GS 1530

TELLING THE STORY: BEING POSITIVE ABOUT HIV/AIDS

A REPORT BY THE MISSION & PUBLIC AFFAIRS COUNCIL

PREFACE

In April 2002 the Primates of the Anglican Communion, meeting in Canterbury, pledged themselves to the promise that future generations would be born and live in a world free from AIDS. Almost two years later that promise has inspired many in the Communion to face the growing challenges of the pandemic, particularly in Africa and in sub-Saharan Africa specifically, with increasing resolve and commitment.

Despite our efforts, we have not yet turned the tide. Even as we effect massive programmes and put huge resources to work, we are told by UNAIDS that infections are increasing, the death toll is mounting and that the future generations of which we speak will comprise of millions of orphans. This is the harsh reality which gives the promise its urgency. As Christians, we need to hold in one heart both present reality and future promise. This is what the cross of Christ represents, marking as it does, a moment of crisis.

At the heart of the AIDS crisis lies the sin of stigmatization. Unless and until we address this central issue, whether it is manifested in our communities, expressed in our personal or national attitudes or, as in the case of Africa, is directed towards an entire continent, stigmatization will remain the single most resistant defence against any fulfilment of our promise to future generations.

If the Church's response is to be effective at parish, diocesan or communion level, then we will need to understand that the only way that we can work for an AIDS-free world is to work for stigma-free hearts, individually, nationally and globally.

We can begin by acknowledging that our very theology as Christians, has sometimes led to the stigmatization of people, not only those living with AIDS, causing suffering to them and to the heart of God. In all our planning and strategizing to do battle with a disease of unprecedented scale we could do worse than ensure that we eradicate stigma in every possible shape or form. This is the spiritual dimension of the fight against AIDS which is too easily overlooked.

People living with AIDS do not want to be regarded as 'suffering from AIDS'. Yet, as many will tell us, stigmatization causes deep and lasting

suffering. We must ensure that the future AIDS-free generations for which we yearn do not carry the deep branding of stigma, especially those children orphaned by AIDS.

In our Primates statement, we recognized the need for co-ordinated action and good communication in the Anglican Communion and we are making good progress in this regard. As Church, we are called to both action and reflection. In reflecting on our response to this global pandemic, we do well to reflect upon the God in whose image we are all created. Ours is the God who excludes none and who, in kairos moments, calls us to recognize Him in the midst of suffering and in the faces of all who carry the marks of suffering. Herein is God's promise and our hope.

Most Revd Njongonkulu Winston Hugh Ndungane
The Archbishop of Cape Town

Living Positively
Binwell Kalala's Story

I was devastated when I discovered that I was HIV positive. My birthday was the following morning. It was terrible. I cut myself off. I would say to people, the results aren't out yet. But it was so out of character, someone who speaks very much, who is so jokey. I was gloomy. I couldn't talk, couldn't eat. After some time, I saw a counsellor and discovered that I would live longer than I feared. I thought, it's not good for me to be thinking of the old days. Let me see what the future can bring. My counsellor arranged for me to attend a meeting of a group of people living with HIV/AIDS. I found there confidence and strength to see that there is still a future. I decided I would do AIDS work. I've been involved in creating support groups for people living with HIV/AIDS. I also performed plays for TV. 'Life is Precious' was about a boy in secondary school who thought HIV is for old people. In the end, when he gets the virus, the play focuses on how his family fares for him. I then started working with prisoners in 1998, training volunteers with the Prison Fellowship of Zambia. Recently I decided that I should go into the prisons myself. I wanted to give a human face to HIV/AIDS. I am trying to make the prisoners aware of HIV/AIDS and I am trying to help people come close to each other, build their confidence – and go for voluntary counselling and testing. Ten years ago, I served four months in prison. I know what a prisoner goes through. I share my testimony, so it is easy for me to tell them that HIV is real, and that they can make a difference. I've seen so much change. Many prisoners become aware of the situation and get involved to make a difference. In Zambia, the Church is taking up the issue. They are now realizing that HIV/AIDS is a problem for everyone. My mother is clear that at any time I may die, so she wants to give me more support. Every time I am sick, she is so close to me. Then for my son, I tell him, 'Son, any time I will die, so you need to concentrate on what you are doing.' He understands. But other family members have shunned me. I look at the future of my children: How am I going to educate them, make them into responsible people? And again, how am I going to look after my mother and others who depend on me? Living with HIV has really destroyed my plans. But it has made me look at new avenues. I feel like I've done a lot, but I still need to do more. I may die soon; I may live. I must leave my skills." Binwell died of AIDS shortly after giving this interview, at the age of 34.

Voices from Africa, CHP, 2003

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SECTION 1 – INTRODUCTION

> "HIV and AIDS are both symptoms rather than causes. They are symptomatic of past injustices, dislocations and inequalities. I think that when one looks at the AIDS epidemic one has to look at the causes – like poverty, violence, the position of women – and downstream at the consequences. So the relationship between AIDS and development is a very complex one."[1]

1. HIV/AIDS is a global crisis. No region of the world is immune to its effects. The HIV/AIDS epidemic that emerged less than thirty years ago is reaching pandemic proportions that are set to worsen over the next decade, especially in parts of Europe, Asia and Latin America. Five million people became infected with HIV/AIDS worldwide and three million people died in 2003 alone – the highest ever. HIV/AIDS thrives in situations of poverty, inequality and conflict. Whilst the spread and impact of the virus is at different stages across regions, HIV/AIDS is a global threat, which shows no signs of abating.

2. While the international community is orchestrating a greater response to AIDS through individual initiatives like the US Government's Emergency Plan on AIDS and the Global Fund to Fight AIDS, it is evident that current global efforts remain inadequate for an epidemic that is spiralling out of control. The international community has reached a crisis situation that calls for immediate action. There is no shortage of goodwill where HIV/AIDS is concerned and it is clear that this is a crisis people want to resolve. How they actually do this, what a practical response might consist of, seems less clear. Whilst there has been some concrete progress in the fight against HIV/AIDS, the current pace and scope of the world's response remains wholly insufficient.

3. *Telling the Story: Being Positive About HIV/AIDS* looks at how the Church of England can most effectively contribute to the campaign against HIV/AIDS. The report assesses the impact of the HIV/AIDS pandemic, focussing particularly on Africa. This is not to suggest that HIV/AIDS is a specifically African problem. Although all continents

[1] A. Whiteside, in L. Lawson (ed), *HIV/AIDS and Development*, Johannesburg, SAIH and Interfund, 1997, p.4.

are plagued by this pandemic, Africa has been disproportionately affected. This report therefore presents an analysis of the current international and national responses to this pandemic in Africa. It provides a brief overview of how the Church of England is contributing to the HIV/AIDS campaign through Christian Aid, the mission agencies and diocesan initiatives.

4. *Telling the Story: Being Positive About HIV/Aids* moves beyond merely auditing existing Church initiatives. It commends to the Church of England's General Synod the recent strategy, *Action Plan for Africa*, developed and adopted by the Council of Anglican Provinces in Africa in 2001 and endorsed by the Primates of the Anglican Communion. This action plan has led many African Churches to develop more co-ordinated and effective responses to the HIV/AIDS pandemic. In some instances as with the Church of the Province of Southern Africa, this has led to creative health care initiatives that have subsequently secured outside funding from the UK's Department for International Development. *Action Plan for Africa* provides an opportunity for the Church of England, as part of the Anglican Communion, to support the work of the Church in Africa as they develop practical and effective ways to tackle the HIV/AIDS pandemic.

Basic facts about HIV/AIDS	
HIV	Human Immunodeficiency Virus (HIV) is the virus that causes AIDS. The virus rapidly multiplies in the blood, stimulating the development of antibodies. A person is then said to be HIV (antibody) positive. Although the person may have no signs of disease, s/he can infect others.
AIDS	Acquired Immune Deficiency Syndrome (AIDS). HIV destroys the immune system, leaving the body susceptible to infections that a healthy person could fight. When this happens, a person has AIDS.
Mode of Transmission	HIV is spread in three ways: • during unprotected vaginal, anal and (rarely) oral sex; • by blood contaminated with HIV being passed directly into the bloodstream. This might happen during a blood transfusion, when unsterile needles are shared (eg between drug users), or during unsterile medical procedures involving blood; • from mother to child during pregnancy, childbirth and via breastfeeding (this is called 'vertical' or 'mother-to-child' transmission).
Seroconversion	Seroconversion is when a person's blood converts from HIV-negative to HIV-positive status, ie when antibodies first develop. Seroconversion usually takes three to four weeks, but it can take up to three months. This time lag between infection and seroconversion is called the 'window phase'. People are highly infectious during this phase as HIV is replicating quickly without being kept in check by antibodies.
Seroprevalence	Seroprevalence refers to the proportion of

Basic facts about HIV/AIDS	
	HIV-positive people in a given population at one point in time.
Asymptomatic phase	People living with HIV can remain healthy for many years after infection. In developed countries it takes on average 11 years for an HIV-positive person to develop AIDS. In developing countries, poor nutrition and health-care services shorten the period to an estimated four to seven years. HIV-positive people remain infectious during the asymptomatic phase.
Related illnesses	During the progression from HIV to AIDS the body gradually become susceptible to opportunistic infections, ie infections that take advantage of weak immunity. Common symptoms of the progression to AIDS are long-lasting and frequent diarrhoea (over one month), weight loss of more than 10 per cent, persistent cough (which could mean tuberculosis), long-lasting swollen glands and skin problems. Common infections include tuberculosis, thrush in the mouth and oesophagus, recurring severe shingles, various cancers including Kaposi's sarcoma, meningitis, pneumonia and many others. Many infections can be treated so that the person experiences periods of relatively good health in between bouts of illness.

SECTION 2 - A GLOBAL CRISIS

> A lot of people have died and we still talk about the statistics in such a bland way. What does an HIV prevalence of 10 per cent mean? It means tragic loss – of families, of people [...] the investment of love that has been ripped away from this earth.[2]

5. The Joint United Nations Programme on HIV/AIDS, UNAIDS, reports that in 2003 an estimated 40 million people were living with HIV worldwide, including 2.5 million children under the age of 15. Globally an estimated 5 million people were newly infected and 3 million people died of AIDS in 2003. Sub-Saharan Africa, the most severely affected region, accounted for over three million of these new infections and 2.3 million AIDS deaths. Every day in 2003 an estimated 14,000 people were newly infected with HIV - more than 95% of those live in low and middle-income countries. To fully understand the global nature of the HIV/AIDS crisis the following section documents regional variations. In doing so it illustrates the complex and varied nature of the epidemic and those factors that have fuelled its growth.

High Income Countries

6. In high income regions like North America and Western Europe the total number of people living with HIV continues to rise gradually. This is largely due to widespread access to antiretroviral treatment. UNAIDS estimates that 1.6 million people are living with HIV in these countries – a figure that includes the 80,000 who were newly infected in 2003. While the number of annual AIDS deaths has continued to slow in high income countries, there is mounting evidence that certain sections of the population are more prone to infection. In the USA for instance around half of the approximately 40,000 new infections in 2003 occurred among African-Americans, with African-American women accounting for an increasing proportion of new infections.

[2] G. Lamont, *Steps Towards a Holocaust*, in Lawson, 1997, ibid, p.9

Global Summary of the HIV/AIDS epidemic – December 2003[3]

Number of people living with HIV/AIDS	Total Adults Children under 15 years	40 million (34-46 million) 37 million (31-43 million) 2.5 million (2.1-2.9 million
People newly infected with HIV in 2003	Total Adults Children under 15 years	5 million (4.2-5.8 million) 4.2 million (3.6-4.8 million) 700,000 (590,000-810,000)
AIDS deaths in 2003	Total Adults Children under 15 years	3 million (2.5-3.5 million) 2.5 million (2.1-2.9 million) 500,000 (420,000-580,000)

7. As in parts of Europe, many of the women who do contract HIV do so not because they engage in high-risk behaviour but because they have unsafe sex with their male partners many of whom inject drugs. UNAIDS believes that heterosexual intercourse may now be the most common mode of HIV transmission in Western Europe with a significant number of persons believed to have been infected elsewhere, in a country with high HIV prevalence. Despite these emerging trends it remains true that an important aspect of the epidemic in most high income countries is the persistence of high risk sexual behaviour – especially among young people, including men who have sex with men or inject drugs.

Eastern Europe and Central Asia

8. While access to antiretroviral treatment has helped to contain the HIV/AIDS crisis in Europe, the AIDS epidemic in Eastern Europe and Central Asia shows no sign of abating. Some 230,000 people were infected with HIV in 2003, bringing the total number of people living with the virus to 1.5 million. According to UNAIDS the virus claimed an estimated 30,000 lives in 2003. The worst affected regions are the Russian Federation, Ukraine and the Baltic States. HIV continues to spread in Belarus, Moldova and Kazakhstan, while more recent epidemics are now evident in Kyrgyzstan and Uzbekistan.

[3] *AIDS epidemic update*, December 2003, UNAIDS/WHO, p.3.

9. These epidemics appear driven by high risk behaviour – specifically injecting drug use and to a lesser extent unsafe sex – among young people. While it is dangerous to draw conclusions across geographical regions UNAIDS suggests that the growing epidemic has been fuelled by jolting social change, widening inequalities and the consolidation of transnational drug-trafficking networks in the region.

Asia and the Pacific

10. In Asia and the Pacific, the epidemic is spreading into areas and countries where, until recently, there was little or no HIV present – including China, Indonesia and Vietnam. Over one million people in Asia and the Pacific were infected with HIV in 2003, thereby bringing the total number of people living with the virus to 7.4 million. According to UNAIDS a further 500,000 people are estimated to have died of AIDS in 2003. Most of these new emerging epidemics are driven by injecting drug use with additional HIV spread occurring through commercial sex.

Latin America and the Caribbean

11. More than 2 million people are now living with HIV/AIDS in Latin America and the Caribbean, including the estimated 200,000 that contracted HIV in 2003. At least 100,000 people died of AIDS in the same period – the highest regional death toll after Sub-Saharan Africa and Asia. In the majority of South American countries HIV is transmitted through drug use and sex between men, with subsequent heterosexual transmission to other sexual partners. In Central America most HIV infections occur through sexual transmission, both heterosexual and between men. In the Caribbean, heterosexual transmission predominates and, in many cases is associated with commercial sex. While many Latin and Caribbean countries have strengthened their responses to AIDS there remains concern that the economic and social instability experienced in parts of the region could undermine those programmes. The effectiveness of such national programmes has also been hindered by the stigmatisation and denial which has fuelled the epidemic.

Middle East and North Africa

12. Even in the Middle East and North Africa it is possible to discern an emerging crisis. 55,000 people acquired the virus in 2003 bringing to 600,000 the total number of people living with HIV in the region. AIDS killed a further 45,000 people in 2003. By far the worst affected country is the Sudan where a mainly heterosexual epidemic is progressing quickly, especially in the South. In Bahrain, Libya and Iran, HIV infections have been linked to infecting drug users and its subsequent transmission through heterosexual sex. In Iran for instance it has been estimated that half of the 200,000 drug users are married, while a further 75,000 had reported extramarital sex. This all points to a potential for secondary heterosexual transmission.

13. Several other vulnerable groups face increasing risk of HIV infection in the region, notably sex workers and men who have sex with men. UNAIDS reports that in Yemen 7% of sex workers are HIV-positive. It is more difficult to estimate the rate of infection and transmission between men who have sex with men. The shortfall in information is largely due to the stigma attached to sex between men. All too often however denial and stigma create an ideal context for the spread of HIV, preventing as it does the development of effective HIV health care and prevention programmes.

Sub-Saharan Africa

14. In Sub-Saharan Africa high levels of new HIV infections are persisting and are now matched by high levels of AIDS mortality. As such it remains by far the worst affected region. In 2003, an estimated 26.6 million people were living with HIV. This figure includes the 3.2 million who became infected during 2003. AIDS killed approximately 2.3 million people. While Southern Africa is home to about 30% of people living with HIV/AIDS worldwide, this region has less than 2% of the world's population. In 2003 South Africa was home to an estimated 5.3 million people with HIV – more than any other country in the world. Given the scale of the crisis the following section examines in closer detail the scale and depth of the crisis in Sub-Saharan Africa.

Regional HIV/AIDS Statistics and Features, End of 2003[4]

Region	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence (%)*	Adult and child deaths due to AIDS
Sub-Saharan Africa	25.0-28.2 million	3.0-3.4 million	7.5-8.5	2.2-2.4 million
North Africa & Middle East	470,000-730,000	43,000-67,000	0.2-.0.4	35,000-50,000
South & South-East Asia	4.6-8.2 million	610,000-1.1 million	0.4-0.8	330,000-590,000
East Asia & Pacific	700,000-1.3 million	150,000-270,000	0.1-0.1	32,000-58,000
Latin America	1.3-1.9 million	120,000-180,000	0.5-0.7	49,000-70,000
Caribbean	350,000-590,000	45,000-80,0000	1.9-3.1	30,000-50,000
Eastern Europe & Central Asia	1.2-1.8 million	180,000-280,000	0.5-0.9	23,000-37,000
Western Europe	520,000-680,000	30,000-40,000	0.3-0.3	2,600-3,400
North America	790,000-1.2 million	36,000-54,000	0.5-0.7	12,000-18,000
Australia & New Zealand	12,000-18,000	700-1,000	0.1-0.1	<100
Total	**40 million (34-46 million)**	**5 million (4.2-5.8 million)**	**1.1% (0.9-1.3%)**	**3 million (2.5-3.5 million)**

[4] *AIDS epidemic update*, December 2003, UNAIDS/WHO, p.5.

SECTION 3 - HIV/AIDS IN SUB-SAHARAN AFRICA – A BARRIER TO DEVELOPMENT

- AIDS has had a direct impact on at least 60 million people. In Sub-Saharan Africa between 25 to 28 million people are currently infected by HIV/AIDS.
- In Africa *today*, 1,500 more persons have become HIV-positive; every 14 seconds a young person is infected with HIV.
- In the last *five minutes* five more children have died from AIDS.
- By 2005 most Africans will die before they reach their 48th birthday.
- Life expectancy in South Africa is expected to fall from 62 to below 40 by 2010. There will probably be around 93,000 AIDS orphans there by 2005.
- In South Africa alone, half of the 15-year-olds today will not reach their 25th birthday because they will die from AIDS.

15. The previous section illustrated that although HIV/AIDS is a global crisis, statistically at least, Sub-Saharan Africa is the worst affected region in the world. In order to better understand the complexity of the HIV/AIDS crisis in Sub-Saharan Africa the following section examines the devastating impact that the virus has at all levels of human society and organisation. HIV/AIDS is not only fuelled by underdevelopment but fuels underdevelopment. It affects the most economically productive elements of society and affects all socio-economic groups, including skilled workers and professionals.

Understanding the Spread of HIV/AIDS in Sub-Saharan Africa

16. The region's epidemics are varied, diverse and complex. It is possible however that socio-economic and socio-cultural inequalities appear to be hindering effective responses. Rates of HIV/AIDS vary widely between urban and rural areas, within a country and between different groups within each region. Contrasting social, cultural and economic factors, as well as migration patterns create different risk environments that all contribute to putting individuals and

communities at risk. Many of the factors that create risk environments are present in Sub-Saharan Africa.

17. Economic pressures within and between states in Sub-Saharan Africa encourage a rural to urban migration that finds men seeking employment in towns and cities while their wives are left to tend the land. As a result it is not uncommon to find men with second wives or multiple girlfriends. Infection rates are highest along trade routes where sex workers cater for migrant communities. Migrant workers who have unsafe sex, either with sex workers or with other women, are more likely to be infected with the virus. They are also likely to transmit this virus to their wives.

18. In addition to economic migration internal conflict within a nation state or within a region can lead to population movement. In such instances social mores and conventions can break down leading to an increase in unsafe sex and a higher risk of infection. It is clear therefore that the levels of poverty and the frustration of human potential which fuels migration can lead to people taking higher risks.

In the words of a young girl in Tanzania[5]:

"As long as I am single, it is easy to stay HIV negative in my parish. Everybody respects my wish not to have sex before I get married. The problem is just that the most dangerous thing I can do is to get married! I then suddenly lose my right to make decisions about my own body. People then just say that I must "obey my husband and fulfil my obligations as a wife" even if I find out that he has other sexual partners than me. Because of this, I lost both my mother and father. My mother knew that my father had other women, but what could she do? What can I do to protect myself when I get married."

19. As noted in the previous section, in Sub-Saharan Africa women are more prone to HIV than men. The high levels of gender inequality across Sub-Saharan Africa puts many women at risk. Many women across the region have little control over their sexual and reproductive health and thus are more susceptible to contracting the virus. In many cases polygamy is accepted practice as is extra-marital sexual

[5] *HIV/AIDS Challenges Facing the Church of Norway: Proposal Document for the Church of Norway General Synod 2003.*

relations. Similarly it is commonplace in Tanzania, Zambia, and Zimbabwe for a husband's brother to inherit a brother's widow. In some parts of the region various sexual rites such as the male preference for dry sex, which can lead to a tearing of the vaginal lining, can increase the risk of infection. This is especially problematic when the cultural norms encourage sex as a rite of puberty. Sexual relations between virgins and older men are encouraged by some traditional healers as a form of cleansing the body of the virus.

> Householder, Lusaka, Zambia
>
> 'Before the onset of the illness the family could utilise two hectares of the arable land. But after the illness (and death) we now utilise only one hectare.'

20. The social inequality of women is reinforced by their economic marginalisation. Although women are more likely to know the risks of un-protected sex, sex workers might have un-protected sex if their client asks, especially if he is willing to pay more. Not all sex workers would necessarily see themselves as sex workers. Many women sell sex occasionally when they need extra income. When droughts produce crop failures parents are susceptible to pressurising adolescent girls into selling sex to supplement declining family incomes. Their low social status and their lack of bargaining power both within the family and with other men in the community makes adolescent girls particularly vulnerable.

The Socio-Economic Impact of HIV/AIDS

21. The impact of HIV/AIDS can be seen at every level and sector of society. It erodes the socio-economic structure of society by causing the ill health and death of the main breadwinner. It denies future generations the chance to learn traditional skills. The mounting cost of HIV/AIDS means that many countries are finding it increasingly difficult to invest for the future in people, their education and the skills necessary not only to foster personal development but also community development. While the development of new drug therapies means that many people with HIV in high income countries can live longer, the prohibitive cost of these medicines means that

many governments in Sub-Saharan Africa design health policies that restrict the access of people living with HIV/AIDS to adequate health care provision.

HIV/AIDS and the family[6]

HIV and AIDS seriously affect livelihoods and family security. Typically:

- there is a loss of cash income when breadwinners lose the capacity to work, and/or a loss of labour for subsistence farming;
- household members are forced to spend time and resources caring for the sick. This burden usually falls on women and girls, who may be withdrawn from school;
- there is increased spending on modern and traditional health care, on travel (to clinics and hospitals and traditional healers), and on funerals;
- savings, including benefits from formal employment, are used up;
- skills and experience do not pass from one generation to the next; this is particularly a problem in farming communities;
- nutrition deteriorates as there is less money for food and less labour for farming;
- a family suffers stress as many of its members become sick and die.

22. At the household level it is evident that families that have direct experience of HIV/AIDS are forced to spend large portions of their time and resources in caring for relatives. This burden usually falls on women and girls who may be taken out of school. Girls who are forced to give up their education are unlikely to become economically independent. Other children are obliged to work at an increasingly young age. Their ability to earn a living will decline with the deaths of their mothers, who would traditionally have taught them trading and other life skills. This increases the likelihood of child labour and child prostitution, which in turn makes them vulnerable to HIV/AIDS. As a result, a whole generation of workers is being lost, both directly and indirectly, to HIV/AIDS.

[6] *HIV/AIDS in Southern Africa: The Threat to Development*, CIIR, 1999, p. 21

23. HIV/AIDS adversely affects developing countries economies. Standard Chartered Bank estimates that 70 per cent of their staff in Africa have close relatives and/or friends, who are infected with the HIV virus. The high turn over in the labour market and the inability of the labour market to retain key skills vital to its development discourages some companies from investing in Africa. In some cases, companies like Metropolitan Life, a South African Corporation, have responded to the rising cost of employee benefits by introducing screening procedures that discriminate against HIV infected workers.

Millennium Development Goals

24. HIV/AIDS threatens to undermine much of the progress that has been made in recent years in such fields as health care, education and agriculture in Africa. It threatens the realisation of the Millennium Development Goals (MDG).[7] Reducing infant and under-5 child mortality by two-thirds by 2015 is put at risk by the increasing infection of infants through mother-to-child transmission of the HIV virus. Increasing primary education in line with international targets appears remote as children are withdrawn from school to care and provide for sick relatives. The need to eradicate this epidemic is thus all the more urgent given that it plays such a significant role in the chronic poverty that has overtaken Sub-Saharan Africa.

[7] International Development Targets: the 1996 OECD Development Assistance Committee Report 'Shaping the 21st Century: The Contribution of Development Cooperation' outlined 7 development goals that OECD members have set themselves. These were drawn from consensus decisions at these conferences, which subsequently became known and promoted as the 'international development targets'. See Appendix 1 for a full list of the Millennium Development Goals (MDG). In September 2000, the member states of the United Nations General Assembly unanimously adopted the Millennium Declaration. The MDG commit the international community to an expanded vision of development, one that vigorously promotes human development as the key to sustaining social and economic progress in all countries, and recognizes the importance of creating a global partnership for development. The goals have been commonly accepted as a framework for measuring development progress. HIV/AIDS features as the 6th of the Millennium Development Goals but in reality cuts across all of them. In sub-Saharan Africa, six out of the eight Millennium Development Goals will not be reached if the international community fails to prevent the continuing spread of HIV/AIDS. The goals are summarised in Appendix 1.

A Young Man's Story

Vitalis Ndusilo is 29 and lives in Njombe in Tanzania. He is HIV-positive but doesn't know how he became infected. He thinks it may have been when he and his elder sister (who is also positive) visited a traditional healer. The doctor's 'cure' for his sister involved cutting both their hands with the same instrument he had used on other patients. But Vitalis was also sexually active at the time.

Although Vitalis has a girlfriend he hasn't told her his status; he has simply said that he has decided he doesn't want children just yet so they must use a condom. He is trained in building construction and still works when he is well and there is work available, but that is not enough to support him, Vitalis gets very depressed, so frequently seeks counselling at a clinic run by the Diocese of South West Tanganyika. He says: 'Sometimes I walk down the street feeling totally isolated and suicidal. Then my counsellor Mrs Marcau tells me to remember that many of the people I am passing are in the same situation'.

Stigma leads to silence and silence leads to feelings of isolation and despair. We are all in some measure responsible for the silence that surrounds HIV; and until that silence is broken, people living with HIV are greatly burdened by it.

Antiretroviral Drugs

25. While it would be wrong to see access to affordable care as the magic solution to this crisis, it is evident that in the past the lack of treatment available in Sub-Saharan Africa, due to the high prices of the antiretroviral drugs (ARV), has caused unnecessary human suffering. The need for affordable and accessible antiretroviral treatment drugs is paramount. The UK Secretary of State for International Development, Hilary Benn, in a recent speech to the UN underlined the importance of reducing the cost of ARV drugs. This is a market currently dominated by a few large pharmaceutical companies defending 20-year patents on their drugs. This practice prevents other companies who offer generic drugs at much lower prices from entering the market. The result is that the people most in need cannot even afford to pay for treatment.

26. Churches in Africa are playing an important role in campaigning for better access. In October 2003 South Africa's *Treatment Action Campaign* and other groups, including churches, brought a case against GlaxoSmithKline (GSK) that the high charges made by GSK and Boehringer Ingelheim for AIDS drugs were unfair. It was argued that these companies have engaged in restrictive practices by refusing licences to other firms making their own low-cost generic versions of AIDS drugs. Although GSK has led the way in cutting the prices of its AIDS drugs in Africa they still remain prohibitively expensive when compared to generic drugs.

27. It remains clear however that with the best will in the world and endless funding it will be many years before everybody has access to ARV drugs. These drugs are not, however, a cure for HIV/AIDS, which means that care for those affected by HIV/AIDS will continue to be needed at some stage. It is worth noting that palliative care is affordable and deliverable at home and is important from a development perspective since it frees carers to return to economic activity or education. Good palliative care reduces stigma and helps to restore human dignity by stopping feelings of helplessness in the face of suffering. This point is especially important given the important role faith-based and Christian-led organisations have had in modelling appropriate and effective ways of providing care and support for people with HIV/AIDS at community level – especially in Sub-Saharan Africa.

28. The severity of the HIV/AIDS crisis in Africa draws attention to the need for a comprehensive review of the effectiveness of current programmes to tackle HIV/AIDS. Even if exceptionally effective prevention, treatment and care programmes take hold immediately, the scale of the epidemic means that the human and socio-economic toll will be considerable for many generations. What is still lacking amongst donors is a real and determined attempt to examine how HIV/AIDS affects all aspects of development activity. In the absence of significantly expanded prevention, treatment and care efforts, the AIDS death toll in Africa will continue to rise before peaking in 2010. The worst of the epidemic's impact will be felt in the course of the next decade and beyond.

SECTION 4 -ELUSIVE PROMISES

As part of their Declaration of Commitment on HIV/AIDS, drawn up at the United Nations General Assembly Special Session on HIV/AIDS in June 2001. Member States agreed to:

… by 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by, people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.

29. Having examined some of the human, social and economic costs associated with HIV/AIDS, this report now turns its attention to examining how the international community has sought to respond to this pandemic. Although it is difficult in a report of this nature to provide a comprehensive overview of international initiatives, it is hoped that the following section will give some indication as to the type of measures that are already in place. Particular attention is paid to the efforts of the British Government.

The UK Government – A Policy Overview

30. After years of insisting that HIV could not be singled out as a particular development priority, the UK Government now appears to be giving the issue the political prominence it needs. On 1 December 2003 they launched the new *UK Call for Action on HIV/AIDS*. This document says that HIV will be a centrepiece of the UK's G8 and EU presidencies in 2005, and its rapid production reflects a new level of commitment from the Department for International Development. This interest and commitment are to varying degrees supported by other Whitehall Departments such as the Treasury and No10.

31. The major recent change in UK Government policy on HIV is that the Government is now explicitly supporting antiretroviral treatment, which they previously avoided doing. The stated reason for this change in policy is that ARV prices have tumbled to a fraction of their level a few years ago. This change in policy was first trailed in Hilary Benn's September 2003 speech to the UN General Assembly. The major reason for the fall in drug prices has been the successful international campaign by developing country governments and others to allow generic versions of drugs to lower prices through competition, combined with international moral pressure on the pharmaceutical companies.

32. The other major policy driver is the commitments made at the 2001 UN General Assembly Special Session on HIV/AIDS (UNGASS). The UK Government has emphasised these targets in particular, and has called on the international community to intensify efforts to:
- Reduce the rate of HIV infection of young people by 25% by 2005
- Provide treatment for 3 million people (2 million in Africa) by 2005
- Develop one national strategy, one national AIDS commission and one way to monitor and report progress in every country affected by HIV (the 'three ones')
- Slow the progress of HIV by 2015.

33. The Government hopes to achieve these objectives through:
- *Stronger political direction* by making HIV a centrepiece of the presidencies; working through African fora such as New Economic Partnership for African Development; and pushing for another UN Security Council Special Session on HIV
- *Better funding* by making HIV a priority for already-announced new funding for Africa; pressing for support for the new International Financing Facility; and working with the Global Fund to enable it to disburse funds quickly
- *Better donor co-ordination* by stepping up co-ordination with the US in five priority African countries; doubling core funding to UNAIDS (£3m to £6m) and working with UNAIDS, EU and UN
- *Better HIV programmes* (by working with countries to strengthen health systems; producing a new UK HIV Strategy in 2004; and issuing new policy guidance on treatment and care).

34. There is much to commend the recent changes in UK policy.
- The commitment to make HIV a centrepiece of the 2005 presidencies and the clear acknowledgement that there is still a funding gap are important developments.
- The Government's clear statement that prevention programmes should take a comprehensive approach, and that abstinence-only programmes have little impact are also welcome. This means that people should be furnished with all the methods of protecting themselves from HIV, including information about and access to condoms. Recent research by Christian Aid has shown that sex education, and access to condoms, for young people, delays rather than hastens their sexual debut and reduces rather than increases promiscuity. Support for comprehensive programmes is particularly important to balance the US support for abstinence-only.
- The Government's increased commitment to treatment comes with the helpful caveat that this treatment must in no way be at the expense of prevention. In addition the Government has stressed that ARV treatment programmes must be integrated with other health programmes to ensure that people have adequate access to food as well as treatment.
- The highlighting of women as particularly affected, with the implication that gender equity needs to be addressed as part of the response to HIV.
- The highlighting of the important links between HIV and conflict.

35. Despite these encouraging developments in UK policy, it is worrying that no new money has been allocated. UNAIDS estimates that $10 billion a year is needed for a minimal prevention care and treatment response to HIV. This is within current infrastructure – it does not include the additional money needed to build health and education systems and promote gender equality. However, less than $5 billion per year is currently available globally. While it is true that the UK has dramatically increased its funding for HIV work over the last few years (from £38 million in 1997/8 to £270 million in 2002/3) a number of development agencies, including Christian Aid, are calling for the UK to commit £750 million a year, following Kofi Annan's 2001 call for a five-fold increase in funding.

36. In addition to funding issues there are other concerns that need to be addressed. It is clear for instance that macroeconomic policy-making has a major positive or negative impact on poverty, and therefore on HIV. HIV should be incorporated into economic policy-making calculations as well as other aspects of development work. To this effect the Government needs to press the World Bank and the International Monetary Fund to consider the impact of their policies on HIV before economic policy recommendations are made to governments in developing countries.

37. Christian Aid and others remain concerned that in the efforts to improve the efficiency and co-ordination of HIV programmes, community-level responses, which in their experience are effective, should not be lost. Support for groups of people living with HIV/AIDS is key to any effective response, and indeed was critical in the Ugandan response. In this respect the 'three ones' approach may be somewhat inflexible in some circumstances. For this reason it is important that the Government provides explicit support for civil-society groups advocating increased political priority for HIV work in their own countries by their own governments. In particular, there is a need to support civil-society run programmes in countries where HIV primarily affects marginalised groups and is not a political priority for the Government.

UNAIDS

38. UNAIDS is the main advocate for global action on the epidemic. It leads, strengthens and supports an expanded response aimed at preventing transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic. Recent activity in the fight against AIDS at an international level is outlined below in *AIDS in Africa – Scenarios for the Future*. This is a UNAIDS initiated project that aims to develop Africa-wide scenarios focussing on the impact of and response to the AIDS epidemic.

The Global Fund to fight AIDS, TB and Malaria

39. In April 2001, the UN Secretary General, Kofi Annan, developed sufficient international consensus to create a Global Fund to fight

HIV/AIDS. The Fund seeks to attract, manage and disburse additional resources through a new public-private partnership. The aim is to develop a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need.

40. The Fund became operational in January 2002 and has thus far approved grants to 93 countries. Overall the amount of funds disbursed to programmes has risen from US$1million at the start of January 2003 to US$131million to date and targeted at US$200million by the end of the year. So far pledges through 2004 to the Global Fund are not enough to finance expected grant applications. US$681million has been pledged towards the needs of approximately US$3billion.

Homosexuality and Human Rights

There is ample evidence that civil society and governments all over the world direct abuse specifically at homosexuals. This ranges from subtle discrimination and everyday hostility to imprisonment, torture and execution, practices aimed at forcibly 'changing' their sexual orientation, and rejection from the church. Homosexuality is erroneously viewed in racial terms, as a white import into the black population.

For these reasons, AIDS Service Organisations and NGOs often find it difficult or impossible to provide appropriate information and support for men who have sex with men. (Many men who engage in homosexual sex do not regard themselves as homosexual, so they are commonly called 'men who have sex with men'.) Self-help organisations for gays and lesbians meet with hostility.

Homosexual sex is not the main mode of HIV transmission in sub-Saharan Africa, but a survey by the Panos Institute found that it is of far greater significance than commonly acknowledged. Yet the importance of homosexual sex is ignored by donors. In South Africa, for instance, funding for gay organisations was cut by 90 per cent in 1997.

SECTION 5 - RESPONDING TO THE CRISIS: THE CHURCH IN AFRICA

> "No one should care alone. No one should die alone. For we are all living with AIDS."
>
> Most Reverend Njongonkulu Ndugane
> Archbishop of Cape Town,
> CPSA & Christian Aid HIV/AIDS Proposal to DFID
> Pretoria, February 2003

41. In a world devastated by HIV/AIDS many people turn to religion for spiritual and pastoral support. Some churches provide enormously beneficial home-care and health services. This is often in addition to the emotional, spiritual and practical support given by local church congregations. It is important that these efforts are recognised and incorporated into national HIV/AIDS prevention programmes. In other instances it is clear that emotional debates within and between churches about the morality of sex outside marriage, sexual relationship between men, or opposition to condom use can act as a barrier against effective HIV/AIDS prevention.

42. The scale of the contribution of the Churches to health care in Sub-Saharan Africa is not widely recognised. And yet, in all countries affected by HIV/AIDS, the community is key in providing care and support. It is natural therefore that the Church, as a major community creator, is part of this process. Nowhere is this more true than in Africa where the Church is central to the community and the voices of church leaders are generally respected. Church leaders are in a position to challenge governments to allocate resources to the pandemic, to challenge pharmaceutical companies to make palliative treatment viable. Churches are also contributing to the huge task of ending the stigmatisation that surrounds the HIV/AIDS pandemic. The following section examines in closer detail the response of the Anglican Church in Africa. Particular attention is given to the *Action Plan for Africa*, a strategy that was drawn up by the Council of Anglican Provinces in Africa (CAPA) in 2001.

Developing an Action Plan for Africa

43. *Action Plan for Africa* spearheaded by Archbishop Njongonkulu Ndungane of Cape Town, originated following a presentation by the Archbishop and Rev Gideon Byamugisha, a Ugandan priest with HIV, to the Primates of the Anglican Communion in 2001 about the spread of HIV/AIDS in Africa. Shocked by the statistics the Archbishop of Canterbury, the Most Revd George Carey, along with other Primates gave Archbishop Ndungane the responsibility for prioritising the response to HIV/AIDS in the Anglican Communion.

44. On his return to South Africa, Archbishop Ndungane consulted the Council of Anglican Provinces in Africa (CAPA), on the breadth and scope of the pandemic - as well as the responses being made by churches. As a result of these conversations CAPA held the All Africa Anglican Conference on HIV/AIDS in August 2001 in Boksburg, South Africa. Church leaders from over 33 African nations attended as did participants from every province of the Anglican Communion.

What fuels stigma and discrimination?

Stigma devalues and discredits people, generating shame and insecurity. In the context of AIDS, it can fuel the urge to scapegoat, blame and punish certain people (or groups) in order to detract from the fact that everyone is at risk. Stigma taps into existing prejudices and patterns of exclusion and further marginalizes people who might already be more vulnerable to HIV/AIDS. It stems from the association of HIV/AIDS with sex, disease and death, and with behaviours that may be illegal, forbidden or taboo, such as pre- and extramarital sex, sex work, sex between men, and injecting drug use. Stigma is harmful, both in itself (since it can lead to feelings of shame, guilt and isolation of people living with HIV), and because it prompts people to act in ways that directly harm others and deny them services or entitlements – actions that take the form of HIV—related discrimination. Such unjust treatment can be tantamount to a violation of human rights.

45. The Boksburg conference was based on a grassroots and consultative approach through workshops. The aim was to develop strategies to educate the clergy, fight the huge obstacle of stigma attached to the HIV/AIDS pandemic and devise programmes that could be developed by individual diocese. Over the course of four days, participants:

- Created a vision statement - "*We, the Anglican Communion across Africa, pledge ourselves to the promise that future generations will be born and live in a world free from HIV/AIDS"*.[8]
- Developed, enacted and documented a strategic planning process, *Planning our Response to HIV/AIDS – A Step by Step Guide to HIV/AIDS Planning for the Anglican Communion.*
- Agreed on six focal areas of concern that would guide the planning process. This involved: leadership, care, prevention, counselling, pastoral care, and death and dying.
- Identified three at-risk or vulnerable populations of particular concern, namely women, children orphaned by AIDS and people living with HIV/AIDS;
- Set a template for strategic planning that could be used throughout Africa and would be available for use across the Anglican Communion;
- Formulated policies that would guide the Anglican Communion's response to the HIV/AIDS pandemic.

Dying to Learn – Young People, HIV and the Churches

The churches have the potential to be highly effective educators about HIV and sexual relationships. In many countries, particularly in Africa, the churches are among the most significant networks that reach distant communities. Moreover, churches reach many out-of-school young people, who are especially vulnerable to HIV. In some countries 70% of young girls and boys are not in school.

Many churches are already very active in caring for people living with HIV, but far less active in tackling issues linked to prevention. The World Council of Churches has said "[It has often been] painful for us to engage, in any honest and realistic way, with issues of sex education and HIV prevention." There is a fear that open discussion of sexual relationships will lead to earlier and greater sexual experimentation by young people.

A new report from Christian Aid, *Dying to Learn – Young People, HIV and the Churches*, suggests that this fear is unfounded. The majority of studies, in both developing and developed countries, have found that

- HIV and sex education do not increase promiscuity.
- High-quality education can lead to young people delaying relationships and having fewer partners.
- High-quality education can reduce transmission of HIV and other sexually transmitted infections, and reduce unwanted pregnancy"

[8] See Appendix 4 for full statement

39. In April 2002, the Primates, meeting in Canterbury, received the Boksburg report and in doing so re-committed the Anglican Communion to participate in the fight against HIV/AIDS. The Primates re-mandated Archbishop Ndungane to spearhead a global strategy. They recognised the importance of de-stigmatising HIV/AIDS. As part of this process the Primates issued a statement recognising that: "We now wish to make it clear that HIV/AIDS is not a punishment from God." In issuing this statement the Primates emphasized the duty incumbent on the Church to speak out on HIV/AIDS. The statement also covered issues such as education, pastoral care and counselling all of which are needed for the fight against HIV/AIDS. The Primates advocated the need for cheaper drugs with which to fight HIV/AIDS by pressing governments and pharmaceutical companies to make treatment more widely available.[9] In September 2002 the Anglican Consultative Council, reaffirmed the Primates' statement by urging the Communion to provide financial or other support to assist the CAPA initiative.[10]

African Churches and HIV/AIDS

40. African provinces have used the strategy developed at Boksburg to frame and shape their ongoing HIV/AIDS work at a local level. Many of the church initiatives range from ending discrimination and stigma to sensitising clergy in the area of pastoral care and support. Numerous seminars and training days have been organised on issues such as caring for the sick and dying, HIV/AIDS awareness education and counselling and adult sexual education classes. It is increasingly common for provinces across Africa to work with governments in sending state-sponsored HIV/AIDS counselling manuals to all dioceses to ensure continuity between churches and government-sponsored prevention programmes.

41. While it is difficult to comprehensively document all the contributions that churches have made to preventive programmes in Africa, the following are of particular interest.

[9] See Appendix 2 for full statement
[10] See Appendix 3 for Resolution 12 of Anglican Consultative Council

- *Uganda*: Through a new project, CHUSA, based on the strategy developed at Boksburg, the church is focussing on ending discrimination and stigma. Developing an inclusive church and one sensitive to the needs of those living or affected with HIV/AIDS is seen as a priority. In addition to this, CHUSA has set up support groups, offered training to health officers and seeks to educate clergy.

A Ugandan Story

Reverend Gideon Byamugisha is a minister in the Church of Uganda in Kampala and the first priest in Africa to declare he was living with HIV. 'When I told the bishop that I was HIV positive, rather than throw me out as I expected, he knelt down and prayed for me, and told me that I had a special mission in the church. We need to integrate HIV/AIDS into the day-to-day life of the church. Religious leaders should condemn not only unlawful sex but unsafe sex as well. That is what I want to advise. Some church leaders are embarrassed by talking about AIDS but if we are to succeed, we need to be aware that there is a lot of sexual activity happening in our communities. Even if we choose to have unlawful sex, we are still bound to do it safely. I am advocating a culture where safe sex can be made easy, acceptable and routine. 'It isn't always easy to be open. One time I went to Rwanda where I was not allowed to address a Christian rally because of my HIV positive status. My daughter has been taunted at school. But most of the time it is okay. I buy condoms in the local shops and sometimes people see me and say, "Hey, here's a reverend buying condoms!" I just say, "Don't be excited. I am a person living with HIV. I am married, that's why I need to buy condoms." '

- *Nigeria*: The Nigerian church is helping to sensitise the clergy and bishops in the area of pastoral care and support. Because HIV/AIDS is the new "growth-industry" of Nigeria, it is critical that the church has the latest and most accurate information to correct local myths and profiteering. To model the role of the church in the larger community an HIV/AIDS committee was established in 2002 at the provincial office of the Archbishop of Nigeria. The committee has had limited success to date. Some

Nigerian dioceses such as Jos, Awka and Enugu have taken the lead by developing education, care and support and prevention programmes. These dioceses have shown that firm leadership and the ability to develop a theology of HIV/AIDS that encourages inclusion and mutual support are paramount in the effective delivery of HIV/AIDS programmes. These diocese are now taking steps to share their experience with other dioceses in Nigeria.

- *Ghana:* The Church is providing HIV/AIDS awareness education and counselling training for clergy, while youth groups receive peer education. HIV/AIDS prevention training is also offered to Sunday school teachers and class leaders. Voluntary church leaders are also being trained so that HIV/AIDS can be discussed by all sectors of the congregation. Finally, the state-sponsored HIV/AIDS counselling manual has been sent to all dioceses to ensure continuity between the churches and the government-sponsored HIV/AIDS prevention programmes.

Ama's Story

"Ama is a 14 year old on the brink of a sexual health and social crisis. She needs urgent support but many religious leaders and groups are extremely uncomfortable with issues related to sexuality and the churches have made little or no impact against the traditions that encourage promiscuity in Ghana. Most of the church leaders have never even discussed HIV/AIDS with their churches and many young people find their parents and teachers ill equipped or afraid to teach them about sexual issues."

USPG, Ghana

- *Tanzania*: The Church has openly discussed the efficacy of condom use and endorsed their use. Home-based care and *Living with Hope* seminars enable clergy and laity to care for the sick and dying. Discussions are under way to create voluntary counselling and testing programmes through the Church.

- *Democratic Republic of Congo*: Despite concerted efforts to bring peace to this region, an ongoing war continues to disrupt civil

society. Nonetheless, HIV/AIDS work goes on. The church is engaged in hands-on care and voluntary counselling and testing.

- *Burundi*: After years of domestic conflict and war, the clergy met for the first time in August 2002. They talked about HIV/AIDS and the response to the epidemic across their province. The Church has also provided food, shelter and HIV/AIDS education as part of its activities in resettlements aimed at stabilising a war-ravaged population.

- *Rwanda*: The Church is offering direct assistance through support groups. Groups have assisted in the purchase of decent and clean homes for parishioners. Other groups are involved in combating stigma. Finally, the church in Rwanda is developing family-focused ministries, which work to support behavioural change for all ages.

- *Central Africa*: HIV/AIDS is included in the theological curriculum for pastors, while the province covering Botswana, Zimbabwe, Zambia and Malawi is also promoting voluntary counselling and testing. For children orphaned by HIV/AIDS, the Zambian church has developed a school-based integration programme that assists them and their recipient institutions in returning to school.

- *Zimbabwe*: The 109 Clergy, Pastors and Laity from 59 Christian denominations in Zimbabwe, together with representatives from the ecumenical community in South Africa, met on 10 - 12 September 2003 and made the following statement: " We are mindful of the pain and suffering that has been caused by the deadly HIV/AIDS pandemic and hereby reaffirm our commitment to raising awareness, combating further infections and protecting the infected and affected from stigmatisation in Zimbabwe."

42. Aware of this background the remaining parts of this section focus on the Church of the Province of Southern Africa.

Church of the Province of Southern Africa

43. The Church of the Province of Southern Africa (CPSA) covers the countries of South Africa, Lesotho, Mozambique and Namibia. CPSA

has over the last three years launched one of the most comprehensive Church based programmes to combat HIV/AIDS. CPSA has a current membership of 10 million baptised people, and is composed largely of the rural and urban poor, among whom the Church's historic mission developed. As has been shown in previous sections of this report Sub-Saharan Africa is the worst affected region globally, with South Africa specifically disadvantaged by the epidemic's impact.

44. With the initiative offered by CAPA, the Church of the Province of Southern Africa have developed further their health care programmes to combat HIV/AIDS. It is using the Boksburg vision statement and its six building blocks as their guiding principles for ministry. Recognising the potential of the CAPA plan but aware of the financial implications of implementing the project in Southern Africa, Christian Aid (CA) approached the DfID for funding. The proposal was put to DfID in December 2002 and the sum of £3.5 million, part of the £7 million budget for civil society allocated by the DfID Multi-Sectoral Framework was awarded to the CPSA through CA. This represents the largest donation from UK government to a single faith based community and thus demonstrates a new way in which the Anglican Communion can play a role in the fight against HIV/AIDS.

45. The money has been allocated, and the project is now operational. The project aims to:

- Educate and inform church community about the issues.
- Strengthen and support grassroots ownership and responsibility for addressing these issues.
- Implement and learn from pilot projects.
- Enable the community, through the creation of 'AIDS friendly' churches, to advocate for change, provide effective HIV prevention and comprehensive care and support, in collaboration with other Faith Based Organisations and actors working on HIV/AIDS.
- Raise these issues and influence policy and practice at government level.
- Disseminate the principles of this model across Africa, the Anglican Communion and beyond.

CPSA's implementation of the *Action Plan for Africa* remains in its early stages. Whilst it is too early to visualise the nature of a second phase (beginning 2006), the current project would seem to lend itself

towards more ecumenical and inter faith involvement. Whether further progress can be made is dependent on securing further funding.

SECTION 6 - WHAT ROLE FOR THE CHURCH OF ENGLAND?

> No progress will be achieved by being timid, refusing to face unpleasant facts or prejudicing our fellow human beings – still less by stigmatizing people living with HIV/AIDS. Let no one imagine that we can protect ourselves by building barriers between "us" and "them". In the ruthless world of AIDS, there is no us and them. And in that world silence is death.
>
> Kofi Annan, UN Secretary General, 1 December 2003

46. Conscious of the efforts of the African churches in Africa in combating HIV/AIDS, but aware of the difficulties that some churches have in grappling with this problem, how best can the Church of England support the development of HIV/AIDS programmes in Africa? To answer this question it is necessary to understand the nature of the Church of England's existing involvement in this field. The following section documents the work of the mission and development agencies as well as dioceses.

HIV/AIDS and Ethical Investment

47. HIV/AIDS represents arguably the major human tragedy of our time. It has an all-encompassing impact on people's lives, including the income, poverty and economic growth prospects for nations heavily affected by the epidemic. It therefore means that any company with substantial operations in these areas will have to consider what their responsibilities are, as well as the impact on their business.

48. The Ethical Investment Advisory Group (EIAG), which offers ethical investment advice to the three main Church of England investment bodies, encourages the three bodies' investment managers to take a proactive and positive approach and engage with the companies in which they invest over non-financial issues, such as HIV and AIDS.

49. The Group is of the view that companies that take environmental and social factors into consideration, will tend to be the better managed and therefore provide better investments over the long term. The engagement process helps companies in understanding the risks and challenges they face. It makes good business sense to respond in a proactive manner to the epidemic; helping to reduce risk, soaring

costs and staff turnover. In turn, those suffering are provided with better education, counselling and treatment and a greater chance of improving and prolonging their lives.

50. HIV and AIDS will undoubtedly weigh heavily on the profitability of any company that derives a large part of its business from heavily infected countries. Some of these impacts may include:
- Increased costs and adverse impact on business overall
- Higher labour turnover
- Higher health insurance & funeral benefits
- Reduced labour productivity
- Increased absenteeism
- Lost experience & skills
- Recruitment and training costs
- Lower morale as a result of illness, suffering and loss of colleagues, family and friends
- Declining markets and threats to consumer base

The EIAG will continue to encourage the Church's investment bodies to consider the risks HIV/AIDS poses to the companies in which they invest, and encourage companies to be active and responsive in the debate.

Dioceses

51. Over the last twenty years there has been a significant growth in the number of English dioceses that have companion or twinning links with other dioceses or provinces of the Anglican Communion. These relationships were first established to encourage prayer, fellowship and sharing in mission between differing parts of the Anglican Communion. Although there is great variety in the range of diocesan companion links, common to all is the desire to assist the companions to get to know each other, and learn from each other and to assist each other in their mission where they are set. These diocesan companion links provide immense potential for development education and for raising awareness within English dioceses as to the conditions and challenges faced by oversees dioceses and provinces.

52. Not surprising the challenge posed by HIV/AIDS features on the mission and development agenda of many English dioceses that have links with dioceses and provinces in Africa. The Diocese of

Blackburn, for instance, used its 2002 Harvest appeal to raise £32,000, for HIV/AIDS projects for the Diocese of Bloemfontein. Similarly, the proceeds from the Bishop of Chelmsford's 2004 Lent Appeal will support the work of four mission agencies in their HIV/AIDS work.

53. Whilst financial support for projects in the link country constitutes a major part of the HIV/AIDS related work for dioceses in this country, there is a strong awareness of the need for greater personal relationships between companion links. This is demonstrated through the number of exchange programmes that bring people from Africa to England and vice-versa. A recent visit by Southwell Diocese to Natal has led one parish to work on a fundraising initiative to support orphanages by making provision for health care workers to visit the UK for study sabbaticals.

54. These face to face encounters enable English dioceses to organise development education seminars through which they can raise awareness as to the challenges posed by HIV/AIDS. The Diocese of Winchester, for instance, organised an AIDS awareness day on February 7th, 2004. The aim of this initiative was to develop a diocesan HIV/AIDS strategy that included advocacy as well as financial support. Similarly, Southwark Cathedral holds an annual service to mark World AIDS Day.

55. The benefits of exchange and development education programmes cannot be emphasised enough. While it is clear that many dioceses have developed high levels of awareness as to the impact of HIV/AIDS on their overseas partners, some diocesan thinking remains in an embryonic stage. Aware, however, of the contribution that some English dioceses have made to combating the stigma within their own context, it is evident that they have much to offer in helping churches in Africa develop similar programmes.

Mission Agencies

Church Mission Society

56. CMS's HIV/AIDS work focuses on the need for advocacy for social transformation. It has developed advocacy programmes with partner churches in Burundi, Rwanda, Kenya, Uganda, Tanzania, Nigeria and the Democratic Republic of the Congo. It hopes to expand these

programmes to other countries like Zambia, Malawi and Zimbabwe. Advocacy projects consist of three inter-related priorities. First to encourage and support the national co-ordinator for HIV/AIDS. Second, to support the national strategy of the churches engaging with the issue. Third, to ensure that this strategy is implemented at a local level. These advocacy projects are designed to assist partner churches to respond locally and nationally to the HIV/AIDS crisis.

Sitsofe's Story

Sitsofe, a 15- year-old girl, and her brother Sellasie (aged 10) live in Sokode-Etoe in the Volta region of Ghana. Their father died eight years ago and their mother three years later. Their grandparents, Richard and Mabel Belle, look after them. Richard is 73 and going blind. The couple have lost two sons to HIV and they are struggling to find the money to care for their two orphaned grandchildren.

Sitsofe says: "Being brought up by my grandparents makes me very sad. My father promised me that I would be well educated but that promise can't be kept because he is dead. Although my friends support me and I can talk to my grandparents I feel very sorry for myself. I have lost all the happiness in life and I won't be able to achieve my ambition to be a nurse. I don't want to get married because I'm afraid of getting HIV."

Mission to Seafarers

57. With centres in over 100 ports across the globe the Mission to Seafarers is well aware of the HIV/AIDS issue at a global level. Their HIV/AIDS work centres around two themes. First, combating stigmatisation by providing counselling to HIV positive seafarers. Often the only available ear is that of the mission chaplain in whichever port the seafarer might find him or herself. Second, distributing literature and educational material for HIV/AIDS prevention which is available in eleven languages. They work with other organisations in using their networks to distribute educational material through the network of Christian Maritime Ministries. This collaboration has led the Mission to Seafarers to work with several different HIV/AIDS prevention projects undertaken by ship-owners, port health systems, unions and government who need a presence on

the ground, in the ports, to ensure that the information reaches the target audience.

United Society for the Propagation of the Gospel

58. USPG's health programme is informed by the individual needs of the local church through their links with the relevant dioceses and provinces in Africa. USPG provides long-term support to ten hospitals and forty smaller clinics or primary health care programmes, all of which to varying extents provide care for people living with HIV/AIDS. As part of this support it provides protection packs to the hospitals which contain HIV test kits, primarily used to prevent HIV transmission through blood transfusions. USPG helps fund HIV/AIDS projects in Ghana, Angola, Mozambique, Namibia, South Africa, Swaziland, Zimbabwe, Malawi, and Tanzania. Such projects include youth counsellors training workshops, home-based care programmes, AIDS prevention programmes, funding towards health surveys, clergy and laity training workshops on HIV/AIDS.

> "Lindiwe has lost her three daughters through AIDS and now cares for her six grandchildren. They live in one room in a mud and stick house. Two other rooms are let out to bring in a small income. She relies on neighbours to supplement their food and provide clothing for the family. There are no welfare benefits or free education and she has to rely on charity for the latter."
>
> USPG, Swaziland

Mothers' Union

59. The Mother Union's (MU) HIV/AIDS strategy is implemented through initiatives led by MU branches across Africa. Their strategy aims to provide health care provision to churches across Africa. This ranges from healthcare prevention and treatment, education and training programmes. The MU works with CPSA in providing community support, provision for the welfare of orphans and awareness training as to the rights of women's rights. The MU is also engaged in developing an effective advocacy strategy. This entails making creative approaches to the British government as well as to

the UN where it has consultative status on the UN's Commission on the Status of Women.

Development Agencies

Christian Aid

60. Christian Aid, the official ecumenical relief and development agency of the British and Irish Churches, recognises HIV/AIDS as one of the most serious global development challenges and as the leading cause of death in Sub-Saharan Africa. As such it is actively involved in combating the HIV/AIDS pandemic in Sub-Saharan Africa. Christian Aid's HIV/AIDS strategy covers four areas:
    - Effective education and awareness raising – equipping staff, partner organisations and supporters with the knowledge and skills necessary to address HIV/AIDS.
    - Strengthening community-based prevention care and support
    - Mainstreaming HIV/AIDS in all their work – ensuring HIV/AIDS is considered in their work to eradicate poverty and challenge inequality
    - Global advocacy - lobbying, influencing and campaigning for national and international responses that are informed by, complement and strengthen community based efforts.

    In implementing this strategy CA works through church based partners who it believes have a catalytic role to play in bring prevention and care to the poor and vulnerable in communities.

Tearfund

61. Tearfund works closely with a number of dioceses in several countries (Angola, Botswana, Madagascar, Malawi, Mozambique, South Africa, Tanzania and Zambia) on HIV/AIDS related programmes. Their work focuses on education and awareness raising through school and church clubs. Other projects concentrate on capacity building within the local community. They offer training to women volunteers and carry out needs assessment studies relating to different projects. Church committees have been formed to receive and distribute material. Tearfund is also engaged in fighting stigma by challenging congregations to embrace and care for those living with HIV through

grant programmes assisting children and vulnerable families affected by HIV/AIDS.

SECTION 7 – CONCLUSION: THE BODY OF CHRIST HAS AIDS

> "We the Anglican Communion, pledge ourselves to the promise that future generations will be born and live in a world free from AIDS."
>
> Statement by the Primates of the Anglican Communion, Canterbury, April 2002

A Renewed Vision

62. This report has shown the potential behind *Action Plan for Africa* in terms of witnessing to the influence of the Christian faith in a society racked by HIV/AIDS. Building on the visionary statement issued by the Primates at Canterbury in April 2002 and the practical steps taken by CAPA in implementing this vision, the Church of England, at all its levels, needs to commit itself both to the vision and to the implementation of this Anglican Communion project. In doing so the Church of England needs to acknowledge, as the Primates of the Anglican Communion accepted at its meeting in Brazil in May 2003, that the "Body of Christ has AIDS".

Communication and Co-ordination

63. The Primates' statement of April 2002 recognised that "*co-ordinated and joint action is the only way to address the enormity of this challenge"*. The Church of England through its mission and development agencies and diocesan companion links is actively engaged in supporting the work of many overseas HIV/AIDS projects in Africa. However there is a scope for greater communication and co-ordination between the different components of the Church of England. Despite the potential offered by *Action Plan for Africa,* this Anglican Communion initiative does not feature as highly on the Church's agenda as it could. There needs to be greater communication and coordination of efforts than has hitherto existed between CAPA and the Church of England mission agencies, development agencies and those dioceses with companion links in Africa. This communication and coordination is probably best handled through the Partnership for World Mission.

Raising Awareness – World Aids Day

64. The ability of the Church of England to become a true partner to CAPA as it implements the *Action Plan for Africa* is dependent on raising awareness within the Church as to the predicament in which African churches find themselves. As part of the process of development education dioceses should consider organising events and activities around World AIDS Day on 1 December 2004 and in succeeding years. The MPA Division's Community and Public Affairs Unit should work with appropriate development and mission agencies to produce relevant educational material to support the wider Church in this task.

Advocacy

65. Much of the ecumenical advocacy work regarding international development has focused in recent years on realising the Millennium Development Goals. It is clear, however, that without a concerted effort to combat HIV/AIDS in Africa, and other parts of the world, these targets will remain a distant promise. Combating HIV/AIDS therefore needs to be a key feature in any advocacy strategy adopted by the Church nationally and locally. Within any such strategy particular attention should be given by the MPA Division's Community and Public Affairs Unit to pressing the Government to:
    - Increase funding for HIV prevention, care treatment and impact mitigation, both through the Global Fund and through other channels, to a total of £750 million a year.
    - Urge the World Bank/IMF to consider the impact on HIV before economic policy recommendations are made to developing country governments.
    - Support civil society groups (including churches) advocating for increased response to HIV in their countries or regions

Appendix 1

UN MILLENNIUM DEVELOPMENT GOALS

By 2015…

1. **Eradicate extreme poverty and hunger**
- Reduce by half the proportion of people living on less than one dollar a day.
- Reduce by half the proportion of people who suffer from hunger.

2. **Achieve universal primary education**
- Ensure that all boys and girls complete a full course of primary schooling.

3. **Promote gender equality and empower women**
- Ensure girls have the same chance to receive education and be treated as fairly as boys in primary and secondary schools by 2005, and at all levels by 2015.

4. **Reduce child mortality**
- Reduce by two thirds the proportion of children dying before they are five years old.

5. **Improve maternal health**
- Reduce by three quarters the proportion of women dying as a result of having children.

6. **Combat HIV/AIDS, malaria and other diseases**
- Halt and begin to reverse the spread of HIV/AIDS, the incidence of malaria and other major diseases.

7. **Ensure environmental sustainability**
- Integrate the principles of sustainable development into country policies and programmes; reverse the loss of environmental resources.
- Reduce by half the proportion of people without sustainable access to safe drinking water.
- Achieve significant improvement in the lives of at least 100 million slum dwellers, by 2020.

8. **Develop a global partnership for development**

Appendix 2

STATEMENT OF ANGLICAN PRIMATES ON HIV/AIDS, CANTERBURY, APRIL 2002

1. We, the Primates of the Anglican Communion, gathered in Canterbury, have received a report from the Council of Anglican Provinces in Africa on the impact of HIV/AIDS on the African continent. The presentation was led by the Archbishop of Cape Town, the Most Reverend Njongonjulu Ndugane, who was mandated by the Primates in March 2001 to co-ordinate a Communion-wide strategy to address this immense global crisis of human suffering.

2. The HIV/AIDS pandemic affects every region of the world. It is however, the poor who are hit hardest. It is the poorer nations, already weakened by the burden of debt, who need our support the most. This problem is not localised in one area of the world. It is a problem of increasing seriousness across the Global south, in many countries of Asia and the Pacific, Africa and Latin America. However, we have given particular attention in our commitment to the continent of Africa because it is in African nations that women, men and children are living with and dying from HIV/AIDS in greatest numbers. It is in Africa that the disease's destructive effects on social and economic growth and development are most deeply felt.

3. We are grateful to Archbishop Ndungane for the leadership he has accepted on our behalf and commend the other African Primates and churches for the direction they have given us. Recognising his strategic position within South Africa and within the Council of Anglican Provinces of Africa, we are pleased to re-mandate the Archbishop of Cape Town to spearhead our policy development and global strategy.

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

5. Our concern over this crisis arises from our ministry as pastors of God's people. We are called to this ministry by our God, the God of love. As pastors we are called to walk with those who are affected by this disease, to offer support and compassion and bring the Christian message of love, forgiveness and hope to the world. We are inspired and guided by the example of our Lord Jesus Christ who ministered to all without fear or discrimination.

6. We also have a solemn duty to speak a word to the world of the scale of this crisis. We wish to encourage collective action with government and non-governmental organisations, development programmes, health and pharmaceutical agencies and with Christians and people of good will everywhere. We believe that such co-ordinated and joint action is the only way to address the enormity of this challenge, and express our regret that certain governments continue to criticise those who lead us in this prophetic witness.

7. We would remind both governments and pharmaceutical companies that it is a basic human right that all who require treatment have access to that treatment. We affirm, therefore, that safe and effective pharmaceutical treatment should be more widely available to alleviate suffering and extend life, and join our voice to the Secretary General of the United Nations in his plea that the profit motive not override the urgent humanitarian need for readily available and cheaper drugs.

8. We call upon our churches to stand compassionately with those who are living with the disease, those who mourn and those who are dying. We encourage a realistic and Christian approach to funeral practices, so that families are not pauperised by bereavement.

9. We seek to guide and educate our people in prevention of the disease and encourage Christian teaching which is frank and factual about abstinence and faithfulness. We reaffirm the teaching of the church on marriage and commend the value of this God-given sign of committed and covenantal love.

10. We are committed to develop a global response to the HIV/AIDS pandemic and encourage a sharing of financial resources through the Anglican Consultative Council to provide assistance to churches seeking to develop strategies and programmes to address this crisis.

We will also seek to facilitate access to international funds which will support such programmes.

11. We commend the six-fold response to HIV/AIDS which has been agreed by the All Africa Anglican AIDS Planning Framework to churches beyond Africa in their strategic planning and policy development to confront this crisis and minister among all affected with this disease.

12. We believe that for this task Christians are sustained by the love of God the Father, the work and example of our Lord Jesus Christ and the grace of the Holy Spirit.

Appendix 3

ANGLICAN CONSULTATIVE COUNCIL 12
RESOLUTION ON HIV/AIDS, HONG KONG, SEPTEMBER 2002

1. Receives the report on HIV/AIDS and expresses its appreciation for it and the leadership of the Most Reverend Njongonkulu Ndungane, who has been tasked to lead the Communion's efforts in this regard;

2. Affirms the Primates' Statement on HIV/AIDS issued in April 2002 at the meeting of the Primates in Canterbury, and commends its widest possible circulation through the churches of the Anglican Communion;

3. Encourages the churches throughout the Communion to make awareness of HIV/AIDS a priority, and to undertake gender-sensitive education and information programmes to alert and protect their respective communities and nations;

4. Urges each church of the Anglican Communion to develop and adopt a plan of action in response to the HIV/AIDS pandemic by ACC 13 in 2005, and report on what has been achieved;

5. Applauds the efforts of the Council of Anglican Provinces in Africa (CAPA) to co-ordinate and lead HIV/AIDS ministry response across sub-Saharan Africa;

6. Recognises and endorses those efforts, both within government and private sector on the continent to Africa, to develop vaccines and make life-saving treatments available to all people living with HIV/AIDS;

7. Thanks the Compass Rose Society for its proactive leadership and financial support in launching the All Africa Anglican Conference on HIV/AIDS in Boksburg, South Africa, in 2001, and acknowledges the outstanding leadership of the Archbishop of Canterbury, the Most Reverend George Leonard Carey, for his inspired and courageous leadership in bringing the Anglican Communion to an awareness of this unfolding catastrophe;

8. Extends gratitude for the financial and technical resource efforts of the international donor community and faith-based charities in supporting and sustaining HIV/AIDS programme efforts within the Anglican Communion, which educate, build capacity to respond, and alleviate suffering around the world;

9. Calls upon the churches of the Communion to support and assist with church resources, human and financial, and provide technical assistance in meeting the challenges of this pandemic to bring about a generation without HIV/AIDS;

10. Requests that the Secretary General of the ACC establish an Anglican Communion Office-managed Anglican Communion AIDS Fund.

Appendix 4

STATEMENT FROM THE ALL AFRICAN ANGLICAN HIV/AIDS PLANNING FRAMEWORK, BOKSBURG, SOUTH AFRICA, AUSGUST 2001

1. Our Vision

We, the Anglican Communion across Africa, pledge ourselves to the promise that future generations will be born and live in a world free from AIDS.

2. God's call to transformation

We are living with AIDS. As the body of Christ, confronted by a disaster unprecedented in human history, we share the pain of all who suffer as a result of AIDS. Faced by this crisis, we hear God's call to be transformed. We confess our sins of judgement, ignorance, silence, indifference and denial.

Repenting of our sin, we commit ourselves to:

- Breaking the silence in order to end all new infections
- Education ourselves at every level within the Church
- Confronting poverty, conflict and gender inequalities
- Ending stigma and judgement, and
- Holding ourselves accountable before God and the world

Only then can we live out the Good News of the all-embracing love of Christ.

3. Our mission

Our mission is to respect the dignity of all people by:

- Securing the human rights of those infected by HIV/AIDS, and giving unconditional support
- Improving the health and prolonging the lives of infected people

- Accompanying the dying, those who mourn and those who live on
- Celebrating life
- Nurturing community, and
- Advocating for justice.

We acknowledge that we cannot do this alone. We are sustained by the love of God and emboldened by the Holy Spirit. We are inspired by the compassionate efforts of the faithful in attending to those affected by HIV/AIDS. We accept the responsibility of our leadership. We invite the wider community into creative, life-giving partnership.

4. Our commission in the context of AIDS

We believe we are created, in the image of God, as physical and spiritual beings. We are created to be in relationship to God, the community and ourselves. We believe that we are given the freedom to make choices, to love, to celebrate, to live in dignity and to delight in God's creation. We believe that suffering and death are neither punishment from God nor the end of life and that we are called to an eternal union with God.

Stigma is a denial that we are created in the image of God. It destroys self-esteem, decimates families, disrupts communities and annihilates hope for future generations. We commit in all our efforts – personal and corporate, programmatic and liturgical – to confront it as sin and work for its end.

Given who we are, and who we are called to be by God, we have defined and embraced a six-fold commission of ministry in response to AIDS.

These six calls in our commission are:

4.1 Prevention

The Church's commitment to prevention recognises that all life is sacred. Because we love our children, we speak and act to protect them from infection. Sex is a gift from God. We are accountable to God and one another for our sexual behaviour. Christian communities have a special responsibility and capacity for encouraging and supporting, loving, just, honest relationships.

4.2 Pastoral Care

Pastoral care supports spiritual growth with the aim of sustaining whole and holy relationships with God, each other and community. This is achieved by affirming the dignity and worth of each human being and making clear the claim of God in our lives.

4.3 Counselling

Christian counselling equips people to live into God's invitation to wholeness, freed of the burdens of the past, and capable of moving in freedom toward the perfection promised in Christ's example with confidence and determination.

4.4 Care

In caring for all who suffer, we fulfil God's purpose by restoring dignity and purpose to people's lives. Christian care, therefore, seeks the fullness of life, in the context of the community, by the restoration of body, mind and spirit.

4.5 Death and dying

Death is a rite of passage in our spiritual journey and into eternal life. The call of all Christians is to uphold the dying by our love, as well as those who live on and those who mourn.

While death brings suffering and loss, our faith can make it a time of enhanced relationship and growth for individuals and communities. We are a resurrection people and our relationship with God does not end with the death of physical bodies.

4.6 Leadership

All authority is accountable before God. All people of the church are stewards of God's creation. We have a unique responsibility to speak truth to power, to act without fear, and to embody Christian values of love, compassion and justice.

Appendix 4

5. Our Response

5.1 Prevention

Out of love for our children, one another and our communities, we commit to speak openly and with moral authority about responsible sexual behaviour, and to support one another, embracing and adopting behaviours that avoid the transmission of HIV.

5.2 Pastoral Care

As the embodiment of the merciful Christ in a suffering world, we commit to equip our clergy and laity to support all people, especially those living with HIV, in life-sustaining relationships with their God and their community.

5.3 Counselling

We commit to promote voluntary counselling and testing for HIV by our own examples and as a ministry of the Church. We call for the establishment of support groups and other counselling services for those who are orphaned, ill, afraid, dying or bereaved.

5.4 HIV Care

We commit to being central to networks of community support, to meet the health care and basic needs of those who are orphaned, ill or excluded due to HIV, freeing them to productive life as long as their health permits.

5.5 Death and Dying

As death transforms the body, AIDS calls us to transform those traditions and practices, by which we care for the dying and honour our dead, that consume scarce resources and contribute to denial.

We commit to:

- Training the Church to provide holistic care for the dying and prepare families for living on

- Offering rituals that honour the dead and promote the well-being of those who survive
- Training the clergy to counsel and protect the rights of those who survive, especially women and children.

5.6 Leadership

Silence permits inaction and is the breeding ground of stigma. We call for bold, compassionate community and institutional leadership at every level, to prevent infection and care for the ill and dying. We invite similar leadership by government, and all sections of society and international partners.

Because leadership must address power, culture and morality, we call on our government leaders to be accountable for health expenditures and to declare an 'HIV state of emergency', in order to combat AIDS and mobilise resources. We further declare that all people have the right to health, which includes access to basic health care.

HIV calls for bold and creative approaches by our leaders, which recognises the reality of power and gender patterns at community levels, and mobilise resources and facilitate development of new models of leadership, particularly among laity and women.

5.7 Education and training

Nothing in our educational systems equips to deal with this catastrophe. In achieving the strategies outlined in the document, it is essential to assess needs and establish education and training capacity, in order to assure that sufficient numbers of clergy and laity:

- Have current and accurate basic information on the science of HIV, standards of home-based care, and the rudiments of treatment.
- Have both the technical information and the interpersonal communication skills to effectively teach and counsel regarding human sexuality.
- Are knowledgeable of local laws and practices regarding inheritance and equipped to impart that information.

- Receive practical training in community organisation and development, so that they may assist in establishing care and support which is needed.
- Are trained and available to meet exploding demands for pastoral care necessitated by HIV/AIDs.

5.8 Theological reflection

As the Church, it is uniquely our task to gather for study, for prayer and for worship. Therefore we much engage in constant theological reflection, seeking discernment on the issues of sin, guilt, grace, judgement and forgiveness. To this we commit ourselves, our families and our friends.

Appendix 5

USEFUL RESOURCES

Agency Resources

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Church Mission Society, *Action Against Aids*, (2002).
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