issues around the balancing of resources dedicated to different program elements and the degree to which integration is effectively applied. The issue illustrates well the complex ethical challenges that the HIV/AIDS pandemic presents but it also offers an example of progress that has come with both dialogue and advances in medicine, negotiations that bring pharmaceutical prices down, and experience that demonstrates the feasibility of care even in very poor communities.

(c) Handling of Male Circumcision?

The issue of male circumcision is an example of a concern that the HIV/AIDS pandemic has recently put onto policy agendas. Most faith leaders have not yet pronounced on the topic in detail. Put simply, overwhelming new research indicates that male circumcision results in sharp declines in risks of contracting HIV/AIDS for the man and therefore of spreading the virus to female partners. The question is whether active promotion of circumcision (including by faith leaders and in faith-run medical facilities) should and will occur.

Where circumcision is routinely practiced, it is commonly associated with cultural, traditional, and religious reasons, e.g., puberty rites or adherence to Islam. A minority of men were circumcised because of medical complications following previous STDs. Study results from Uganda are indicative of both the ethical and practical issues involving circumcision. In Rakai, Uganda, in 2001, overall 16.5% of all men were circumcised; 99.1% of all Muslim men were circumcised, against only 3.7% of non Muslim men. A variety of factors associated with Muslim men may explain their lower HIV infection rates: lower alcohol consumption; polygamous marriage establishes closed sexual networks which reduce chances of HIV being introduced into marriage; and the obligation of men to perform ritual cleansing after intercourse and before prayer. Among Muslims, only 12% reported circumcision after puberty. Among non-Muslims, 75% were performed for medical reasons and 50% were post-puberty.

(d) Gender and Social Justice Issues

Nearly 40% of people worldwide infected with HIV are women, with majorities of women among HIV positive people in several countries. Gender-related issues that the pandemic highlights go well beyond HIV and AIDS, and touch on fundamental issues of social justice, cultural and traditional practices, and technical medical issues. The book “Children of AIDS” by Emma Guest, cites the case of a 13-year old Kenyan AIDS orphan who “gave away” her virginity for an apple. Asked why, she replied, “Because no one has ever given me anything before.”

The feminization of HIV/AIDS, while often recognized, is far less discussed than its importance would suggest, and that includes within faith communities. The disproportionate infection of women in sub-Saharan Africa is also being observed in Asia, Latin America, and parts of Eastern Europe (and among certain groups within the United States as well). For a variety of biological, cultural, and social reasons, the disease affects and infects women in markedly different ways than men. Girls and women are biologically more vulnerable to sexual transmission of HIV. Girls and women are also at greater risk of infection due to economic and social inequities that limit their choices or force them into transactional sex. At the root of these and other factors are gender inequality and the poverty that often accompanies it.

Of particular note is the fact that, disaggregated by age cohorts, young women are at much greater risk of infection than young men. Women also shoulder a disproportionate share of care giving. Low literacy rates curtail women’s ability to negotiate safe sex and make them vulnerable to sexual exploitation. Pressure to bear children and obey one’s husband may outweigh the pressure to use condoms even when the husband is suspected or known to be unfaithful. Pre-wedding instructions tell women to service the needs of their husbands. Thus the abstinence and fidelity paradigm focusing on the individual needs to shift to the social structures within the community and the family if it is to be effective. How faith leaders conceptualize women’s role in the home and in any public arena is a key determinant of how the pandemic progresses and how effective programs are in combating it. Yet few HIV/AIDS strategies, faith-based or secular, reflect this crucial gender dimension of the issue.
For faith communities, the special issues for women fall into two sets. First, is the recognition that behavior change, however important, is a medium term strategy at best. Predominating cultural norms that define manhood in terms of multiple sexual partners need to be squarely confronted, but, realistically, change here could be gradual and slow. Add to this high levels of fatalism, helplessness, economic disenfranchisement, and gender disparities, and it is obvious that more direct outreach and support to vulnerable women, especially young women, should be a near term high priority for HIV/AIDS programs. Thus, the second set of issues relates to what can be done in a more immediate time frame. Some practices lend themselves to pastoral counseling and intervention, including postponing early marriage (especially where young girls marry older men with likely previous sexual experience, thereby increasing their chances of HIV infection) and debunking prevalent myths such as that sex with a virgin can cure AIDS. The vital importance of keeping girls in school is a cause faith leaders and institutions could embrace more whole-heartedly.

That domestic violence is widespread across societies is increasingly well known and there is solid evidence linking sexual violence to spread of HIV/AIDS. This uncomfortable issue should be much harder to ignore than in the past and it seems reasonable to expect that faith communities and leaders, led by their ethical values and sense of compassion, would be at the forefront of addressing the issue.

More attention needs to be focused on issues of women’s rights, including poor literacy, low socio-economic status, and policies that foster unequal participation and biased inheritance and property laws. All of these factors combine to make women more vulnerable. In many situations, girls and women have few opportunities outside commercial sex to support themselves and their children. For many others, unprotected sex with their husbands or partners puts them in a high risk category, as these often uneducated women have little information about HIV and how it is transmitted. Unmarried girls and women, often with little sexual experience, are discouraged from exploring sexual matter before marriage. Numerous acts of violence—wife burning, honor killings, wife inheritance, and “normal” domestic violence—are practiced with impunity in many countries. Despite fidelity in a monogamous relationship, women are often blamed for becoming HIV positive. Faith leaders and communities could and should exploit church gatherings and networks to become much more engaged in support and outreach efforts to strengthen the rights of women and girls.

(e) Marginalized Groups

The approach of faith organizations towards marginalized groups often raises a series of sensitive issues. While the path of the epidemic varies by country and community, it is often in the first instance focused among several specific groups; from here, the disease takes root and is transmitted to the broader population. The most common groups are sex workers, intravenous drug users, and homosexual communities (where special issues of acceptance and legality arise) but also include the military, truck drivers, and prisoners. The tendency of many faith communities to disapprove of these groups, thus marginalizing or stigmatizing them, can undercut efforts to reach out to them through effective programs. This issue has arisen in many societies from the earliest days of the pandemic (witness approaches to homosexual communities in the United States in the 1980s) and remains a significant issue to this day. A live current issue is how best to work with sex workers—how to engage and reach them by promoting knowledge and condom use. This is sometimes seen as opposed to working to end prostitution as immoral and degrading to women. The greatest problems arise when approaches which aim to curtail the activities of such marginalized groups drive them to avoid services that could help curtail the pandemic or when unease leads to denial. To reiterate, several issues are involved, prime among them the vital importance such groups play in transmission of disease, and the compassion for the marginalized which many faith traditions demand of their followers.

At one extreme sit various faith-inspired groups which are intolerant of any approach to marginalized groups; at the other are communities which reach out to such groups, moved by faith and compassion. The key groups at issue are commercial sex workers, drug users, men who have sex with men, and prisoners. The issue, like those described above, entails wide diversity among different faith groups and considerable change of position over time. For example, some faith-based groups had avoided direct involvement in HIV/AIDS but have
been drawn into such work through their core engagement with communities that are directly affected by HIV/AIDS, such as orphans and vulnerable children. As negative perceptions of PLWHA decrease, communities are more likely to address the needs of high-risk populations that often serve as the first incubators of the pandemic. Concurrently, treatment and care programs (especially among evangelical Christian groups) often stress the need to help faithful and monogamous women cope with the consequences of their husbands’ philandering—hardly a successful segue for work with marginalized populations such as commercial sex workers. Also problematic is the fact that marginalized groups are often engaged in criminally prohibited behavior, which allows groups to level criticism on both the moral and legal criteria.

However, in areas where a generalized pandemic does not yet exist, HIV/AIDS efforts necessarily entail reaching out to high-risk populations. Groups that may be hesitant about adopting measures such as condom promotion on a wide scale often exhibit much greater willingness to do so in this context. In other cases, efforts to help sex workers improve their quality of life spring up at the grassroots level. These can take a wide variety of forms, from sex workers banding together to demand better working conditions and access to condoms, to programs that offer skills training so women do not need to sell sex to support themselves financially. Examples include the case of a Namibian Catholic priest, Father Klein Hitpas Herman, who offers counseling to prostitutes in the slums of Windhoek.

There are many other examples of faith-based outreach efforts. One, funded by the American Jewish World Service, Arcoiris, is a Honduran organization created in 2003 to address the needs of the LGBT (Lesbian Gay Bisexual Transgender) community. It aims to foster human rights, expand political participation and popular acceptance, and promote HIV/AIDS education. Arcoiris coordinates its community activities out of Rainbow House, a center for prevention and human rights workshops. Programs in Vietnam supported especially by World Vision are highlighted in Box 13.

(f) Children and Youth
The HIV/AIDS pandemic has resulted in an overwhelming number of orphans and vulnerable children. Globally, infection rates among young people are rising the fastest. Faith communities are deeply engaged in both care and prevention for these communities. They represent one of the most important sources of support

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<td><strong>World Vision Program with Commercial Sex Workers in Vietnam</strong></td>
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A national affiliate of the US-based World Vision International, World Vision Vietnam has actively tried to find ways to encourage risk reduction practices such as condom use by commercial sex workers. HIV/AIDS in Vietnam has not yet spread to the general population, and consequently World Vision is part of an effort to prevent a full-blown pandemic from erupting. In 2004 World Vision conducted a STI/HIV/AIDS prevention study among sex workers in Hanoi and Da Nang that drew on both quantitative and qualitative research data. Other World Vision affiliates in India and Bangladesh have targeted sex workers and their clients (often long-haul trucker drivers or manual laborers) with messages on prevention and the importance of using condoms if they do engage in risky sex.

The Time to Change program, run by World Vision Vietnam with support from World Vision Australia and AusAID, focused on a popular resort town and major travel hub with a flourishing sex industry. The three year program (2003-2006) used local volunteers to distribute information on safer sex practices and encourage at-risk individuals to visit the clinic for free health check-ups. It also offered support to PLWHA and their caregivers. The volunteer group in May Chai wharf is one of many volunteer groups in Haiphong set up to spread information about HIV/AIDS since 2000, when World Vision Vietnam started a US$300,000 project to help high-risk groups understand the danger of HIV transmission. As the most developed harbor city in northern Vietnam, with around 1.8 million people, Haiphong is said to be the most vulnerable to the HIV epidemic, with a large group of drug users and sex workers who are speeding transmission of the disease.
for young people affected by HIV/AIDS. Hardly surprisingly, important questions and disagreements arise around best approaches, ethical constraints, and some technical/economic issues. Among these is the question of how best to care for orphans, whether in communities or in institutions such as orphanages.

The protracted nature of HIV/AIDS forces families to expend resources on the ailing breadwinner(s), leaving little for the remaining children once the parent(s) have died. Some children are also HIV positive after the virus is transmitted during childbirth. Repeated on a massive scale, this phenomenon would tax even the most sophisticated and well-financed social network and, in the underdeveloped nations where the pandemic is most deadly, the consequences are devastating. In 2005 12 million children in Sub-Saharan Africa had been orphaned. Extended family members often try to accommodate their young relatives but can only afford to care for one or two extra children, which further splits traumatized families. Elderly grandparents are the backbone of the network, providing for up to half of the world’s AIDS orphans. Large numbers of AIDS orphans in practice fend for themselves. In either case, there are unfortunate corollary effects on educational achievement and health, along with worriesome social implications for present and future generations as large numbers of orphans may become street children, with higher rates of crime and other social perversions.

Children fostered with relatives are usually the first to be negatively affected by family resource deficiencies (inadequate food supply, insufficient money for school fees, etc.), while their peers in child-headed households may have quit school long before to care for ailing parents and other siblings. Their chances of returning to school are very low. In some cases any assets left behind by a parent—a house for example—are confiscated by relatives either because orphans cannot prove their legal claim to them or because they have little power or legal resources against adult relatives. In order to earn enough to support others who depend on them, orphans and other vulnerable children are then often driven to dangerous activities like crime and prostitution. Faith-based organizations have responded to this sad situation with fervor. Whatever the other controversies surrounding religious perspectives on HIV/AIDS, the plight of orphans and other vulnerable children resonates with the core values of every major religion. Local FBOs or religiously-motivated volunteers are often the first to offer help to children in these difficult circumstances. International FBOs, in turn, are eager to support the work of these organizations; for example, 10% of the PEPFAR budget is dedicated to work with orphans and other vulnerable children. The most plentiful and forthcoming aid comes as material assistance. Part of the standard panoply of development services, material assistance can include nutritional supplements, clothing, medicine, or access to basic healthcare. Some programs offer vocational training to give older children safer employment alternatives.

Helping orphans and other vulnerable children programs may be particularly appealing to religious groups—especially conservative Christians and Muslims—since they offer an opportunity to promote the kind of behavioral standards that many believe can prevent the spread of HIV/AIDS most effectively: abstinence and faithfulness. Younger children are less likely to be sexually active or have entrenched attitudes about sexual behavior, and consequently they are better prepared to accept and internalize a conservative sexual ethic.

In Africa, traditional fostering systems, along with community support, have supported growing numbers of orphans, and will likely continue to do so as long as coping mechanisms remain in place, despite the fact that they will be severely strained as the number of orphans increases. The effectiveness of these systems has paradoxically engendered complacency on the part of donors and governments. Institutional responses are generally inadequate given the scale of the crisis, often running counter to social and cultural realities, without addressing in any comprehensive way the needs of orphans and vulnerable children.

The most common support activity for orphans and other vulnerable children is the provision of material needs (clothing, food, meals). One estimate (UNICEF and WCRP) suggests that more than 80% of FBO activities for orphans and other vulnerable children are community-based. Issues for faith-based groups include developing outreach that is relevant and connected to the situation and concerns of young people. Internal dynamics between clergy and congregations and between youth and elders will also influence their effectiveness.
A “Framework for the Protection, Care, and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS” has been endorsed by DFID, USAID, UNICEF, UNAIDS, and the Global Fund, among others. It comprises five key components: strengthening the capacity of families to care for orphans and other vulnerable children, mobilizing and supporting community-based responses, ensuring their access to basic essential services, insisting that government policy and legislation protects them, and raising awareness at all levels to create a supportive environment for children and families affected by HIV and AIDS.

Projections of the future number of orphans vary, and, inter alia, will be affected by progress in providing care to larger numbers of parents so that their lives are both extended and enriched in quality. Some estimates, nonetheless, indicate that there could be as many as 25 million orphans by 2010 directly because of HIV/AIDS.

The orphan challenge is increasingly recognized as central to the efforts to treat HIV/AIDS. The special roles of faith organizations, particularly because of their ability to mobilize resources to address the orphan crisis, are appreciated more and more within global HIV/AIDS policy circles. Nonetheless, there are still major obstacles both to addressing the issues, at policy and practical levels, and to engaging faith communities, whose efforts tend to be widely dispersed and poorly coordinated, in the most effective ways. Sadly, responding to the needs of children is often not a priority of governments and donors, as revealed in resource allocation and policy action. One reason is the dearth of clear and comprehensive strategies on how to manage the issue. While they shoulder a significant share of the burden, family and community structures do not always have the capacity to absorb and care for the rising number of orphans. Most of all, resources simply are not getting down to the community level. As one report observed: “there are increased resources available yet the amount reaching affected communities appears to be shamefully low.” This is an area where information, dialogue, and partnerships can make a major difference.

**(g) Stigma Surrounding HIV/AIDS and the Roles of Faith-based Organizations and Leaders**

Stigma directed towards people and communities affected by HIV/AIDS is widespread. It presents major moral challenges to those whose faith and principles calls for compassion and equitable approaches and is a practical, central reason why HIV/AIDS spreads and why programs to prevent it work poorly. Stigma is a complex and delicate subject which raises extremely sensitive issues, those that faith groups often have the most difficulty in addressing in open debate.

Stigma and discrimination are grounded in complex systems of beliefs about illness, disease, and often reflect powerful social inequalities. Yet, the persistence of stigmatization and discrimination against people living with the disease represents perhaps the most powerful

**Box 14**

**Watoto Child Care Ministries**

Founded in Kampala, Uganda, in 1992, Watoto Child Care Ministries currently provides comprehensive care for over 1500 parentless children, many orphaned by HIV/AIDS. Using an innovative model that attempts to mimic normal family life as much as possible, eight orphans live together in a home with a housemother within one of three larger villages of similar Watoto houses. Each Watoto village includes a school (open to the surrounding community), medical clinic, and church/community center. Electricity, running water, and food are also sourced within the village.

In early 2007 Watoto created The Bulrushes, a home for babies aged 0-2 before they transition into the wider Watoto system. Watoto also provides similar assistance to extended families who have taken in orphaned relatives. The organization’s most distinctive feature is its traveling Watoto Children’s Choir. A rotating group of orphans (always nine boys and nine girls) and adult caretakers travel the world to promote awareness about the pandemic and prove that HIV/AIDS has not robbed them of hope.

Watoto Child Care Ministries is associated with the Kampala Pentecostal Church, which boasts 13,000 members. For more information, see [http://www.watoto.com/](http://www.watoto.com/).
impediment to effective prevention, care, and treatment of HIV/AIDS. The most common examples would be the frequently made association between sin and sexuality and the presumption that HIV/AIDS is contracted through sinful behavior, whether sexual or injecting drug use. Even children born HIV positive are often stigmatized in a secondary sense since their mother carried the disease. While many faith groups have undertaken significant efforts in recent years to combat stigma and discrimination associated with the disease, in many instances, stigma continues to exist, sometimes promoted by clerics, even during worship. Evidence from Ghana suggests that stigma promoted from the pulpit can in fact increase the sense of fatalism, which deters behavior change as people opt to leave solutions “to God.”

The emerging dialogue within social science circles increasingly links poverty, disease, and powerlessness with the notion that stigma is generally employed by dominant, more powerful groups as a tool of control, to legitimize, and to perpetuate inequalities (such as those based on gender, age, sexual orientation, class, race or ethnicity). The process of stigmatizing creates damaging stereotypes and perpetuates injustice, discrimination and exclusion. Social scientists describe stigmatization as seeking to separate the “tainted” from the “normal” people with labels and negative attributes, thus justifying stigmatizing and discriminatory actions. The result is the loss of status and discrimination and, sadly, the frequent acceptance among the stigmatized group that they deserve to be treated poorly, thus further entrenching the stigma.

Arachu Castro and Paul Farmer, who have extensive experience in treating HIV/AIDS in the poorest communities of Haiti, go further: “Stigma and discrimination are part of complex systems of beliefs about illness and disease that are often grounded in social inequalities. Indeed, stigma is often just the tip of the iceberg. Because it is visible and generally accepted in public health discourse without further qualification, the term has frequently served as a means of giving short shrift to powerful social inequalities that are much harder to identify and conceptualize.” They go on to suggest “structural violence” as a framework for understanding AIDS-related stigma, by which they mean large-scale social forces such as poverty, racism, political violence, gender disparity, and other social inequalities. “Structural violence predisposes the human body to pathogenic vulnerability by shaping the risk of infection and the rate of disease projection. Structural violence also determines who has access to counseling diagnosis and effective therapy for HIV. Finally, structural violence determines in large part who suffers from AIDS-related stigma and discrimination.” Farmer contends, as he does in the case of other diseases, that the causality and correlation between poverty and dis-

**BOX 15**

**ANERELA+ (African Network of HIV-Affected Religious Leaders Living With or Personally Affected by HIV and AIDS)**

The African Network of Religious Leaders living with or personally affected by HIV and AIDS (ANERELA+) was formed in Uganda in 2002, marking the 10th anniversary of Anglican Canon Gideon Byamugisha living openly with HIV. Members include religious leaders, ordained or lay, who are either HIV+ or are personally affected by the disease, generally those that are nursing or have lost a child, spouse or parent to HIV or AIDS. Having all experienced stigma and discrimination first-hand, the goal of ANERELA is to break stigma, silence, indifference, and discrimination around HIV and AIDS. As religious leaders who are openly living with HIV and AIDS, the power and influence of this group is considerable. Their network began with members in seven countries, and quickly expanded to 12 countries.

The ultimate vision is an African region where HIV positive religious leaders and those affected by HIV and AIDS are empowered to live openly as witnesses to hope and be forces for change in their congregations and communities. Such role modeling is a powerful force for breaking the silence, stigma, indifference, and discrimination around HIV and AIDS, but also for ensuring that all people of every creed are treated with dignity and respect, and that they receive the non-judgmental support they need to be full and active members of their various communities.
ease is direct, strong, and inescapable. Hence, poverty, already a universal stigma, will contribute heavily to poor people’s living with HIV/AIDS suffering more from stigma than wealthier people with greater access to medical care.

But stigma also emanates from fear, ignorance, and perceived threats to moral values and codes. In the case of disease-related stigma, the more rapid its spread, the higher the degree of uncertainty regarding its epidemiology, and the higher its incidence of fatality, the stigma’s magnitude will be greater. Disease which results from perceived deviant behavior and thus is brought on by the responsibility of the victim invokes the most profound stigma. “This becomes particularly strong when the illness is associated with religious beliefs and thought to be contracted through morally deviant activities. Stigma is also more evident when the condition is unalterable, incurable, severe, and degenerative and leads to readily apparent physical disfigurement or…to death.”

HIV/AIDS clearly includes all of these characteristics. HIV-related stigma and discrimination undermine prevention efforts by making people afraid to find out whether or not they are infected, afraid to seek out information about how to reduce the risk of exposure to HIV, and afraid to change their behavior as this might reveal their HIV status. The stigma associated with being HIV positive discourages people from disclosing their HIV status, even to family members and sexual partners. Even those associated with the infected, such as spouses and children, can suffer stigma and discrimination. Young people are particularly at risk, being confronted by peer pressure even in situations where major efforts have been made to communicate about HIV/AIDS and curtail stigma.

Within some religious groups, the stigmatization associated with HIV/AIDS reflects the notion that HIV infection may be God’s punishment for sin, from having failed to take responsibility for upholding the moral codes and value structures of their faiths. There is, therefore, in many circles including faith communities,
considerable denial that the disease even exists. In some cases, stigma is the result of ignorance, or inadequate or inaccurate information. It is a paradox of the HIV/AIDS pandemic that the FBOs, which provide a significant percentage of the programs addressing HIV/AIDS, are also connected with value structures that have tended to perpetuate stigmatization. Thus, as faith communities have become increasingly active in the fight against HIV/AIDS, they have had to confront their religious philosophies and shift their emphasis towards other fundamental tenets of their faiths, such as compassion, mercy, forgiveness, inclusiveness, the duty to care for the sick and needy, and the self worth of the individual.

Most faith groups have begun to view the HIV/AIDS crisis in a different light, not as the result of moral failure, but the consequence of human behavior, which has always been and will always be less than perfect. While a small number of groups still believe that HIV/AIDS positive individuals have reaped their just rewards, the great majority of faith leaders and communities are developing prevention, treatment, and long-term care programs that eschew stigmatization. An important priority for faith leaders is education and training about the disease as this can provide a basis for overcoming stigma. The work of MAP International (a faith-inspired organization based in the US) in developing curricula for theological training institutions offers an example and inspiration.

Stigma is an important priority for research and case studies. Research objectives could include (i) exploring current thinking of major faith groups about stigma, including particular issues associated with major individual faiths; (ii) seeking out programs which have successfully addressed stigma and discrimination and identify what have been the key elements of their success, such as for example including people living with HIV/AIDS in the design and implementation of such programs; and (iii) highlighting the roles of education and training both for faith leaders and congregations in designing antidiscrimination programs.

V. Technical, Capacity, and Financing Issues

Ten years ago, HIV/AIDS was poorly recognized and HIV/AIDS programs received far too little attention and financing. The situation today is very different. HIV/AIDS has risen on the global policy agenda, thanks in large part to passionate advocacy by world leaders from many domains (including faith). While the effort and financing available falls far short of what many estimate is needed (current estimates are that at least $15 billion in international support each year is essential), it is vastly greater than it was in the past. Thus current challenges have changed and now turn on how to deliver programs most effectively, how to coordinate the myriad efforts that are underway, how to learn from and adapt to experience, and how to ensure that large amounts of funding reach the people and communities where it is most needed. Faith leaders, communities, and institutions have large roles to play on all these issues.

The Global Picture

The global “architecture” for HIV/AIDS is complex and changing, with many players, large and small. The Global Fund to Fight AIDS, Malaria and Tuberculosis plays a central role (Box 17). Other key players are the WHO, the technical “heart” of the effort, the Bill and Melinda Gates Foundation, which is investing extraordinary efforts in developing vaccines and advancing programs, the Clinton Foundation, the US Government, through the President’s Emergency Program for HIV/AIDS (PEPFAR), and the World Bank (the latter two are summarized in Boxes 18 and 19).

Faith Institutions and their Roles

Given the enormous breadth of the size, scope, and experience of their activities, it is impossible to place all faith-based organizations within a monolithic category. While some of the larger international faith-based groups evidence high levels of sophistication and capacity in their institutional structures and their ability to access funding resources from a variety of donor sources, other local grassroots groups depend largely on contributions from congregations. Each faith-based organization will have different strengths and weaknesses in terms of their institutional structure, their religious beliefs and practices, and their international connections, all of which will have a determining impact on their willingness and ability to deliver successful interventions.

For many donors, issues of financial stewardship, corruption, and mismanagement arise less frequently in the case of funding faith-based organizations as compared to their secular counterparts. Many donors assume, and
rightly so, that standards of honesty and integrity should be higher in organizations whose activities are motivated by spirituality and values. Several recent studies suggest that the organizational capacity and financial accountability of many local faith-based groups is on a par with UN and other secular NGOs. However, a cause for possible caution is the sometimes rudimentary financial accounting practices in some organizations which may not always be able to fully monitor and account for all funding flows. In addition, although by no means the norm, corruption, sadly, does exist within some faith organizations. This is a real challenge for some faith-based groups to strengthen their financial transparency and accounting procedures in order to be able to expand their access to outside funding.

According to a recent survey (supported by the World Council of Churches, Ecumenical Advisory Alliance, and Caritas), the lack of capacity in the areas of proposal writing, management, and implementation of large scale projects as well as their monitoring and evaluation practices, are key obstacles that prevent faith-based organizations from successfully applying for funding from large donors. Capacity issues here include lack of personnel, training, technical knowledge, and access to technical support such as computers, internet, and other means of communications.

Another consideration for most faith-based organizations is their heavy dependence on donor organizational funding. Such funding can vary dramatically from year

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**Box 17**

**The Global Fund to Fight AIDS, Tuberculosis, and Malaria: A Sketch**

The largest single source of public financing for HIV/AIDS programs today is the Global Fund, which began its work in 2002. As of July 1, 2007, the Global Fund had committed US$7.7 billion in 136 countries to support aggressive interventions against the three diseases.

The Global Fund was created following high level leadership interventions, notably discussions by G8 country leaders at their meetings in 2000 in Okinawa, Japan and in Genoa in 2001, African leaders at the Abuja Summit in April 2001, and a United Nations General Assembly Special Session on AIDS in June, 2001. Its purpose is to increase dramatically resources to fight three of the world’s most devastating diseases, as a partnership between governments, civil society, the private sector and affected communities. The Global Fund operates through principles that deliberately distinguish it from other financing mechanisms, including a commitment to operate as a financial instrument, not an implementing entity, to support programs that reflect national ownership, to operate in a balanced manner, to balance support to prevention and treatment, to evaluate proposals through independent review processes, and to work through simplified, rapid and innovative grant-making processes. The Global Fund works closely with other multilateral and bilateral organizations involved in health and development issues to ensure that newly funded programs are coordinated with existing ones. The aim is for the partners to work together and participate in local country coordinating mechanisms.

The Global Fund works through successive financing agreements and “rounds” of grants and implementation of programs. In its first two rounds of grant-making, it committed US$1.5 billion in funding to support 154 programs in 93 countries worldwide. Six rounds have been completed through 2007.

The Global Fund is an independent organization, established as a Swiss incorporated foundation, governed by an international Board that consists of representatives from donor and recipient governments, nongovernmental organizations (NGOs), the private sector (including businesses and philanthropic foundations), and affected communities. The Fund works in close collaboration with other bilateral and multilateral organizations, supporting their work through substantially increased funding. It aspires to a high level of transparency and much information is available through its website (http://www.theglobalfund.org/en/).
to year, reflecting for example changes in the political make up or the priorities of the donor country. Gaps in funding can undermine sustainability and distort local priorities to conform to those of donors.

An equally important factor in an organization’s ability to access funding relates to its interactions and networking, with other faith-based groups, with government, with donors, and with secular NGOs. These networking relationships are valuable means of accessing information (both technical and programmatic) and for supplementing capacity constraints (e.g. assistance with proposal preparation, design of financial architecture, monitoring, and evaluation). The importance of building relationships and networking is highlighted repeatedly in the literature.

To some extent, the ability of an organization to build networking relationships hinges on the pre-existing degree of organization and hierarchy within the respective overall faith community. More organized structures can generally work more readily in consonance with public health facilities. It is worth noting that Christian organizations in general, and Catholic organizations in particular, generally show higher degrees of organization and structure, while Muslim groups usually have a much looser degree of networking and organization, reflecting the largely autonomous nature of Islam within and between many countries. A notable exception is the Islamic Medical Association of Uganda, (IMAU), frequently cited as a best practice example of faith-based intervention in HIV/AIDS. IMAU, in order to disseminate prevention and care messages, focused on how to promote a consistent pattern of candid, open, and wide ranging communication. The goal was to avoid any suggestion of arrogance or blame so that people felt free

| BOX 18 |

**PEPFAR Highlights**

President George W. Bush has led a US Government program of a size and scope without precedent in US foreign policy. Announced in his State of the Union address on January 28, 2003, the “President’s Emergency Plan for AIDS Relief” is described as an emergency plan focused on the poor countries with the highest HIV/AIDS incidence and is the largest commitment ever by any nation for an international health initiative dedicated to a single disease—a five-year, US$15 billion, multifaceted approach to combating the disease in a selected set of countries (fifteen countries: Botswana, Cote d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia.). President Bush announced in June 2007 that he was seeking US$30 billion for PEPFAR’s next phase. Dr. Mark Dybul is the US Global AIDS Coordinator.

There is wide recognition of PEPFAR’s extraordinary commitment of resources and important results. The program has also been criticized as having an inherent conservative Christian agenda, especially in its promoting abstinence over condoms as a means of prevention. PEPFAR does not support the provision of information on safer sex strategies or condom use as part of a comprehensive program designed for the general population. Instead, it generally supports condom distribution in the case of high risk groups, such as prostitutes, discordant coups, and substance abusers. Faith groups receiving PEPFAR funding may choose to exclude information about contraception, including condoms, if this is inconsistent with their religious beliefs.

On May 27, 2003, President Bush signed P.L. 108-25, the United States Leadership Against Global HIV/AIDS, Tuberculosis, and Malaria Act of 2003, the legislative authorization for the Emergency Plan. On February 23, 2004, one month after the first congressional appropriation of resources for the Emergency Plan, the Coordinator submitted to Congress a five-year strategy that set forth in detail the goals of the Emergency Plan. The Emergency Plan, like other large scale programs (both bilateral and multilateral) supports multisectoral national responses in host nations through the principles known as the “Three Ones”: one national plan, one national coordinating authority, and one national monitoring and evaluation system.
to seek information and those already infected would not feel isolated and disempowered. The strategy relied on a solid groundwork of defined networks of district kadhis, imams, and local volunteers mobilized through communications and clear delineation of responsibilities and mandates.

Limitations of Faith-based Organizations in HIV/AIDS Interventions

Globally, faith-based organizations are increasingly regarded by development institutions and governments as important partners in HIV/AIDS efforts, reflecting their proximity to communities and the deep levels of trust they engender in the communities they serve. They are also often regarded as moral authorities, with voices of wisdom and with the potential to reach local people in a powerful way. Many governments now refer to faith-based organizations and faith leaders as key leaders. However, a number of factors operate to constrain the full effectiveness of these partnerships. This section will review some of these key impediments: capacity issues, including HIV/AIDS literacy and the need for further education; administrative/financial capacities; “nuts and bolts” of design, implementation, and monitoring of sustainable programmatic approaches to HIV/AIDS interventions; reticence to make their voices heard and to work outside “faith-based communities” and the resulting impact on their ability to mobilize funding and enhance networking; and suspicions that faith-based groups’ activities are focused more on proselytizing than service delivery goals, and that religious teachings which link sin to disease can impede their technical capacity.

At the outset, it should be recognized that the ability of faith-based organizations to work with government (and vice versa) takes place within the context of the overall framework of government/civil society relations. This relationship differs markedly from one country to another. Many governments in developing countries, where human and financial resources are stretched thin, increasingly view civil society organizations (both international and local) as worthy partners across an array of challenges, including HIV/AIDS. This includes both secular and faith-based groups, who play especially prominent roles in health delivery in many countries. However, the historical legacy in many countries remains a somewhat suspicious view of civil society,
**Figure 1**

**Much Higher Global Funding for HIV/AIDS (US$ millions)**

![Graph showing funding for HIV/AIDS from 1996 to 2005 with key milestones such as the G8, PEPFAR, and World Bank Map, indicating a significant increase in funding.](image)

*Projected funding. Source: UNAIDS, 2004*

**Much Lower ARV Prices and More Emphasis on Expanding Access to Treatment**

e.g. Uganda 1998-2003, first line ARV, US$/year

![Graph showing the decline in ARV prices with key milestones such as the Accelerating Access Initiative, negotiations by the Clinton Foundation, and further price reductions, indicating a significant decrease in prices.](image)

whether through resentment that they are receiving considerable amounts of foreign aid over which the government feels it has little or no control, or as a result of a lingering perception that foreign non-governmental organizations may represent some, albeit latent, threat to internal security. With the HIV/AIDS pandemic, a new chapter in overall government/civil society relations is being written in many countries.

Capacity issues are perhaps the most frequently cited limitation in working with faith-based organizations. In large measure, these concerns relate more to local faith-based groups, than to the larger, more sophisticated, international faith-based organizations cited elsewhere in this report. In many countries, a large and increasing number of locally based faith organizations are involved in a wide spectrum of HIV/AIDS interventions, with recognition from many governments of their important potential role. To realize this potential, however, many faith-based groups have to overcome weak administrative, financial, and technical capacities and relatively poor coordination, in order to make their activities more long term, programmatic, and sustainable, rather than short term and ad-hoc.

The most obvious manifestation of low capacity is the organization’s ability to access funding from external sources, whether government or foreign donors. Faith-based organizations have tended to have more limited experience than secular NGO counterparts with the processes required to access external funding—proposal preparation, evaluation, financial management, documentation and reporting. They are also frequently more reticent to seek secular external support—their “language” is different and the financial management processes of faith communities can be very rudimentary, which is frowned upon by funding agencies.

To address some of the more basic “nuts and bolts” aspects of capacity limitation, the World Bank sponsored two multi-country workshops in Addis Ababa, in 2003, and in Accra, in 2005 (see box 20). Other similar efforts are much needed.

For many smaller faith organizations, which have laudable, albeit sometimes limited, experience in HIV/AIDS activities, their potential, while recognized, is far from being fully mined. Many operate on quite a small scale, and their engagement has evolved organically, generally starting with specific congregations and small organizations. At the level of program design, some faith-based organizations lack the ability to design programmatic interventions; instead, their “projects” tend to be short term, “one off” or unique activities designed to respond to a particular situation, with little sustainability, which inhibits their ability both to access resources and to scale up their activities. Collaboration among organizations is poor.

There is thus a real need for training, capacity building, and for building partnerships between larger more experienced organizations with greater technical capacity and smaller local community based groups with more in depth local knowledge. This will be especially relevant for interventions outside of the public health system, where the multisectoral HIV/AIDS response will depend fundamentally on community-based initiatives and volunteers.

Another area for education and training—for both faith-based groups and for donors—relates to “language” and approach. The activities of governments and donors are rooted in economic and technical justifications. Faith groups, on the other hand, tend to be more motivated by commitment, values, and altruism, a factor which largely explains their rudimentary institutional processes, especially with respect to monitoring and reporting of finances. Greater knowledge and basic “literacy” by donors about faith-based organizations and their activities, as well as vice versa, could demystify the policies and activities of each in the eyes of the other and remove a significant obstacle to greater communication and collaboration.

Fitting in the Overall Picture: Overlapping and Complex Arrangements A major and growing problem is the complexity of financing arrangements and the multitude of actors working on HIV/AIDS, resulting in large demands on governments and communities, with overlapping mandates, and sometimes contradictory advice. Figure 3 illustrates this problem in a single country. An important response is the “Three Ones” framework adopted in 2004 by major HIV/AIDS donors. The “Three Ones” principles are aimed at achieving the most effective and efficient use of resources, increasing country ownership and accountability, and ensuring rapid action and results-based management. The ratio-
nale is that in order to make effective use of increased resources, better coordination at the country level will be necessary. According to these principles, each HIV/AIDS affected country should have:

- A single, well-articulated HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners, in other words, a national multi-sectoral strategy for combating the disease.
- One National AIDS Coordinating Authority, with a broad-based multisectoral mandate.
- A single country-level Monitoring and Evaluation System by which progress in combating HIV/AIDS in all of its aspects can be monitored.

To meet these challenges, the engagement of non-governmental and community organizations is crucial. However, overall engagement of such civil society organizations, including faith-based organizations, in the processes of national and transnational coordination has been extremely limited. Very few civil society groups, and no faith-based groups, were involved in developing the “Three Ones.” While the vital and significant role of non-governmental and community organizations in general, and faith-based organizations in particular, is recognized increasingly, including in efforts to streamline procedures to ensure effective and efficient disbursement of funds, limited participation of groups working at the community and grassroots levels remains a significant shortcoming.

The “language” employed in both the formulation and the dissemination of the Three One’s is shaped by bureaucratic culture and is liberally sprinkled with buzzwords. As such, the terms are familiar to large international organizations but less so for many small grassroots groups, for whom, for example, the concept of “harmonization” may not be entirely clear.

**BOX 20**

**Addressing Faith Organizations on Nuts and Bolts of Financing: Workshops in Addis Ababa and Accra**

As part of the World Bank’s effort to engage faith groups more effectively in working with HIV/AIDS, two workshops were organized to help improve access to funding from national HIV/AIDS programs. The first was held in Addis Ababa, Ethiopia in 2003, the second in Accra in January 2005.

The workshops were designed to offer faith-based organizations information on areas such as proposal preparation, financial management, and documentation and evaluation, in order to improve their access to external funding, including the World Bank MAP program.

Both events brought together local faith-based organizations from a number of countries, along with representatives of national AIDS councils, with the objective of offering training in basic operational areas such as proposal preparation, reporting and documentation, institutional administration, fiduciary architecture, and monitoring and evaluation. Some sessions focused on thematic areas, but the main purpose was to lay the groundwork for these local organizations to be better able to access funding through their respective national HIV/AIDS programs, supported by the World Bank and others. These workshops were highly valued by most participants, as a means of educating them about available resources, and demystifying processes (many had assumed much more cumbersome and complex requirements than actually existed). Two additional side benefits were first, it provided an opportunity for faith-based groups to confront national AIDS councils concerning the latter’s often cumbersome processes, resulting in overly lengthy reviews and delayed disbursements, and, second, it provided a valuable forum for participants to share their own experiences.

To be sure, the Three One’s offers opportunities to non-governmental and faith-based organizations to collaborate. These include the chance to become more recognized and meaningfully involved in national strategies and, in turn, to be able to scale up successful activities; the opportunity to help government and other donors develop interventions that address real needs within a community and to better address marginalized groups otherwise often neglected by other service providers; and the possibility to access needed technical support and capacity building, including, especially the development of practical systems for monitoring and evaluation. However, without more active outreach to non-governmental actors, namely community and faith-based organizations, the Three One’s framework could equally prove detrimental to community and faith-based organizations by concentrating policy and decision making in the hands of government and overseas donors, further accentuating power imbalances and rendering faith-based groups even more voiceless. Equally, faith-based organizations and non-governmental organizations could usefully join together and demand greater voice in policy and resource allocation decisions. Governments’ openness to this sort of engagement will be a major factor determining the success or failure—or tokenism—of such efforts.

For some secular groups, the growing partnership, and the associated funding flows, between faith-based organizations and governments/donors, remains a deeply divisive topic. This is especially relevant in the United States, as it pertains to the Bush administration’s deliberate strategy to channel resources to faith-based organizations—virtually all Christian—within the context of the President’s Emergency Plan For AIDS Relief (PEPFAR). Concerns basically revolve around the issue of...
of proselytizing, the balance between service delivery and efforts at conversion, and whether funding such groups constitutes an appropriate use of public funds. Because project proposals are generally structured to support the supply of construction and other physical inputs, there is little means of judging how deeply any implementing agency is engaged in proselytizing activities. However, it has been suggested\(^3\) that service delivery is often linked to religious activities, whether through implied promotion of attendance at religious services, the presence of religious artifacts (icons, crucifixes, bibles, films showing in hospital waiting rooms, etc) in service delivery areas, or proselytizing by doctors, nurses, etc. For example, Samaritan’s Purse, under the direction of Franklin Graham, states clearly on its website “The hospitals we support in Africa bring thousands of people each year to salvation in Jesus Christ…. Knowing the hearts of the doctors and church leaders in Angola, I believe the Lubango [a city south of the Angolan capital of Luanda] hospital will have a tremendous impact for the kingdom of God.” This is not to suggest that services are restricted on the basis of religion, but rather, that religion and service delivery are so closely intertwined that it raises questions of propriety, especially if the missionary services are the only ones available. The implication that healing is related to conversion joins proselytizing with medical practices to a degree that deeply troubles some medical ethicists.

A number of prominent secular NGOs (CARE, for example) have seen their US government funding diminish in recent years while some organizations with less robust capacities have received increasing support. A closely related criticism is the appointment of people with strongly conservative faith-based ties to high level positions within the US aid bureaucracy. In response,
Mark Dybul, the head of PEPFAR, has denied that funding decisions are based on any criteria other than merit and capacity, but he has suggested that faith groups are essential elements in PEPFAR’s activities, declaring: “Our goal is not the recruitment of faith-based organizations…but…you cannot achieve those goals without faith- and community-based organizations.”

There are also questions about whether non-Christian groups face undue discrimination. A recent survey by the Boston Globe of prime contractors and grantees indicated that 98.3% of funds to faith-based groups went to Christian-led organizations. The Globe quotes a USAID official as suggesting that the faith-based program within USAID caters mostly to evangelical Christians. Of 167 organizations invited to discuss potential grants within a 15-month period prior to September 2004, only five were non-Christian. In the wake of the tragic tsunami in 2004, no Muslim organization received USAID funding for relief work in Indonesia.38

The alleged favoring of evangelical Christian groups by USAID and PEPFAR raises a question concerning what impact this has had on policy and programming issues. The ABC framework (Abstinence, Be faithful, and responsible use of Condoms) has been the cornerstone of the US-supported anti-AIDS strategy in developing countries. However, there is frequent criticism that in practice, as a result of pressure from conservative Christian groups within the US, the emphasis has been placed on “A” and “B” while “C” has been heavily discouraged. One third of the administration’s $3 billion international AIDS prevention budget must go toward projects promoting abstinence until marriage. A number of conservative Christian leaders and politicians within the US have lobbied heavily to restrict funding condom distribution in favor of abstinence programs. In spite of its debatable constitutionality, organizations receiving US funding must sign a pledge renouncing prostitution, perceived by many to restrict anti-AIDS outreach efforts to engage prostitutes, a key vector group in many countries.

Three major areas for future emphasis are 1) capacity and training issues especially as they relate to ability to access funding; 2) HIV/AIDS literacy; and 3) the central importance of networking, both with faith communities and with government and donors, as means of expanding education and accessing resources.

VI. The Path Forward and Issues for Further Study

Future work on roles of faith-inspired organizations on HIV/AIDS will take many forms: briefly, these will involve (a) more efforts to understand what the organizations are doing, at country, global, and community levels; (b) thoughtful assessment of program impact and what is being learned; (c) better sharing of this information; (d) a host of capacity building efforts, to allow programs to increase in scale and enhance quality; (e) dialogue within faiths and between faith and secular actors on key issues; and (f) finding ways to engage with the global HIV/AIDS institutions, both to improve the reach and quality of programs and to ensure that financing reaches the communities which need it most. Brief notes on each category follow.

(a) Mapping: a better overall picture of what faith institutions are doing will be helpful in global planning and reflection but specific country-based information, for example on religious/health infrastructure, is what is most urgently needed. This sort of work would involve some basic definition of units of measurement. Hospitals/clinics are easy to count. Much more difficult is cataloguing of smaller faith-based programs and initiatives at very localized levels, not necessarily visible at national/international levels. Some of the intangible assets/programs might include prevention, care, and health-promoting activities.

(b) Evaluation and assessment: is the main missing link. This includes qualitative assessments, better quantitative research, and exploration of different on the ground experiences. While there is anecdotal evidence that faith-based organizations are providing good services in countries’ efforts to combat HIV/AIDS, and that they are learning to improve the quality of their delivery over time, there is remarkably little in-depth analysis of impact or of issues that arise, such as cost-effectiveness and impact of programs on behavior change. Nor is there much guidance for policy makers/governments/donors on exactly what are the strengths and weaknesses of FBOs and what constitutes best practices by FBOs.

(c) Building networks: to share information, support common efforts, help in problem solving, enhancing fund raising capacity. Often cited as a major
weakness in faith-based organizations’ technical, financial, and administrative capacities, these networks can and will take many forms and will be a vital to many faith-based organizations’ ability to be aware of and to benefit from future technological advances, especially in care and treatment efforts.

(d) **Capacity building:** This term encompasses a wide range of challenges, from strengthening program management, financial management, grant-writing, monitoring and evaluation, to more complex questions about governance.

(e) **Dialogue:** Because communication among faith institutions tends to be patchy, and because of the historical disconnects between faith and development institutions, dialogue deserves intentional, intensive, and careful effort. The priority topics are those highlighted in this report but a host of additional issues are present and will emerge, for example the current hope that faith communities can contribute to a better framework for shifting testing for HIV from a voluntary basis to a broader, opt-out approach.

(f) **More effective global engagement:** At the global level (for example, in the governance of the Global Fund and at major international gatherings) and at the national level, faith institutions need to be more effectively involved in global dialogue, advocacy, and programs for HIV/AIDS. Faith institutions should be recognized as the major players they are. On special topics their leadership is vital. These include approaches to children and orphans and work on HIV/AIDS in conflict situations where faith institutions have prominent roles.
Sub-Saharan Africa (SSA)

In 2006, 63% of people living with HIV/AIDS (PLWHA) worldwide and 72% of AIDS deaths were in sub-Saharan Africa. Many of SSA’s epidemics are stable, meaning that a balance has been reached between AIDS deaths and new infections. In general, epidemics in East and West Africa are stable; those in southern Africa, excepting Zimbabwe, are showing no signs of abating. However, it is important to note that stabilization is occurring at very high prevalence rates; this may reflect higher death rates as the epidemic matures, rather than a slowdown of infection incidence.

South Africa has the largest number of PLWHA (5.5 million) in the region. Swaziland now has the highest adult HIV prevalence in the world, at a staggering 33.4%. Prevalence levels in severely affected countries like Lesotho and Botswana remain shockingly high, but there is evidence that they may be stabilizing. In Lesotho, the prevalence rate is 23.2% and has been stable for the last five years. However, increasing death rates are masking high levels of new infections. Since 2001, Botswana has seen a slight decrease in HIV prevalence among pregnant women (from 36% to 33%), but this is still unacceptably high. In Mozambique however, prevalence among pregnant women aged 15-49 increased from 11-16% from 2000-2004. This represents one of the largest infection increases that SSA has seen in recent years. The island nations in the region have much smaller epidemics, with prevalence of less than 1%. In 2005 and 2006 there have been outbreaks of multi-drug-resistant TB (MDR TB) in the South African province of Kwa-Zulu Natal, largely due to high HIV prevalence rates in that area. There is great concern, given the highly contagious nature of TB, and the high costs of treating MDR TB, that this could spread to other regions of South Africa and neighboring countries. In addition, a lack of routine TB culture and drug sensitivity testing in resource-poor health settings means that the extent of the epidemic is unknown.

East Africa has generally witnessed stabilizing or declining HIV prevalence. In Kenya, prevalence declined from 10% in the late 1990s to just over 6% in 2005. Similarly, Tanzania’s prevalence rate diminished from 8.1% to 6.5% between 1995 and 2004. The epidemic in Burundi exhibits divergent trends in different parts of the country, with five times more infections in urban (10.5%) than in rural (1.9%) areas. A similar pattern is found in Rwanda and Ethiopia. Unfortunately, there is new evidence that the gains made in Uganda during the 1990s may be eroding. Studies carried out in rural areas have shown increases in HIV prevalence, from 5.6% in men and 6.9% in women in 2000, to 6.5% in men and 8.8% in women in 2004. In addition, national behavioral data have shown erratic condom use among sexually active men and women aged 15-49, as well as rising numbers of men with more than one sexual partner. Injecting drug use appears to be on the rise in the region.

The picture in Central and West Africa is mixed. In West Africa, which has much lower HIV prevalence than in other parts of Africa, studies found declining infection rates in Burkina Faso and Ghana. In Burkina Faso, prevalence among young women attending antenatal clinics fell by half between 2001-2003, while the overall prevalence in Ghana dropped from 3.6% in 2003 to 2.3% in 2005. Mali’s epidemic appeared to be growing, with prevalence among pregnant women increasing from 3.3% in 2002 to 4.1% in 2005. Nigeria, behind India and South Africa, has the third largest number of PLWHA in the world, with some 300,000 new infections in 2005. In Senegal, there are fears that men who have sex with men could be a bridge for HIV transmission into the general population. One study found a prevalence rate of 22% among men who have sex with men, of which 94% also have sex with women. Due to poor data collection, trends in Central Africa are less clear. However, it appears that Cameroon and the Central African Republic are most affected by HIV/AIDS in this region. In Cameroon, adult HIV prevalence is more than 5% and in CAR it is almost 11%. It is estimated that as many as 1 million people in DRC are living with HIV, but surveillance data are not available for many parts of the country.
SSA has had a tenfold increase in the number of people on antiretroviral treatment (ARV) since December 2003, with more than 1 million people receiving ARV therapy by June 2006. However, this still represents only about 23% of those people living with advanced AIDS who would otherwise be good candidates for treatment. Provision of ARVs has been scaled up in Botswana, Kenya, Malawi, Namibia, Rwanda, South Africa, and Zambia. The successful introduction of voluntary opt-out testing (where an HIV test is a routine part of a prenatal or other health care visit) in Botswana suggests the merits of this system in situations where treatment is widely available. It is estimated that only one in three adults in Botswana know their HIV status.

Recent initiatives within the World Health Organization may encourage all patients (receiving treatment for any disease) in developing countries to be tested for HIV (http://www.who.int/hiv/who_pitc_guidelines.pdf, p. 5).

South, East and Southeast Asia

Home to billions of people, South Asia also has some 40% of the world’s absolute poor, subsisting on less than $1 a day. In 2006, this region registered 960,000 new infections, bringing the total number of PLWHA up to about 8.6 million. Approximately 630,000 people died from AIDS-related illness over the course of last year. The region’s highest infection rates are found in South-East Asia. Because of large populations, the epidemics in India and China are of special concern. Although overall prevalence rates remain low, at least in comparison to Africa, the recent rates of growth are cause for concern, and the absolute numbers, even now with low prevalence rates, are extremely high. Indeed, last year India overtook South Africa as the country with the largest number of PLWHA in the world (5.7 million). In both India and China, the epidemic is concentrated in a few regions. Unusually, HIV in China initially spread in rural areas, but has recently moved to urban areas, a process accelerated by massive rural-urban migration. The key risk factor in China’s epidemic is injecting drug use. India’s epidemic is very diverse, with different prevalence and risk factors, as well as different regional trends—stable and diminishing in some places, and growing in others. The epidemic is concentrated on the north eastern tip and in industrial parts of the south and west. Infection levels among pregnant women in Andhra Pradesh, Maharashtra, and Karnataka exceed 1%, while there is evidence that prevalence may be declining in Tamil Nadu. Most infections in India are due to unprotected heterosexual intercourse. In addition to these predominating risk factors, there are serious epidemics among men who have sex with men throughout the region.

Epidemics in South-East Asia are spurred by unprotected paid sex and sex between men, as well as injecting drug use. High levels of international migration play an important role in the Philippines’ epidemic. With more than 50% of those in need receiving ARV therapy, Thailand leads the region in provision of treatment for PLWHA.

Eastern Europe and Central Asia

The 270,000 people newly infected with HIV in 2006 brought the total number of PLWHA in Eastern Europe and Central Asia to 1.7 million. This increase represents a stabilization of the infection rate during the previous year, although longer-term trends indicate dramatic increases in the number of infected individuals—a twenty fold increase over the last decade. Russia and Ukraine account for 90% of the region’s infections, with smaller epidemics elsewhere, which are driven primarily by injecting drug use. In contrast, there is evidence that the Russian and Ukrainian epidemics may be quickly moving from high-risk groups into the general population. For example, in Ukraine over 35% of new infections in the first half of 2006 were transmitted through heterosexual contact. Uzbekistan, which sits at the crossroads of major drug-trafficking routes, has the highest prevalence in Central Asia—the number of reported cases has doubled since 2001. In the region as a whole, only 13% of PLWHA are receiving necessary treatment. Every day, we have dying cases. Every day. People come with sicknesses for which they are not able to get treatment. They are coming and dying; just entering the house dying.

Source: Sister Glenda, in CRS, “Grace for Everyone: A Refuge for Kolkata’s Destitute.”

Epidemics in South-East Asia are spurred by unprotected paid sex and sex between men, as well as injecting drug use. High levels of international migration play an important role in the Philippines’ epidemic. With more than 50% of those in need receiving ARV therapy, Thailand leads the region in provision of treatment for PLWHA.
Appendix 2:
Annotated Bibliography of Key Reference Documents

This article is a summary of the ongoing theological debate within the Catholic Church about condoms. It describes two of the major moral arguments that are advanced in favor of allowing condom use among discordant married couples: first, in this case the use of a condom is not contraception, but rather disease prevention; and second, the so-called “lesser evil” argument.

This study compares the knowledge levels and prevention behaviors of men and women in mainline and charismatic churches in Mozambique. It finds that there is a gender gap, which is more pronounced within the healing churches than the mainline congregations, despite the presence of the same prevention rhetoric. Some reasons that the author advances to explain this discrepancy are the relatively high status of HIV/AIDS educators within mainline congregations, the economies of scale of bringing education programs to larger mainline congregations in contrast to small and widely dispersed charismatic churches, and finally, the more generally ideologically tolerant character of mainline Protestant religious bodies.

This statement lays out the Bahá’í perspective on critical issues surrounding the HIV/AIDS pandemic. Gender inequality, stigma, and the role of faith communities in mitigating both of these are the main focus. The Bahá’í view is that as interaction between people of different faiths and cultures increases, the traditions and practices that discriminate against women will gradually give way.

Overall a very general piece on the role of Christian FBOs in the fight against HIV/AIDS in SSA, this article especially focuses on CRS and CWS initiatives. It offers many examples of CRS/CWS-sponsored grassroots programs operating all over Africa, including the Kampala-based Kamwokya Christian Caring Community (KCCC). The article also discusses other case studies of grassroots (but often NGO-sponsored) FBO care, treatment, and advocacy efforts.

This article is a critical examination of the ABC approach in light of the feminization of AIDS. The authors argue that the letters ‘GEM’ need to be included for a comprehensive prevention response that takes account of the asymmetrical power structures that foster vulnerability. G, or gender, represents the many reasons that AIDS disproportionately affects women. E, or economics, acknowledges that poverty limits individual choice. Finally, M, or migration, points to the heightened risk concentrated within highly mobile social groups. Dworkin and Ehrhardt insist on the necessity of placing comprehensive, long-term efforts that focus on gender relations in the forefront of the fight against HIV/AIDS.

This article details the slowly dawning awareness in the Middle East and North Africa that HIV/AIDS is a serious problem that requires a concerted response. El Feki describes some of the education, prevention, treatment, and stigma reduction initiatives being carried out throughout the region. She also notes the diversity of
attitudes and level of response from country to country, contrasting, for example, Morocco, which has seen a relatively large-scale social mobilization, with Saudi Arabia, where silence still prevails.


In Vietnam the pandemic is still primarily confined to high-risk groups, such as sex workers and long distance truck drivers. To help prevent new infections, World Vision Vietnam funded an 18-month education effort in the busy port city of Haiphong. Using local volunteers, the program offered fishermen, truck drivers, and sex workers information on HIV/AIDS and distributed free condoms.


This article is a preliminary attempt to measure the impact of FBOs in HIV prevention in Uganda, Dominican Republic, Senegal, and Jamaica. Green holds up behavior change statistics as evidence of the positive impact of the moral authority enjoyed by FBOs in promoting risk avoidance prevention methods. Also, the engagement by FBOs in the HIV/AIDS issues plays an important role in breaking the silence and opening up a national discourse about the virus, which, along with strong leadership, is one of the critical success factors for reducing HIV prevalence.


This study makes the case for the ABC approach to prevention, pointing specifically to the Ugandan success story. The article also argues that it is important that different prevention messages not undermine each other, specifically that condom promotion (i.e. risk reduction) needs to support rather than clash with behavior change (i.e. risk avoidance). It also touts the cost-effectiveness of ABC education campaigns. Finally, Green claims that there is no evidence that condom promotion has had an impact in contexts of generalized epidemic.


Dr. Biangtun Langkham, an Indian physician, received the Dignity and Right to Health Award from the HIV Initiative of the International Christian Medical and Dental Association for his HIV/AIDS work. Langkham founded the SHALOM project, which combines harm reduction efforts with care and support services and community empowerment. Though originally an effort aimed at the Christian community in Northeast India, the SHALOM project now works successfully throughout a variety of Indian faith communities.


This statement by Christian, Jewish, and Interfaith organizations discusses the strengths of FBOs and the potential for partnership with secular institutions. It acknowledges shortcomings in response but also highlights successes and innovations that have been developed by religious actors in the fight against HIV/AIDS.

Jeffrey discusses the increased participation of faith-based groups in the 2004 Bangkok AIDS conference, a reality which received mixed reactions from other attendees. As explanation he offers the thoughts of CMMB president John Galbraith, who argues that “something “gets lost in the translation” between pastoral workers on the ground and church hierarchies,” and consequently faith-based HIV/AIDS efforts can be both harmful and helpful.


This study reviews the impact of religiosity on key factors related to HIV/AIDS. Main findings include interesting gender dynamics, where religious men were less likely to cite AIDS as a major health problem or to feel at risk of contracting HIV. In contrast, religious women were much more likely to feel at risk than their non-religious counterparts, were unlikely to have discussed AIDS openly, and less likely to declare an intention to change their behavior in response to the risk of HIV/AIDS.


This article looks for clues within Islam for the slow response to HIV/AIDS in the Muslim world. Specifically, Kelly and Eberstadt argue that the lack of a clear separation between church and state and lack of democracy as main reasons for government inaction. Iran is singled out as one Muslim country that is taking steps to tackle their epidemic. In Bangladesh, prevention and awareness programs supported by health and development NGOs are being run through the mosques. The authors highlight the inadequate information on most epidemics in the Muslim world.


Klunklin and Greenwood examine the impact of Buddhist religious tenets and Thai culture on high-risk sexual behavior and HIV prevention. The focus is more on Thai cultural norms, specifically the implications of the idealized Thai woman, kulasatrii, and man, chaaii chaatrii. In particular, cultural acceptance of casual sex with CSWs is a critical risk factor in the Thai epidemic, despite the government’s “100% Condom Campaign.”


This article details a study that explores Buddhist temple-based HIV/AIDS treatment, the views of the monks administering this care, and the perceptions of the PLWHA that seek treatment at temples. This article describes the services provided by three temples that focus their health services on caring for PLWHA. More than half of the patients had come to live at the temple because of the discriminatory acts or attitudes of their families and/or neighbors. Many study participants cited the fact that by moving to a temple, they were able to share their thoughts and feelings with other PLWHA without fear of judgment. The article concludes with a description of some of the stigma-reduction measures taken by head monks at these hospice temples and a consideration of the potential of grassroots health care models in the fight against HIV/AIDS.


This study found that a domestic “faith-based program emphasizing spirituality” was relatively successful in reducing the risky behavior of African-American substance abusers. Researchers noted the program’s emphasis on nonjudgmental assistance and affirmation of self-worth.


The author offers an “essay in practical theology” to
motivate and inspire Christians to put the HIV/AIDS crisis at the top of their list of priorities. Messer appears to be directing his book primarily at the US-based church. The book advances three arguments: 1) personal behavior change must be mirrored by behavior changes among church leaders, 2) more resources need to be allocated to HIV/AIDS prevention, treatment, and support initiatives and, 3) FBOs need to respond creatively to the challenges put forward by the pandemic. Messer advocates a new theology of AIDS that emphasizes inclusion, not exclusion, and compassion, not condemnation—he argues that the very essence of the church is at stake when people are excluded from God’s mission and ministry. The book specifies six challenges that Christians must address: 1) recognize human realities, 2) declare stigmatization and discrimination as sins, 3) advance the status of women and children, 4) promote the ABCs of prevention, 5) advocate social justice, and 6) ensure supportive care and treatment for PLWHA.


This article frames the debate between scholars who attribute Uganda’s success in reducing HIV prevalence to the ABC prevention message *per se*, and those who focus more on the efforts at promoting women’s empowerment throughout the 1990s. Murphy and Greene argue that ABC is not a strategy, but rather a behavioral response to social mobilization, leadership, and empowerment. They also make the point that abstinence was not the initial focus of ABC programs, while the most important characteristic of successful prevention programs is that they address the underlying power structures that create vulnerability.


This is a general overview, from the perspective of the head of a major international FBO (MAP International), on the comparative advantages of faith-based responses to HIV/AIDS. The basic message is that “religious-based initiatives, when properly supported and coordinated, can be some of the most strategic vehicles through which to slow the spread of HIV and AIDS.” One interesting development is the Certificate in Pastoral Care and HIV/AIDS offered jointly by St. Paul’s Theological College (Limuru, Kenya), the Oxford Center for Mission Studies, and the University of Wales.


This piece offers good discussion of shades of meaning for terms like discrimination and stigma. It outlines how FBOs have been part of the problem and how they are becoming part of the solution. Parker and Birdsall argue that HIV/AIDS stigma has been over-elaborated relative to other forms of stigma and that its pervasiveness in African communities has been overstated. It discusses the dangers of generalizing from anecdotal accounts.


Phiri presents a theological reflection on HIV/AIDS by African women. The author calls for a new theology of HIV/AIDS that is analogous to liberation theology’s depiction of God as on the side of the poor and oppressed.


The archdiocese of Ho Chi Minh City received permission from the local government to open up Phuc Sinh Centre, an HIV/AIDS treatment center. The diocese also carries out a wide variety of other work with children and the poor, and workers are encouraged to meet and share information about their respective projects.


This briefing paper introduces various donor initiatives targeted at FBOs that work on HIV/AIDS, explaining...
some of the limitations of these partnerships and barriers to scale-up. The paper argues that while the particular strengths of FBOs have been acknowledged, the amount of financial and technical support they receive is rather limited, and FBO agendas often do not correspond to those of donors. Specifically, increased attention to FBOs has coincided with a new trend towards direct budget support through the PRSP process. Also, donors often push FBOs into areas of action that they are not always comfortable with, and often lack expertise in. Some examples are HIV prevention and provision of ARV therapy. The paper concludes that while the potential for fruitful collaboration between donors and FBOs is significant, the limitations to such partnerships need to be acknowledged and addressed.


This paper describes the shortcomings of the PRSP process and product with regards to HIV/AIDS. Tearfund criticizes both the lack of “deep” inclusion of all sectors of society (including people affected by AIDS) in the PRSP formulation process, as well as the (neo-liberal, Washington Consensus) prescriptions for poverty reduction that come out of most PRSPs.


This report examines community-based FBO responses to the growing issue of orphans and other vulnerable children and the role of donors and governments in fostering these initiatives. It emphasizes the need to support and strengthen community motivation—the message here is that local initiatives are already ubiquitous and that “all it takes is a little technical assistance and training to motivate communities to do more.”


Tearfund offers a critique of the Global Fund’s approach to FBOs. From the perspective of FBOs, the Global Fund does not understand how they operate and what values underlie their work, they feel excluded from proposal development, and they argue that the Fund’s monitoring and evaluation arrangements do not adequately measure the reach of various initiatives. Zambia (where 30% of all health care and 50% of rural health care is delivered by FBOs) represents an approach to the Fund that is considered an exemplary model. The Zambians appointed four Primary Recipients (PR), each representing a discrete “leg” of the response (ministry of health, ministry of finance, national AIDS network, and umbrella church organization). Sub-implementers have developed tools and processes that simplify proposal development for small, community-based FBOs, which generally don’t have the capacity to write detailed and professional proposals.


Although this paper focuses on the World Bank’s MAP initiative, Tearfund argues that international funds in general do not yet have effective mechanisms for enabling FBOs at the local level to access resources.


This briefing paper outlines the potential opportunities and challenges for collaboration between FBOs and traditional international development agencies (IDAs). Tearfund emphasizes that FBOs are not just a subset of NGOs, but rather that their faith character gives them unique qualities. Community-based FBOs often feel that this uniqueness, along with their long-term commitment to the poor and the sick, is underappreciated by IDAs. Other obstacles to partnership include different conceptions of appropriate M&E, the inflexibility of many funding mechanisms, and residual counter-productive attitudes within many faith communities. The paper gives examples of how these issues have been addressed and outlines a series of recommendations for both churches and IDAs to improve understanding and cooperation.

This report details how the Islamic Medical Association of Uganda networked with local religious leaders and volunteers to bring accurate information on HIV/AIDS to Muslim communities.


This best practices case study describes a project run by the Catholic Church in South Africa from 2000. Choose to Care is a comprehensive faith-based response to the HIV/AIDS epidemic in South Africa, characterized by wide-ranging initiatives and innovative partnerships with the private sector and the government. Project activities fall under the categories of prevention, care, treatment, orphan and other vulnerable children services, advocacy, capacity building, interfaith involvement, and theological reflection. The case study discusses the successes and the barriers of limited capacity of many implementing partners such as NGOs and congregations.


A collection of conference papers focusing on the theological aspects of stigma. The papers address both practical and theoretical questions and collectively sketch out a framework for thinking about stigma-related issues. This framework focuses on the themes of God and Creation, interpreting the Bible, sin, suffering and lamentation, covenantal justice, truth and truth-telling, and the Church as a healing, inclusive, and accompanying community.


Varsalona describes World Vision’s success in applying for PEPFAR funds, which are used primarily to address the needs of HIV/AIDS-affected orphans and vulnerable children through its Hope Initiative. While World Vision focuses on abstinence and faithfulness education, the author notes that their willingness to support condoms as a harm reduction strategy has not met with approval from conservative evangelical leaders.
Endnotes

1. This work is supported by the Henry Luce Foundation.

2. AIDSPortal is a joint initiative of the DFID Global AIDS Policy Team and the UK Consortium on AIDS and International Development. The UK Consortium is a network of over 80 UK based organizations working together to understand and develop effective approaches to the problems created by the HIV epidemic in developing countries. See http://www.aidsportal.org/overlay_details.aspx?nex=122.

3. UNAIDS, the Joint United Nations Programme on HIV/AIDS, brings together the efforts and resources of ten UN system organizations to the global AIDS response. Cosponsors include UNHCR, UNICEF, WFP, UNDR, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. Based in Geneva, the UNAIDS secretariat works on the ground in more than 75 countries world wide. Established in 1994 by a resolution of the UN Economic and Social Council and launched in January 1996, UNAIDS is guided by a Programme Coordinating Board with representatives of 22 governments from all geographic regions, the UNAIDS Cosponsors, and five representatives of nongovernmental organizations (NGOs), including associations of people living with HIV/AIDS. See website: http://www.unaids.org/en/.

4. For an analysis of different types of faith-based organizations operating in the United States see http://berkleycenter.georgetown.edu/fbobackgrounder.doc.

5. In some countries, there is a recognized difference between traditional healers and herbalists. Herbalists have learned the application of African traditional medicines from elders, while traditional healers are “guided” by spirits. Some religions The New Yorker Magazine tolerate the practice of herbalists, but shun traditional healers.


7. Ibid UNAIDS.


13. See Peter Grey article and its many references.


21. South African Bishops, Choose to Care, “ABCD” acronym, Abstain, Be faithful, Change your lifestyle, or you are in danger of contracting AIDS (18).


23. Presentation by Dr. David Serwadda at 1st International Muslim Leaders’ Consultation on HIV/AIDS, November 2001, Kampala, Uganda.


25. For more information, see http://www.ajws.org/index.cfm?section_id=8&sub_section_id=13&page_id=680.

26. For more information, see http://www.worldvision.org.vn/index.php?option=com_content&task=view&id=45&Itemid=0.


34. Ibid.

35. Ibid.

36. Disentangling HIV and AIDS Stigma in Ethiopia, Tanzania and Zimbabwe.

37. See Boston Globe series.

38. Ibid.

39. UNAIDS Update, 2006, p. 3.

40. Ibid., 11.

41. Ibid., 13.

42. Ibid, 14 (also, see table).

43. Ibid.

44. Ibid.

45. Ibid., 15.

46. Ibid., 16–17.

47. Ibid., 12.

48. Ibid., 18.

49. Ibid.

50. Ibid., 19.

51. Ibid., 17.

52. Ibid., 18.

53. Ibid., 21–22.

54. Ibid., 21.

55. Ibid., 20.

57. Ibid., 22.

58. Ibid., 22–23.

59. Ibid., 10.

60. Ibid., 14.

61. Ibid., 24.

62. Ibid.

63. Ibid., 27.

64. Ibid., 29.

65. Ibid., 24.

66. Ibid., 37.

67. Ibid.

68. Ibid., 41.

69. Ibid., 43.

70. Ibid., 37.
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This paper is part of a series of reports that maps the activity of faith-based organizations around key development topics. These reports explore the role of religious groups in addressing global challenges as a way to bridge the coordination gap between secular and religious organizations in the common effort of international development work.