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For a life with dignity

**The global threat of HIV/AIDS:
possible courses of action for the Church**

**A Study
by the Evangelical Church in Germany's Advisory
Commission on Sustainable Development**

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Foreword

Since the first recorded appearance of HIV/AIDS a quarter of a century ago more than 60 million people have become infected with the virus, over 25 million of whom have died. AIDS is still an incurable disease and causes untold suffering. It often leads to lack of prospects, not only for AIDS sufferers, but also for their relatives and families.

In many parts of the world AIDS*¹ has become the leading cause of death for adults. In the worst affected regions this has led to dramatic falls in life expectancy. It is also thwarting many of the efforts to improve economic and social development in the poorest countries. Christians and Churches cannot remain unmoved by premature deaths and lives lived in deprivation and dependency².

In recent years a series of Church statements have been issued on HIV and AIDS. The last publication of the Council of the Evangelical Church in Germany (EKD) was called "AIDS: orientations and paths to danger" in 1988³. Since then, however, the pandemic* and its dramatic consequences have changed radically, making a new study seem necessary.

In Germany, awareness of HIV and AIDS has dropped dramatically. After initial fears that Germany too would experience a massive epidemic*, the disease is now once again seen as a disease that "other people" get, which does not strike a particular chord with the German public. Less and less is being invested in prevention* and education, and many people have been lulled into a false sense of security by new treatment options. Yet there is no basis for sounding the all-clear. AIDS remains a fatal illness that kills approximately three million people every year. Even in Germany and other wealthy countries, the disease can only be alleviated, not cured.

Although the infection rate in Germany can be said to be very low in comparison to other parts of the world, that does not mean that HIV/AIDS is "other people's" problem. This is particularly true from a Christian perspective, for the Church is a community in which, as members of the body of Jesus Christ, the healthy and the sick, those affected directly and indirectly by HIV/AIDS and people who are not sick themselves are accepted as being of equal value and equal dignity, and support one another in solidarity. Christians also apply this approach to society; for the dignity of human beings is indivisible. Yet all too often those infected with HIV and even their families have been and are excluded; even in Churches this happens time and again. In discussions with church partners around the world we must therefore continue to remind one another that in local communities and in the global Christian community we belong to a single body of Christ that knows no exclusions - including

¹ Terms marked * are explained in the glossary at the end of this study.

² See the explanation of the Central Committee of the World Council of Churches of February 2006: HIV/AIDS – Loving one's neighbour as a basis for action, EKD-Texts 39/2006, 32-36.

³ AIDS, Orientations and paths to danger. A Church Position Statement, published by the EKD Church Office, EKD- Texts 24, 1988.

on the basis of a certain infection or an incurable disease. Instead, the Church is characterized by compassionate solidarity: when one member suffers, then everybody suffers with them. Christians and Churches today must be as steadfast in their dedication to those afflicted by HIV/AIDS as Jesus was in his continual dedication to those who were excluded from society due to their illness, the lepers and the lazars.

In all the societies of the world, HIV/AIDS is exploding the societal taboos and misunderstandings that promote the spread of the disease. The disease makes it necessary to examine issues of sexual orientation, the right to self-determination of husband and wife, drug addiction, poverty, exploitation and sexual violence. Consequently, a statement by the Church cannot confine itself to looking only at the aspects of HIV/AIDS that relate specifically to the disease itself, but must also consider social, economic and ethical issues. This disease is no one's fate, but is preventable and treatable. Churches throughout the world make an important contribution to this. In many African countries Churches provide up to 60 % of national health care.

People with HIV/AIDS expect solidarity and community; they expect support in their fight for life. For their part, those who are potentially threatened and directly affected by HIV/AIDS must turn to the community and take responsibility for their lives. This is what this study by the EKD Commission on Sustainable Development hopes to encourage.

The EKD Council thanks the Commission on Sustainable Development for developing this well-researched study, which it hopes will find broad and intensive resonance in Germany and the global ecumenical community.

Hannover, 13 June 2007
Bishop Dr. Wolfgang Huber
President of the EKD Council

1. Designed for dignity, called upon to take responsibility, made to be in community

The belief in God the Creator, the Redeemer and the Reconciler is at the heart of Christian theology; it gives direction to all speech and action. Belief in the Triune God highlights humankind's indivisible dignity, our responsibility towards others and our lasting relationship in community that sustains us. Faith provides both a critical standard and the foundation and motivation for all those who engage in our Churches and in social responsibility. This applies particularly to the Churches' examination of the issues that arise from the fact that HIV/AIDS has become around the world a threat to people's personal lives, social relationships and important cultural achievements.

1.1 Designed for Dignity

It is a fundamental tenet of Christian belief that God bestows indivisible dignity on every human being. This human dignity is the basis of human coexistence and of all human rights. Political, economic, social and cultural rights set down what every person needs and should not be violated under any circumstances.

From a Christian viewpoint, the indivisible dignity of human beings is rooted in the fact that human beings are made in God's image. Human beings are called upon by God to preserve and protect God's creation. This is justified biblically by reference to the first account of creation: "So God created humankind in his image, in the image of God he created them; male and female he created them. God blessed them, and God said to them, 'Be fruitful and multiply, and fill the earth and subdue it; and have dominion over the fish of the sea and over the birds of the air and over every living thing that moves upon the earth' (Genesis 1: 27-28). In this account of creation humankind is understood as being in God's likeness. Humankind is spoken to by God and is expected to respond to Him. Humankind has a calling and is called in freedom into community with God. The earth is entrusted to humankind in order that human beings might use it responsibly. It is this that confers indivisible dignity on humankind.

Being made in God's image is therefore not based on human beings' biological make-up, but on God's continuing promise. It is through this relationship to God that human beings earn respect as human beings – i.e. every person at every stage of his or her development and in every facet of his or her being – because each individual receives God-given dignity. It is this indivisible dignity of humankind that provides the foundation for and driving force of all church efforts and socio-ethically based examination of the current AIDS pandemic. Christian theology speaks up for the dignity of human beings where it is not being respected.

1.2 Called upon to take responsibility

From the Christian viewpoint, dignity belongs to all human beings not because of something within them but because God bestowed on humankind indivisible dignity by making us in his own image. Human dignity is also founded on the covenant of the Gospel of God's love, which was revealed in Christ and is in every human being – especially the weak and the mourning (Matthew 5, 4). For in Christ himself, God revealed himself as a God that did not turn away from suffering, weakness and death, but who suffered and in so doing took away the last power of suffering and death.

God's powers are attested to in the life, death and resurrection of Jesus Christ. Jesus' death on the cross is a demonstration of humankind's alienation: the hopelessness of our situation before ourselves and before God, our entanglement in guilt and alienation are concentrated in Jesus' death on the cross. Through Jesus Christ, God works face to face with humankind.

Face to face also with sin and guilt, paralysis and alienation there is the call to freedom, and the vocation of humankind to become a "new creation". Even as sinners and in guilt, human beings, since they are made in the image of God, are called upon to take responsibility for themselves and others and are free to love.

1.3 Made to be in community

Christian faith in the Triune God believes in the living power of the Holy Spirit. Human beings are touched by the work of the Holy Spirit, who through the "community of God" binds them in to the rest of humankind and to the earth that was created alongside them.

Called upon to be in community with humanity and with creation, human beings bear responsibility for the community and the community for the individual. Believing that it is the Holy Spirit who brings people back into community with God and with one another, forms the basis of all efforts by the Church and for Christians to accept HIV/AIDS sufferers among them and to integrate them into the healing and reconciling community of Christians.

2. HIV/AIDS – its spread and the medical basics

2.1 HIV/AIDS and its treatment

AIDS is an immunodeficiency disease in which a distinction is made between infection with the human immunodeficiency virus (HIV) that causes the disease and the onset of actual illness. “AIDS” stands for *Acquired Immunodeficiency Syndrome*. Following infection, the virus attacks and damages the human defence cells. Without treatment, the immune system breaks down and after several years AIDS develops as a disease. AIDS makes the body more susceptible to what are known as opportunistic* infections, which result from the collapse of the body’s immune defences*. These include pneumonia, skin diseases, diarrhoeal diseases and meningitis.

Science currently has no cure for HIV/AIDS. AIDS generally develops eight to ten years after infection occurs. Without treatment, infection with HIV leads to death. However, the progress of the disease can be slowed by means of antiretroviral medicines⁴, which work by inhibiting the ability of the HI virus to multiply in the body, so that the onset of AIDS is delayed or prevented. With the help of medication a person who has already developed AIDS can go back to being HIV-positive without symptoms. Opportunistic infections such as cancer or tuberculosis*, which is the most common opportunistic infection in Africa, are becoming less common.

Since 1996, in Germany and other industrialized countries, different antiretroviral medicines have been used in combination in order to increase the effectiveness of the treatment, which is where the term “combination treatment”* or “combination therapy” comes from. As a result, illness and deaths from HIV/AIDS have been reduced dramatically. HIV-positive people are living longer; at the same time, they have an improved quality of life thanks to the prevention of the illnesses that come with HIV. This means that HIV/AIDS has become, although incurable, a treatable chronic disease, albeit under appropriate conditions, such as those that exist in developed societies.

Antiretroviral medicines are not generally given from the time of infection, but only once the disease has reached a certain stage of development, at the latest at the onset of AIDS. Once somebody starts taking the medicines, he or she has to take them for life. Although infectiousness* remains, it is significantly lessened, as the amount of the virus in the blood (known as the viral load) is reduced considerably.

The effective treatment of people with HIV also requires other elements besides antiretroviral therapies*, namely: an adequate and balanced diet, contraception or the treatment of sexually transmitted and opportunistic infections, and spiritual, psychological and social care.

⁴ See Chapter 3.3.1 Access to antiretroviral medicines

2.2 Routes of transmission

HIV can be transmitted through four different routes of infection:

- unprotected sexual intercourse (vaginal, anal, oral);
- blood and blood products;
- sharing injecting needles or medical instruments;
- mother-to-child transmission.

The likelihood of HIV transmission is quite dramatically different for different routes of infection. Most HIV-infections are sexually transmitted. Sexually transmitted diseases increase the risk of transmission for women and for men. For anatomical and physiological reasons, women are at considerably greater risk of catching the disease from a sexual act with an infected person than men. The risk is particularly high for young girls and in cases of sexual violence. The likelihood of transmission also depends on what stage the disease has reached in the infected person; the risk of passing on the infection is highest in the first weeks after infection and during the untreated advanced stage.

Transmission through sexual intercourse can be prevented through abstinence (no sexual intercourse) or for persons not infected with HIV through a monogamous relationship. The proper and consistent use of condoms also offers considerable protection from infection.

Drug addicts are at high risk of HIV infection, if syringes and needles are re-used. The percentage of new infections resulting from drug use is increasing⁵. It is estimated that 10% of new infections worldwide and one third of those outside Africa are connected with drug use. In many countries, more than 70% of drug users are HIV-positive. Drug addicts can also become infected with HIV through unprotected sex and from an HIV-infected mother to her child. Thus a third of new infections in the United States of America, for example, or a majority of new infections in China are directly or indirectly connected to drug use.

In health care facilities, HIV transmission can occur when HIV-infected blood is given in a transfusion or when needles used for blood are re-used. HIV can also be transmitted from an infected woman to her baby during pregnancy, during the birth or through breastfeeding. The risk of this kind of “vertical” transmission is approximately 30 %. With optimum medical care, such as is found in the countries of Western Europe and the USA, the risk of a mother transmitting the infection to her child can be reduced – by using a variety of measures such as delivery by caesarean section, preventive medication and by not breast-feeding – to less than 2 %.

In developing countries the situation is, despite increasing efforts in recent years, somewhat different. In Africa fewer than 10% of all pregnant women have access to a voluntary HIV test and counselling; antiretroviral medicines are not sufficiently

⁵ For the data on drug use see United Nations Office on Drugs and Crime: World Drug Report 2007 (www.unodc.org/pdf/research/wdr07/WDR_2007.pdf).

available; there is scarcely any possibility of caesarean sections being done; and lastly, for most women not breast-feeding is not an option, as bottle feeding is either not available or is too expensive and the water needed for bottle feeding often carries diseases.

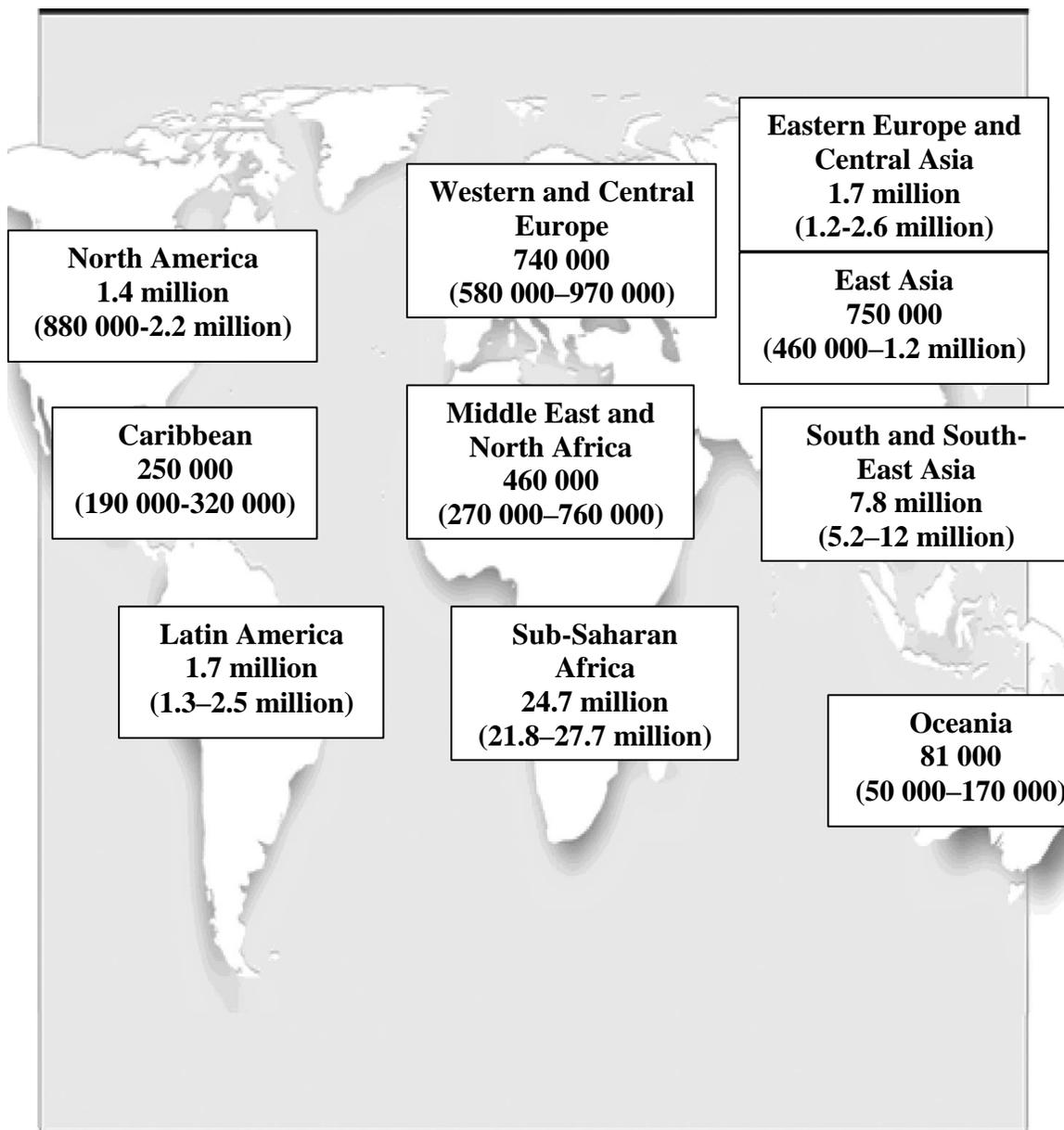
2.3 The Spread of HIV/AIDS

2.3.1 Worldwide

Since the first recorded appearance of HIV/AIDS in 1981, more than 60 million people have become infected with the virus, more than 25 million of whom have died. According to the World AIDS Report 2006 by the United Nations AIDS programme (UNAIDS*) and the World Health Organization (WHO), almost 40 million people were living with HIV and AIDS in 2006, of whom 4.3 million were newly infected with HIV. During the same period, some 3 million people died from AIDS, which equates to approximately 8500 people a day. In many regions of the world, rates of new HIV infections are particularly high among young people (15 –24 years). Forty percent of HIV infections in 2006 occurred in this age group.

The rates of infection have risen continuously since the pandemic began and are still rising. More than 90% of people infected with HIV live in developing countries. On the global scale, the HIV/AIDS epidemic is only in its early stages. The disease has spread like an explosion. What course the epidemic will take in the long term is not yet sufficiently clear. The dynamics of the epidemic must in any event be considered over a timescale of decades.

ADULTS AND CHILDREN ESTIMATED⁶ TO BE LIVING WITH HIV IN 2006



Total: 39.5 (34.1-47.1) million

⁶ All data in the following chapter are taken from the report published by UNAIDS and WHO, "Aids Epidemic Update: December 2006" (http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf); see map on p. 65.

AIDS is an unusual disease in that there is no sign of it reaching a plateau in the way that other epidemics do. In Botswana, Swaziland and other parts of southern Africa the rate of infection in adults has reached approximately 40 % and in places it is still increasing. In recent years the biggest increases have been seen in East Asia, Central Asia and Eastern Europe.

The point in time when the epidemic spreads from the so-called risk groups to the general population varies considerably from region to region. In large parts of Africa this has already occurred.

HIV and AIDS disproportionately affect young adults, i.e. the sexually active population and the group with the highest risk of drug use. This also explains why it wreaks such havoc on societies: young adults fall ill, die prematurely and are no longer there as parents and providers.

People's increasing mobility increases the risk of infection for certain groups. The risk is particularly great in places where people have to live temporarily or permanently apart from their families (perhaps as long distance drivers, migrant workers, or soldiers for example) and seek contact with prostitutes. These groups and environments play an important role in the spread of HIV/AIDS.

2.3.2 Sub-Saharan Africa

The region worst affected by HIV/AIDS is sub-Saharan Africa. Almost two out of three of all infected persons live there. Although the proportion of infected persons has fallen in some countries in the region, the trend is neither strong enough nor widespread enough to genuinely weaken the epidemic. UNAIDS attributes this downward trend to improved knowledge about AIDS, an expanded healthcare infrastructure, an increasing fear of dying from AIDS and the changes in behaviour that this brings about (such as a reduction in the number of sexual partners, more frequent use of condoms and an increase in the age at which the first sexual activity occurs).

Nonetheless, in 2006 there were 24.7 million people living with HIV and AIDS in sub-Saharan Africa. 2.1 million people died from AIDS and 2.8 million people became newly infected with HIV. Thus the continent is home to 10 % of the world's population, and 63% of all HIV infected persons and 72% of all AIDS-related deaths. HIV/AIDS is the leading cause of death in the region⁷.

In sub-Saharan Africa HIV/AIDS has become "endemic", which means that the epidemic has become widely established in the countries, as some other infectious dis-

⁷ Compare Heiniger, E. / Walpen, B. (Ed.): *Gegen Aids – Für das Leben. Kirchliches Handeln im Südlichen Afrika – eine Handreichung für die Praxis [Against AIDS – For Life. Church action in Southern Africa – Assistance for Practice]*, Lucerne 2005.

eases have done. This occurs at a very high rate of infection: 9 out of 10 States in southern Africa have infection rates of more than 10% of the adult population. States such as South Africa, Lesotho, Swaziland, Namibia and Botswana now have infection rates of more than 20%⁸. National statistics on HIV rates are averages for the population aged between 15 and 49 years. The rates can therefore be much higher in certain age groups and regions. In general, they are highest for women aged between 20 and 29 years (where rates can reach 50 % in some areas) and for men aged between 30 and 39 years old.

The reason that an AIDS- epidemic (with increasing death rates) is only now establishing itself in many countries is that many of the people who became infected with HIV in recent years have become ill and died. Without adequate care and treatment, the number of deaths will continue to rise in the years to come. If that happens, the negative consequences of the epidemic will only become apparent in the course of this decade and beyond. This jeopardizes the sustainable development of parts of Africa, in particular when teaching staff, doctors, medical staff and people working in agriculture become ill.

2.3.3 Eastern Europe and Central Asia

HIV is currently spreading fastest in Central Asia and Eastern Europe. In 2006, according to the World AIDS Report, an estimated 270 000 people were newly infected with HIV in these two regions, bringing the total number of HIV-positive persons to 1.7 million – this represents a twenty-fold increase in less than a decade. Ukraine has the highest rate of HIV infection among adults. The majority of infected persons are young people, with approximately 80% aged under 30. Approximately a third of those infected with HIV are women, although this trend is increasing.

Apart from Ukraine, the worst affected countries are Russia, Belarus, and Moldavia. An increasing trend can also be seen in Afghanistan. In other countries in the region the reported numbers are low, but there is growing potential for the further spread of HIV and AIDS. Along transportation routes HIV spreads above all in the structurally weak industrial centres of Eastern Europe. Sex tourism near borders is a risk factor for the spread of HIV.

Most transmissions occur through drug use. The economic and social conditions in many countries in the region encourage drug use by young people especially. Up to 3 million people are estimated to be injecting drugs in Russia, which is 2% of the population – relatively high compared to other countries in other parts of the world. Approximately 62% of drug addicts are HIV positive. At the same time, sexual

⁸ South Africa has since changed its policy in the fight against AIDS. With an investment of 2.4 billion Euros it hopes to halve the number of new infections by 2011, improve access to AIDS medicines and develop educational work (Evangelical Press Service Report, 15.3.2007).

transmission is increasing dramatically including among the non drug-using population.

Prisoners are another risk group: the prevalence* of HIV in prisons is estimated to be up to 4%, which is four times higher than in the normal population. There is very little data about transmission among homosexual men, or among trafficked women or those in forced prostitution.

2.3.4 Asia

In South-East Asia the number of new HIV infections has increased by 15% in the last two years. In total there were 8.6 million people living with HIV in Asia in 2006. The steepest increases in the number of infections were recorded in China, Indonesia and Viet Nam. India has the highest number of people who are HIV positive.

Due to the high population numbers in Asia, even a relatively low prevalence of HIV equates to a large number of infected people. There is great variation in the severity and spread of the epidemic. There are high rates of infection among female and male prostitutes (called “commercial sex workers”* in the specialist literature) and their clients, who then transmit HIV to their partners. Most HIV-positive people in South-East Asia became infected through unprotected, paid sex. Sex tourism contributes to the spread of HIV/AIDS.

Thailand and some parts of India were affected early on. The prevalence of HIV in India is about 1%, but that equates to more than 5 million people living with HIV and AIDS. Some Indian Provinces already have “generalized” epidemics, which means that HIV/AIDS has spread to the general population, as characterized by prevalence in pregnant women of over 1%. In many communities AIDS is “visible” due to illness and death. In the most southerly parts of the country HIV is predominantly transmitted through heterosexual sex, while in the north-eastern States transmission is primarily through drug use.

In China, HIV/AIDS is spreading particularly fast; since 2004 it has reached all Provinces. The official number of approximately 650 000 HIV-positive people in 2005 is suspected to be an under-estimation of the true situation. Much of the spread of the disease occurs through drug use and prostitution. The transportation routes along which drugs from other countries are traded, are mainly located in southern China. In Henan Province, tens of thousands of villagers became infected with HIV when they sold their blood to commercial blood transfusion companies that failed to adhere strictly to the safety rules. It is feared that there may be epidemics in other provinces caused in the same way.

In Indonesia and Nepal the number of HIV infections has increased in recent years, primarily as a result of drug use and prostitution. HIV rates in Papua New Guinea have increased steadily since the 1990s and are the highest in the Pacific region;

here the epidemic spreads predominantly through heterosexual transmission, in the context of widespread violence against women.

2.3.5 Germany

The Robert Koch Institute has estimated that in 2006 there were approximately 56 000 people living with HIV and AIDS in Germany – approximately 47 000 men, 8500 women and 400 children ⁹. Approximately 2600 people became newly infected with HIV in 2006, of whom 61% were homosexual men, 14% originated from countries with high rates of AIDS, 17% were infected through heterosexual contact, 7% through infected needles and drug use and 1% through mother-to-child transmission. Compared to 2005, the number of new infections increased by 4%, the biggest increase since the 1993 survey. Some 600 people died in 2006 as a result of HIV infection or AIDS. The total number of people to have developed full-blown AIDS since the beginning of the epidemic rose to approximately 32 500, of whom approximately 26 000 have died. The number of fatal cases has fallen rapidly since the introduction of the antiretroviral combination therapy in 1996.

⁹ For the data see “HIV/AIDS-Eckdaten” [HIV/AIDS – Key Data] and the Robert Koch Institute’s biannual report on HIV/AIDS of 1 March 2007 (www.rki.de).

3 Challenges and areas for action

As was shown in Chapter 2, HIV/AIDS has become a global threat from which no country is safe. Although there is significant variation in the degree to which the individual countries presented in Chapter 2 are affected, the worldwide effects can now be felt everywhere.

3.1 The effects of HIV/AIDS

HIV/AIDS is not only a disease; it is also a complex social problem that has considerable impact on development in affected countries. The effects of HIV/AIDS threaten the economic, social and political stability of entire countries and regions and therefore also pose a global challenge.

HIV/AIDS is a disease linked to poverty. Its effects are particularly harsh for poor people and population groups in developing and industrialized countries. Poverty implies not only a lack of money, but also discrimination, lack of participation in political life, lack of access to resources (information, health care, education), the non-respect and violation of human rights and values, lack of prospects for the future, stigmatization and discrimination. All of these promote the spread of HIV/AIDS.

The chronic illness and deaths of people in their most productive years leads to a vicious circle: poverty leads to illness and illness aggravates the poverty. For private households in poor countries the direct costs of the disease (treatment and care) and the indirect costs resulting from the loss of income are enormous: in the final stages of the illness, AIDS devours the entire income resulting in acute indebtedness¹⁰. The system of solidarity among the extended family that provides social security in poor countries is overstretched and in many places has already collapsed.

In sub-Saharan Africa, food security is being jeopardized by HIV/AIDS. HIV/AIDS is increasingly a contributing or aggravating factor in famine disasters. Here too there is a vicious circle at work: when people die, their knowledge is also lost, and less land is farmed as a result. When the yield is smaller, there is also less money available for health care, which can in turn lead to a loss of manpower.

Industry and the public sector are affected too. Many poor countries depend in key areas on a small number of highly qualified specialists. In the worst affected countries, large numbers of these well-educated people are dying.

In some countries for example more teachers are dying than are qualifying, thus restricting the educational opportunities of entire generations. For girls especially, this

¹⁰ See Weinreich, S., Benn, Ch.: Aids – Eine Krankheit verändert die Welt. Daten – Fakten – Hintergründe [AIDS – A Disease that is Changing the World. Data – Facts – Contexts]; Frankfurt 2005.

hampers their prospects of being independent in adulthood. This in turn leads to a deterioration in the health situation of further sectors of the population, as the health of families depends to a large extent on women's level of education.

Health systems in developing countries, weak in general, are being weakened further by the deaths of doctors and nurses, whilst at the same time the high number of patients with HIV and AIDS is producing an increase in demand.

The negative social and economic effects promote the continued spread of HIV/AIDS as a result of the increase in poverty and the vulnerability of entire population groups. This impedes sustainable development and frustrates the progress made so far. Communities and States are gradually being weakened by death, illness, the orphaning of children and the loss of informal and formal knowledge. The effects of AIDS on the economic and social structures of countries with low and middle incomes and high infection rates are catastrophic, but even in countries with lower HIV rates, the effects on some aspects of development are worrying. For example, it has been estimated that AIDS will diminish poverty reduction in Cambodia by 60% each year until 2015. In Eastern Europe and Russia, the epidemic is hampering the prospects for human development and economic growth.

HIV/AIDS therefore has serious consequences for the achievement of the Millennium Development Goals* set at the United Nations Millennium Summit in 2000¹¹. One of the goals that Heads of State and Government undertook to achieve by 2015 was to combat the HIV/AIDS epidemic. In the Least Developed Countries especially, it is unlikely that this goal will be achieved, as was indicated in the overview report issued by the Secretary-General of the United Nations at the beginning of 2005¹². As a result above all of the HIV/AIDS epidemic in Africa, the situation has in fact even deteriorated in comparison to 2000. HIV/AIDS is undermining the achievement of the other Millennium Development Goals (reduce poverty, reduce child mortality, improve access to education, promote gender equality*, improve maternal health and combat the main infectious diseases). The further expansion of existing approaches to combating HIV/AIDS is above all being thwarted by the lack of health facilities and staff¹³. In the resolutions of the United Nations World Summit of September 2005 the international community made a commitment to increase investment in improving the health systems in affected countries, in order to be able to achieve the Millennium Development Goals by 2015 after all. All the commitments set out in the

¹¹ See "Schritte zu einer nachhaltigen Entwicklung. Die Millenniumsentwicklungsziele der Vereinten Nationen. Eine Stellungnahme der Kammer für nachhaltige Entwicklung der EKD zur Sondervollversammlung der Vereinten Nationen im September 2005" [Steps to Sustainable Development. The United Nations Millennium Development Goals, A Statement by the Advisory Commission for Sustainable Development of the Evangelical Church in Germany] EKD-Texts 81, Hannover 2005.

¹² See Sachs, J. et al.: Investing in development: a practical plan to achieve the Millennium Development Goals, 2005 (www.unmillenniumproject.org/reports/index.htm).

¹³ See Ruxin, J.: Emerging consensus in HIV/Aids, tuberculosis, malaria, and access to essential medicines, *Lancet*, Vol 365, Feb 12, 2005.

HIV/AIDS declaration of commitment should also be fully implemented¹⁴. Church authorities are also affected by HIV/AIDS in their daily work: clergymen are dying from HIV/AIDS; parishes are losing parishioners, are becoming poorer and are unable to care for the orphans left behind and for the chronically ill; and ministers can scarcely cope with the additional burden of pastoral care and funerals. Church authorities in Europe may not be so massively affected, but in their midst too there are people living and working with HIV/AIDS.

3.2 Women and gender equality

Although the equality of men and women has been set forth in law many times, there is still all around the world a great chasm between the political aim of equality and the reality in society. In development policy, attempts to counteract this trend currently take the form of “gender mainstreaming”*, which means always thinking about gender issues with the aim of achieving equality. Gender* has established itself as the specialist term for sex-specific social roles including in the German-speaking world. Current research is proceeding on the basis that “gender” always encompasses social, cultural, political and biological components that are alterable.

The gender perspective also focuses our understanding of the AIDS issue. AIDS affects men and women, but not equally, in part due to differences with regard to power, privileges, access to resources etc. Most of the work of HIV/AIDS is done by women: unpaid care for the sick in the home; as mothers and grandmothers caring for orphans. Women undertake heavy labour in order to provide for themselves and their families in the face of poverty and the AIDS epidemic. Many women have managed by accepting their positive HIV status* to find new strength and power; they are active within communities and in networks of women living with HIV.

In many countries, women are dependent on men financially, legally and due to their lower level of education. It is not just biology, but also the oppression and lack of recognition of the rights and values of women that help explain why women are affected and burdened by HIV/AIDS disproportionately and in a variety of ways. These structural causes – in conjunction with men’s exploitation of this situation and irresponsible behaviour – make women more vulnerable to HIV infection and to the effects of the epidemic. Their lack of self-determination also has consequences for their sexuality: in many countries women have very little or no say as to the form of and conditions under which sexual intercourse takes place.

In Africa young girls are at highest risk of becoming infected with HIV, as many are married to men who are significantly older than they are. Women and girls know little about sex; it is considered unbecoming to talk about it or to make decisions. In many places, the attitude persists that a woman’s body “belongs” to her husband, that

¹⁴ See the outcome document of the World Summit 2005, paragraph 57.
(<http://daccessdds.un.org/doc/UNDOC/GEN/N05/487/60/PDF/N0548760.pdf?OpenElement>).

women do not have the right to say no within marriage (or sometimes even outside marriage). Talking about contraception or insisting that it be used is unthinkable for many women, as it is seen as a sign of lack of trust in the marriage and the non-fulfilment of the female role as child-bearer.

Women who are forced to sell themselves are particularly affected by stigmatization. Often they are blamed for “causing” AIDS. They are also shunned and discriminated against by and within some churches. Women experience worse stigmatization when they are HIV positive or are widowed by HIV/AIDS. They are accused of having brought HIV into the family. Women and girls are at greater risk of becoming infected through abuse and the use of violence. They experience violence through genital mutilation, domestic violence, sexual exploitation, forced prostitution and – often systematically – through rape in armed conflicts and wars.

In many countries up to 40% of drug addicts are women. Added to their risk of becoming infected through shared needles is the risk that they are exposed to as a result of the prostitution they use as a means of paying for their drug habit. In addition, women are often not included in HIV prevention and other programmes as a result of the still widespread assumption that drug addicts are male.

Women are made poorer than men when HIV/AIDS afflicts a family through illness and death, and are often robbed of their land and inheritance when they are widowed.

Until now, the primary or only aim in the debate about gender and HIV/AIDS has been to “strengthen and promote” women, which was supposed to change their tremendous vulnerability to HIV. However, it is also important to change the patriarchal structures that disadvantage women and give men power. We must try to effect change in the awareness and behaviour of men, so as not to expose women to the risk of HIV infection. This includes using condoms as well as refraining from promiscuity* and combating sexual violence.

Churches in Africa should consider these aspects in their AIDS work: “We shall remember, proclaim and act on the fact that the Lord our God, created humankind in his image. In his image, he created them male and female, he blessed them both and gave both of them leadership and resources in the earth; he made them one in Christ (Gen. 1:27 -29; Gal. 3:28 -29). We shall, therefore, denounce gender inequalities that lead boys and men to risky behaviour, domination and violence; that deny girls and women leadership, decision making powers and property ownership ...”¹⁵.

In the resolutions of the United Nations World Summit of September 2005 the international community resolved to promote gender equality and eliminate pervasive gender discrimination. Member States undertook to actively promote the mainstreaming of gender into the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres. States further

¹⁵ All Africa Conference of Churches: The Covenant Document on HIV/Aids, www.wcc-coe.org/wcc/what/mission/ehaia-html/cameroon-covenant-e.html)

undertook to strengthen the capabilities of the United Nations system in the area of gender. They declared that progress for women was progress for all.¹⁶

3.3 Treatment, care and prevention

3.3.1 Access to anti-retroviral medicines

For many years, whether people received life-extending antiretroviral treatment depended on whether they lived in a rich or a poor country and whether they could pay for the treatment. This meant that until recently people living in poor countries were very unlikely to have access to antiretroviral treatment.

Those in Africa had the worst chances. Until 2003 only 1% of all the people in Africa who needed antiretroviral medicines had access to them. In total, only 400,000 of the six million AIDS sufferers in countries with low and middle incomes received the necessary treatment with antiretroviral medicines.

The reasons for the low number of people receiving treatment were and are the pricing policies of the multinational drugs manufacturers as well as the international trade agreements that protect patents even for vital medicines, thus preventing competition with unpatented medicines, as well as lack of infrastructure and a poor level of education among health workers (lack of investment, emigration of qualified staff).

Another reason for the lack of access to the life-saving treatment was the lack of commitment by Governments and civil society, including Churches. For years, national and international efforts to combat AIDS were predominantly focused on the prevention of HIV, as access to adequate treatment seemed unobtainable. That led to millions of deaths from AIDS which thus also weakened the HIV prevention efforts.

In recent years however, thanks to the commitment of many actors around the world, there has been a rethink. The lack of access to treatment of millions of HIV-positive people was taken up as an ethical challenge. At the same time, it was increasingly being recognized how important access to treatment was for maintaining the workforce, specialist knowledge, education and health as well as for good governance* and sustainable development in developing countries affected by HIV. It remains to be seen whether the change has been sufficient and how resilient it proves to be. In many countries, old prejudices have only been covered up out of necessity in the fight against AIDS, and not genuinely overturned.

International lobbying – including by Churches – and the competition generated by generic medicines* have prompted the manufacturers of antiretroviral medicines to

¹⁶ See the outcome document of the 2005 World Summit, paragraphs 58 und 59 (<http://daccessdds.un.org/doc/UNDOC/GEN/N05/487/60/PDF/N0548760.pdf?OpenElement>).

substantially lower the price of these medicines for the poorest countries. However, this is still not enough for people in poor countries to receive adequate provision with medicines. In particular, the prices for the subsequent therapies that are needed in the event of resistance* to the initial therapy still run at several thousand Euros per year and are thus much too high. There is also a great need for treatment in the countries of Eastern Europe and the Russian Federation, which as European Union or middle-income countries do not benefit from the permitted discounts.

At the United Nations General Assembly at the end of 2003, HIV/AIDS was declared a “global health emergency”. Through the Global Fund* and other financial instruments as well as the “3 by 5” initiative launched in 2003 by UNAIDS and the World Health Organization¹⁷, it has been possible to increase the number of people receiving treatment for AIDS in countries with low and middle incomes to some two million at the end of 2006. This is a first step; the original goal of three million by the end of 2005 was not achieved. It did bring about a rapid increase in treatment, but the aim of treating six or even nine million people by 2010 can now only be achieved if further increased efforts are made.

In Africa most countries have in the meantime developed “national treatment plans”. Demand for treatment generally far exceeds capacity, but the situation did improve significantly between 2003 and 2005. Whilst in 2003 only 1% of all AIDS sufferers had access to antiretroviral medicines, now 10% have the option of this life-saving treatment. All treatment initiatives include training health staff in prescribing and monitoring antiretroviral therapy and creating the infrastructure needed for widespread implementation of the programme. The experience of Brazil – as a middle-income country – shows that early “antiretroviral treatment for all” can reduce the costs of HIV/AIDS and stem the flow of new infections. Brazil’s experience shows that the implementation of treatment should commence from the beginning of an epidemic. The consequential costs are higher for every person who is already ill or has died from HIV/AIDS. In the programmes conducted to date in developing countries, as in industrialized countries, it has been possible to achieve a considerable reduction in deaths from HIV/AIDS. In Uganda, for example, where more than a third of AIDS patients receive antiretroviral medicines, more than 90% of patients were still alive after 15 months of antiretroviral therapy, whereas without treatment only 50% of those ill with AIDS survived that long.

The improvements to health infrastructure carried out for the purposes of antiretroviral treatment also benefit the entire health sector, as they also help with prevention and the treatment of other diseases. In many African countries, up to 60% of national health care is provided by Churches. Consequently, church health facilities also play an important role in antiretroviral therapy. Churches in Kenya, Uganda,

¹⁷ The 3 by 5 Initiative was launched on World AIDS day 2003 by WHO and UNAIDS with the aim of making it possible for three million people (3) in developing countries to have access to antiretroviral therapy by the end of 2005 (5). The aim was to reach at least half of the six million people estimated to be in need of therapy worldwide. At the end of 2005 however only about 1.3 million people were provided for. Nonetheless WHO considers the Initiative to have been a positive catalyst and trail-blazer for the new initiative “Access for All”, which will achieve its goal in 2010.

Zambia and India for example provide vital staff training, programme implementation and support for the community.

Failure to take medicines regularly or stopping therapy once it has been started can lead to “resistance”, which means the partial or complete ineffectiveness of the medication, which has serious consequences in terms of restricted treatment options. Under current conditions, when it is only the medicines for the initial therapy that have become relatively cheap, this is particularly difficult. The medicines for subsequent therapy and all newly developed antiretroviral medications are patented, which means no competition from cheaper generic versions. At the same time, pharmaceutical concerns are delaying significant price reductions. For that reason, Anti-AIDS activists, Churches and the German Action Alliance against AIDS (*Aktionsbündnis gegen Aids*) are calling for big pharmaceutical companies to voluntarily relinquish their patents in poor countries and to guarantee affordable prices for newly developed and not-yet-developed medicines. A swift and comprehensive expansion of the treatment programme would be a significant contribution to the fight against AIDS, which would also help to stop resistance from developing.

The active participation of people with HIV and AIDS, communities and civil society is crucial for the success of therapy programmes, as antiretroviral therapies present considerable challenges: the medicines must be taken for life, regularly and daily. People who receive treatment need the support of their families and communities. They need an explanation of the side effects and the specific modalities of the therapy. It is important to avoid a false sense of security. This “treatment literacy”^{*} is promoted by many civil society organizations and in many places by Churches too.

Ensuring that disadvantaged population groups (women, children, people in rural areas, prostitutes, prisoners, drug addicts, homosexual men etc.), have access to antiretroviral therapy is a particular challenge. In order that treatment programmes do not worsen existing inequalities, treatment must be made possible for all sufferers. A sixth of all those who have died are children. Until now they have not been adequately considered in treatment programmes, because medicines are not sufficiently available in paediatric formulations and the price of such medicines is very high. Research into paediatric formulations of medicines proceeds only slowly and takes years because, due to the relatively low level of HIV-infected children in rich countries, there is not the profitable market for these medicines that would provide the stimulus for the private-sector development of paediatric formulations of medicines. However, such medicines are urgently needed in order to save the lives of millions of children. Between 2005 and 2006, the prices for paediatric formulations of medicines fell for the first time and now only cost around 12 cents per day, or 47 Euros a year¹⁸.

¹⁸ See UNICEF: Children and Aids. A stocktaking report. Actions and progress during the first year of Unite for Children, Unite against Aids, 2007; (<http://www.who.int/hiv/paediatric/stocktakingreport.pdf>).

Antiretroviral treatment is also crucial for HIV prevention. The reduction in infectiousness reduces the risk of an HIV transmission. Furthermore, as the effect of treatment is that AIDS is no longer a death sentence, this gives people the hope and strength to come to terms with HIV infection and tackle it openly. Accordingly, demand for HIV-tests soared in many treatment programmes, and there is a reduction in stigmatization. There are countless examples from church communities of people living with HIV and AIDS, who had been close to death but were now able to go back on with their lives thanks to antiretroviral medicines, giving moving accounts of their stories and thus reducing stigmatization.

One such example is the Masangane Project, which was launched in 1996 by the Moravian Church in South Africa's Eastern Cape Province and was implemented largely voluntarily by members of the community. Masangane initially focused on prevention work and on improving living conditions for young people. In 2002, Masangane introduced the antiretroviral therapy. This demonstrates that treatment with antiretroviral medicines is not something that has to be restricted to large health facilities, but can also be achieved under the responsibility of a community and in a rural area. It was possible to break the silence, and as a result it is possible for women, men and young people affected by HIV/AIDS today to talk openly to the community in Sunday church services about their lives and their experiences¹⁹.

Overall, we have only made a start at providing the quantity and quality of this important treatment for AIDS to people in poor countries. The challenges described will in future require stronger commitment on the part of everybody involved.

3.3.2 Care

The introduction of antiretroviral combination therapy has resulted in the symptom-free stage of the disease in the lifetime of people with AIDS being significantly extended. It is AIDS sufferers in rich industrialized countries who currently benefit most from this medical advance, as for them combination therapy opens up much improved life prospects. Nonetheless, home, outpatient and in-patient care continues to play an important role in the care of people with HIV/AIDS.

In developing countries, only a fraction of those with HIV and AIDS receive essential medical care, psychosocial support and the nutritional help that is so often needed. Churches and church organizations play important roles with regard to the care of those affected by HIV. They care for the chronically ill in home-nursing programmes and for orphans and other at-risk children, who lack material and social support. The overwhelming share of the work has so far been done on a voluntary basis, unnoticed and without being explicitly valued and supported. This voluntary work is carried out almost exclusively by women. It includes the care work by mothers, wives and other females for sick family members, as well as the work done in the volunteer

¹⁹ www.ems-online.org/77.html

home care projects provided by many churches in Africa. This is generally not only not properly valued and supported (eg. through taking on the cost of materials), it is also often not appreciated how much time and energy women expend and is expected of them – time and energy that is taken away from their own (including financial) development.

In most African countries there is no alternative to such home care, as professional care would be unaffordable. This makes it all the more important for the voluntary work carried out in home care to be valued and for there to be more efforts to help the carers appropriately, such as by network building or a more equal division of care work between men and women.

Consideration of specific care situations requires a particularly sensitive approach, because it is care in particular areas of conflict:

- between the self-determination and heteronomy of those being cared for;
- between the life cultures of AIDS sufferers and carers;
- between short and long-term life planning;
- between phases of denial and acceptance of the disease;
- between carers and others involved in the care.

People with HIV/AIDS who have comprehensive knowledge about their disease and its treatment are less well adjusted, more self aware, more individual and more vulnerable than many other patients. This requires carers for example to consider the sexual orientation of the sufferer or the lifestyle of a drug addict. The willingness to face this challenge openly also offers a chance for an encounter that could lead to learning and a tolerant approach. It can lead to questioning and alteration of one's own care routine and the entire care concept.

3.3.3 HIV prevention

Treatment and prevention go hand in hand: they need one another and are mutually reinforcing. Thus, prevention must not be limited due to the cost of treatment and treatment must not be neglected at the expense of prevention. Both must be energetically strengthened and facilitated through the appropriate financial means. Only in this way will it be possible to reduce the estimated four million new infections and three million deaths each year.

Prevention measures are not universally in place and have not yet reached everybody. Achieving universal access to prevention, so that everybody has adequate information and the appropriate means of implementing that information in their lives in order to prevent new HIV infections, is a considerable challenge. In general, women are less well informed about HIV than men; the rural population generally knows less than city dwellers.

The effectiveness of prevention programmes is affected by the following factors:

- the general level of education of the population sector and their access to information about HIV/AIDS and psychological counselling.
- the degree of gender equality and poverty reduction.
- the protection of human rights in normal life as well as in situations of war and civil war.
- the elimination of marginalization* and stigmatization of certain population groups (prostitutes, drug addicts, homosexuals).
- For Churches it is of particular importance to consider how the issues connected with HIV/AIDS will be dealt with theologically and can be expressed in sermons and spiritual guidance, pastoral work and community life, as well as in the open attitudes and declarations of the Churches and their officers.

Work to improve these framework conditions must be intensive and ongoing. At the same time, it is critical for further HIV infections to be prevented and for the progression of the disease in people who are HIV positive to be delayed. This requires direct prevention work to be qualified, intensified and expanded in order that clear and sustainable progress can be made with regard to the urgently needed behaviour change.

Many African cultures have a strong community spirit (“I am, because I am a part of the community”). Prevention work must take this into account. This offers certain benefits, in that the community assumes particular responsibility for the people affected by HIV/AIDS. However, there are also specific dangers with regard to particularly vulnerable groups within the community and the possibility of individually responsible attitudes to sex. This makes great demands of prevention work.

General information and awareness-raising campaigns are not enough for prevention. Information alone does not result in behaviour change. For that reason, the *Voluntary Counselling and Testing** (VCT) prevention approach aims to enable people to arrive at a sustainable change in their behaviour: it provides the knowledge and individual skills that make it possible for people to adopt a responsible approach to their positive or negative HIV status. This means that prevention work is not only focused on the acute stage of AIDS.

AIDS prevention also encompasses the “ABC strategy”, which is also known as the “Prevention ABC”. Experts²⁰ distinguish between the following terms:

²⁰ In a working-paper of the World Council of Churches it is critical remarked that this prevention-abc without any differential reflexion could effect to stigmatise people and to detain them from secure sexual practises . To avoid this an alternative model of prevention under the acronym “SAVE” is propagated. SAVE means Safer practise, Available medications, Voluntary counselling and testing and empowerment through education. The aim is to combine components of prevention and treatment and to face the stigmatisation. (World Council of Churches, Towards a Policy on HIV/Aids in the Workplace – Working Document, 2006, S. 3f; www.wcc-coe.org/wcc/what/mission/workplace-policy-e.pdf).

1. For people who have tested negative for HIV: **A**bstain – **B**e faithful – **C**ondomize. This involves either abstaining or remaining faithful to one sexual partner, or if neither is possible, the use of condoms. One must note, however, that women have no means of ensuring the efficacy of these methods if their male partners do not comply with them.
2. For those who have tested positive for HIV, in addition to abstinence, faithfulness and condom use, one must add: **A**cknowledge – **B**elong – **C**ompetence. This includes accepting that one has been infected, joining self-help and support groups, and learning about the illness and its course, about necessary testing, and about nutrition and other behaviour.
3. One further ABC Strategy is crucial to people living with AIDS: **A**RV (anti-retroviral drugs) – **B**elief – **C**are: Taking care to take anti-retroviral drugs properly, coming to terms with one's own faith beliefs (and coming to terms with one's own life and death) and seeking out necessary care.

In the years to come, it will be crucial for preventative efforts to shift from programmes of general preventative information toward programmes that teach and enable each individual to translate the various elements of the ABC prevention principles into a change of behaviour. The underlying procedure, involving voluntary counselling and testing (VCT), has already been introduced in many places, at least to a degree.

The churches bear particular responsibility in this regard and an increasing number of churches have now in fact integrated the internationally recognized and implemented "ABC Strategy" into their HIV prevention programmes. The use of condoms, however, continues to be a matter of controversy in many churches. Certain churches, including some of considerable size, recommend only abstinence and faithfulness to the exclusion of condom use. The regular and correct use of condoms is, however, a major part of the "safer sex"* strategy. Comprehensive campaigns to support condom use have been successful in reducing the rate of HIV infection in a large number of countries (particularly in North America and Europe, as well as in Thailand).

However, religious and cultural constraints on campaigning too strongly for condom use prevail in many countries. Churches sometimes argue that supporting condom use is morally unacceptable as it could encourage a general rise in promiscuity, and that condoms prevent conception as well. For most people in developing countries, having children is indeed a matter of existential proportions. In the minds of many, moreover, condoms are tied to prostitution and to extramarital and premarital sex, and are thus additionally objectionable. Many men are also convinced that only unprotected intercourse can be a source of real pleasure. And, furthermore, condoms are neither universally available nor does everyone know how to use them properly.

Many young women and men are in a phase of their lives in which they are only partially able to make decisions concerning their own sexuality. Campaigns that focus

on HIV/AIDS prevention through abstinence – without taking the living conditions of young people into consideration – thus often fail to meet expectations. Education for young people, and sex education for girls in particular, is of particular importance in preventing HIV infections. Sex education kindles an awareness in young people of the dangers of HIV and of unwanted pregnancy. This can promote condom use and a delay to the onset of sexual activity. Sex education also provides girls with a better understanding of their own bodies, greater self-confidence, and consequently a stronger position from which to discuss matters with their partners such as sexuality, contraception and condom use.

In the future, microbicides*, chemical substances that are applied to the vagina, may prove to be an effective preventative measure for girls and women. A variety of substances are currently in development, although it will take at least five years before they can be introduced to the market. Microbicides and condoms for women²¹ are women-controlled options for HIV prevention, requiring less male cooperation than conventional male condoms. The first results of controlled studies among heterosexual men in Africa have shown that circumcision provides a degree of HIV protection. This could add a relatively uncomplicated and inexpensive method of HIV prevention if this result were to be borne out in further studies.

3.3.4 Treatment and prevention in Germany

Antiretroviral drugs now provide HIV patients both with a longer life expectancy and a new outlook on life. One result of this could be a shift in the pastoral care of people with AIDS from a focus on end-of-life hospice care to one on helping them to move ahead with their lives. Treatment is, however, not guaranteed equally to all patients, not even in Germany. Foreigners without residency permits generally do not have the access they need to medical care. People from high-prevalence countries* and others who are infected while abroad often first discover their infections during a late phase of the illness, and are thus at risk of having a more limited therapeutic success. As a result of the reorganization of Germany's social security system over the past few years, access to the best life-preserving therapies is no longer guaranteed for many HIV patients. Health insurance companies, for example, no longer always provide coverage for these costs. Related social problems have also worsened, leaving many HIV patients alone with their fears of marginalization and isolation, and of suffering and an early death.

Two German institutions have been working on HIV prevention since the mid-1980s: While the “Gib Aids keine Chance” (“Don't give AIDS a chance”) campaign of the

²¹ Female condoms have been available for women since the 1990s. These condoms are some 18 cms long and feature two rings. The outer ring is placed outside the vagina in front of the labia majora and the inner ring is inserted into the vagina like a diaphragm. Sales in female condoms did not meet expectations due to the complicated nature of their use, leading to a significant reduction in their availability.

Federal Centre for Health Education (*Bundeszentrale für gesundheitliche Aufklärung* - BZgA)²² is geared towards the general public, *Deutsche Aids-Hilfe e.V.* (DAH)²³ is a self-help organization with prevention programmes for particularly vulnerable groups. Another organization, *Deutsche Aids-Stiftung* ("German AIDS Foundation" - DAS)²⁴ deals mainly with the social dimensions of HIV/AIDS.

For some time now, concerns have been raised both by a rising rate of sexually transmitted diseases and by a (somewhat less precipitous) rise in the rate of new HIV infections among homosexual men. Possible explanations for this include:

- Prevention campaigns have lost some of the intensity they had during the early years of the epidemic;
- People are beginning to grow weary of preventative measures;
- AIDS has been in a process of normalization and banalization;
- The topic has been receding in public awareness.

A large number of people have developed a false sense of security, imagining that HIV no longer poses a threat and that protective measures are no longer required. We must be decisive in fighting this erroneous notion. The threat of an outbreak of epidemic proportions still looms, even in Germany. HIV prevention measures should therefore be boosted – instead of being curtailed. These measures must especially be extended to people who are more difficult to reach such as immigrants, prostitutes and drug addicts. The particularly rapid rise in the infection rate among people from high-prevalence countries* requires particular attention, as they often lack the necessary access to medical and psychosocial care.

3.4 Children with HIV/AIDS, orphans, children and adolescents at risk

Children and adolescents can be affected by HIV/AIDS in various ways. Some are infected themselves, while others live in families affected by HIV/AIDS or even lose their parents to AIDS. HIV/AIDS can also reduce young people to poverty, destroying any future opportunity. As of the end of 2006, 2.3 million children under 15 years of age lived with HIV/AIDS, over 2 million in Sub-Saharan Africa alone.²⁵ In 2006, 380,000 children died of AIDS, while 530,000 children were newly infected with HIV, mostly via mother-to-child transmission. Most of these children die before reaching

²² www.bzga.de

²³ www.aidshilfe.de

²⁴ www.aids-stiftung.de

²⁵ Cf. UNAIDS / WHO: AIDS Epidemic Update, December 2006, (http://data.unaids.org/pub/EpiReport/2006/2006_epiupdate_en.pdf) and UNICEF: The State of the World's Children 2006: Excluded and Invisible (www.unicef.org/sowc06/pdfs/sowc06_fullreport.pdf).

the age of two, although some survive to the age of 5 or even longer, depending on factors such as nutrition and medical care.²⁶

HIV/AIDS impairs and destroys the lives and futures of millions of children whose families are affected. Children who live in poor households that include adults with AIDS are particularly subject to malnutrition and its effects such as stunted growth. Children can also be traumatized by taking care of their parents until their deaths. The loss of their fathers, mothers, or both parents affects the children's well-being in every way, including their emotional and physical health, security, and mental and social development. Their parents' deaths can also often lead to stigmatization, isolation, and curtailments of the children's human rights.

As of the end of 2006, there were an estimated 15.2 million orphans in the world due to AIDS, of whom 12 million were in Sub-Saharan Africa. The number of orphans could rise to some 20 million by 2010 if major measures are not introduced to treat the disease.

Due to their vulnerability, children and adolescents have been one group for whom the churches have always felt a particular responsibility. Many church parishes run programmes for orphans to satisfy their material, social and emotional needs. Orphans are more likely to be the victims of sexual exploitation, child labour, violence and abuse. The churches cannot, however, come close to meeting all of these needs due to the large and growing number of orphans and the impoverishment of the parishes.

Germany's Protestant churches and its Christian aid organizations are increasing their efforts to encourage and enable church parishes to provide for these children. Orphans should be cared for within their own (extended) families or in foster families as much as possible. Orphanages are more expensive by comparison, and often face financial uncertainty, while the children there are removed from their family surroundings. Orphanages should thus be a last resort in helping these children when no other options are available.

3.5 Overcoming taboos and stigmas

HIV/AIDS is often the subject of taboos, denial and prejudice. The close connection between HIV/AIDS and topics that can be sensitive or taboo, such as poverty, sexuality, unequal gender relations, prostitution, homosexuality, and drug addiction, makes fighting the illness particularly difficult. The very long incubation period* exacerbates this even further. While the number of those infected rises rapidly during the first phase of the epidemic, only few begin to take ill right away. For many, this

²⁶ Cf. UNICEF: Children and AIDS. A stocktaking report. Actions and progress during the first year of *Unite for Children, Unite against AIDS*, 2007 (http://data.unaids.org/pub/Report/2007/20060116_stocktaking_report.pdf).

creates the illusion that the illness does not pose a real threat, making it easier for people to avoid thinking about the problem. This sort of denial, both at congregational and national levels, leads to neglect in dealing with the illness and, subsequently, to the further spread of the epidemic.

HIV/AIDS is often connected to stigmatization and discrimination. People infected with HIV are disadvantaged and treated unjustly in society, including widows and orphans. It is a common false assumption that HIV infections result only from prostitution and extramarital sex.

Since the risk of infection is high in many prisons, education programmes should be provided to both prisoners and prison personnel alike. Protective measures (especially condoms) should also be made available to prisoners.

Many churches have now recognized that, as the result of taboos, stigma, and denial, they have often exacerbated the HIV/AIDS problem themselves more than they have contributed to solutions. Over the past few years, the churches have begun new efforts with positive new approaches toward undergoing self-critical reflection and overcoming stigma.

In December 2003, for example, the “Strategy Consultation on Churches and HIV/AIDS in Central and Eastern Europe” established that the “political, social and economic changes in Central and Eastern Europe throughout the last two decades have made certain population groups vulnerable to HIV/AIDS.” These groups include children and youth, women, prisoners, and drug users. The statement called for care for these groups in particular since as “Christians, we are called to care for and support all those in need regardless of social status, religion, lifestyle or health condition.”²⁷ The founding of the *African Network of Religious Leaders Living with or Affected by HIV and AIDS* (ANERELA) in 2003 represents another promising step towards the integration of people with HIV into the church.²⁸ The organization includes pastors and lay church leaders who are either HIV-positive themselves or otherwise affected by HIV. The network has the potential to achieve greater recognition in the churches for people living with HIV/AIDS.

3.6 Global commitment and the mobilization of financial resources

The difficulties that developing countries have in fighting the AIDS epidemic effectively are also a reflection of a lack in available resources. Such countries, for example, often spend more on servicing debt than on health and education. HIV/AIDS can, however, only be contained and defeated if the necessary means are available. This poses a particular challenge during steep rises in financial needs due to the increased spread of HIV/AIDS. Preventative measures then need to be intensified just

²⁷ www.wcc-coe.org/wcc/what/mission/petersburg.html

²⁸ www.cpsajoburg.org.za/hiv aids/anerela1.html

when an increasing number of people require treatment and care. Treatment must also continue throughout each patient's life, in contrast with other illnesses such as tuberculosis, which, once successfully treated, require no further intake of medicine. This means that, in the case of HIV/AIDS, the number of people in treatment programmes never ceases to rise.

Yet it is not an option to never even start medical treatment, as is still sometimes suggested. We are ethically obliged to save human lives. Mere economic calculation demonstrates that the financial and social costs arising from the death of a young adult far surpass the cost of antiretroviral therapies.

At the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, the member states committed themselves to a considerable increase in financial funding for the international campaign to fight HIV/AIDS, and to specific goals in HIV prevention and treatment.²⁹ The United Nations, with the support of governments and non-government organizations, also decided to establish a *Global Fund to Fight AIDS, Tuberculosis and Malaria** with the aim of securing the funds needed to fight these three illnesses, which combine to pose the greatest health threat to the world's poorest countries.

Since its establishment in 2002, the *Global Fund* has authorized 6.8 billion USD in funding for five-year HIV/AIDS programmes in 136 countries. The programme has afforded antiretroviral treatment to some 770,000 patients to date, and has paid for over 1 million HIV tests with counselling services. In total, over 1.6 million people will receive antiretroviral treatment in the course of the five-year projects that have been authorized thus far. The *Global Fund's* long-term financial needs have not, however, been adequately met over the past few years, with financial commitments falling far short of the amounts required to meet the goals set by the United Nations. A "replenishment process" was therefore set into motion in 2005 in order to provide reliable and sustainable financial support for the *Global Fund* that can be planned long in advance, as is usual for other international financial institutions.

In addition to the *Global Fund*, other major international financial instruments and programmes have emerged in the struggle against HIV/AIDS: The World Bank's *Multi-Country HIV/AIDS Program for Africa* has provided over 1 billion USD, while the American *President's Emergency Program for AIDS Relief* has made 15 billion USD available to 15 countries over a period of five years. This has all contributed toward a strong increase in funds available in the fight against AIDS.

Such funds are also available to churches for use in the expansion of their commitment to combating HIV/AIDS. This requires that the churches comply with international standards in the execution and evaluation of their programmes. Many governments of developed countries, including Germany, have also made fighting AIDS into a focus of their bilateral developmental efforts.

²⁹ United Nations (2001). General Assembly Special Session on HIV/Aids Declaration of Commitment (www.unaids.org/UNGASS/index.html).

Using state and multilateral funding to finance church HIV/AIDS programmes can, however, also lead to difficulties. A 2005 consultation in Bossey, Switzerland³⁰ held by organizations including the *World Council of Churches*, *Caritas Internationalis* and the *Deutsches Institut für Ärztliche Mission e.V.* (“German Institute for Medical Mission” – Difäm)³¹ pinpointed major difficulties in the financing and administration of HIV/AIDS programmes. These included deficiencies in educational, technical and other capacities, a lack of network resources, and donor requirements perceived to be overreaching and overly restrictive in the work of the churches.

In addition to their own financial support of HIV/AIDS programmes, church development agencies should also assist their partners in applying for other governmental and multilateral resources. It is also important that information be exchanged on rapidly changing conditions and guidelines in areas such as diagnosis and treatment; that enough people are employed to meet expanding needs, especially when it comes to the management of additional funding; and that networks are financed through church funding if they are not funded otherwise.

Financing for the fight against AIDS must be secured with long-term stability. In addition to the financial instruments used so far, new recommendations for priorities in developmental cooperation are now under discussion. These ideas include an International Finance Facility, which would increase short-term developmental aid by issuing capital market bonds, the introduction of a tax on international currency transactions, and taxes on air travel such as the one already introduced in France. Poor countries can be afforded greater long-term financial support in their fight against AIDS in ways such as: the May 2005 decision of the EU to gradually approach its goal of spending 0.7% of its gross national income on aid by 2015; the debt cancellation scheme that was decided at the July 2005 G-8 summit in Gleneagles; and the decision to spend 44 billion euros on the fight against infectious diseases at the June 2007 G-8 summit in Heiligendamm.

³⁰ www.e-alliance.ch/hiv_accessingresources.jsp

³¹ www.difaem.de

4 Church commitment

The issue of HIV/AIDS has become a key issue in ecumenical dialogue for the German churches. This reflects the wide range of contacts maintained by the churches, their developmental organizations and their mission agencies with partner churches and groups in the countries of Eastern Europe and the Global South. Differing theological and national-political views on the pandemic have led to an intensive discussion on the role that churches play, and on the common development and implementation of promising new approaches.

4.1 Church aid and mission agencies: Mainstreaming HIV/AIDS

Numerous church development and mission agencies have chosen to concentrate their efforts on HIV/AIDS in the coming years, and plan to establish this issue as a permanent focus within their own organizations.

“Mainstreaming HIV/AIDS”* means integrating HIV/AIDS efforts into developmental programmes, or conversely, integrating programmes dedicated to general human development into HIV/AIDS work. HIV/AIDS can thus be incorporated into the “mainstream” of developmental programmes, which can in turn be reevaluated and adapted accordingly.

Aid and mission agencies develop their own regulations and recommendations concerning HIV/AIDS. These provide transparent standards for dealing with HIV/AIDS within each organization, and serve as guidelines for project work, financial and staff support, advocacy efforts, political education and public relations, and in other areas such as staff deployment. Regulations are often developed in close cooperation with partner churches abroad.

The Division for World Mission of the Evangelical Lutheran Church in Bavaria (*Missionswerk der Evangelisch-Lutherischen Kirche in Bayern* – MWB) has, for example, supported the Evangelical Lutheran Church in Congo’s development of HIV/AIDS guidelines. This is important in establishing the church’s HIV/AIDS strategy in the aftermath of a civil war that has been exacerbated both by HIV/AIDS and by the traumas of sexual violence, social uprooting and a loss of hope and perspective.

Most agencies employ and train specialized staff for work on HIV/AIDS. Workshops and consultations on numerous HIV-related topics allow the staff to improve their knowledge and learn from each other.

Support for these projects is provided by representatives of the AIDS working group of the *Deutsches Institut für Ärztliche Mission e.V.* (“German Institute for Medical Mission” – Difäm), which acts as a national centre of health expertise for German Protestant aid agencies. The group was founded in 2001 upon the recommendation of the EKD Council. The *Brot für die Welt* aid agency (“Bread for the World”) has also appointed additional advisors to work for a time on the issue of HIV/AIDS.

4.2 Ecumenical cooperation – advocacy and support

The EKD, its member churches, developmental and mission agencies enjoy a wide range of ecumenical relations with their partner churches. This spans from direct partnerships between congregations to regular church leadership meetings; some ecumenical staff from partner churches are stationed in Germany, visiting foreign students are sponsored by German mission agencies, the EKD social service agency (*Diakonisches Werk*), the EKD, and the Church Development Service of the Protestant Churches in Germany (eed). These students can then put this experience to good use and share their expertise with others in their home countries. Developmental aid agencies also support their partner churches through their staff and with financial assistance.

Ecumenical partnerships help to build trust and to carry out a common mission to bring people within the churches closer together as sisters and brothers in Jesus Christ. People from different countries can learn a great deal from each other in this way.

Meetings between German AIDS chaplains and African patients have shown that partnerships involving German experience in areas with a high HIV rate can prove fruitful and helpful for everyone involved. The United Evangelical Mission (*Vereinte Evangelische Mission - VEM*) has HIV/AIDS advisors in countries such as the Democratic Republic of Congo and Indonesia to educate local churches on the topic of HIV/AIDS and to encourage them to get involved. The VEM is also involved in promoting a successful exchange between developing countries of the South, such as church delegations travelling to other countries to learn from each other's positive experience and ideas.

HIV/AIDS has become an important topic for ecumenical discussion over past years. It is one of the most important topics for many African churches who would like to exchange information with their German partner churches and receive their support.

In Africa, churches are most actively involved in AIDS-related work. In many countries, churches have been carrying out programmes on AIDS education and prevention since the mid-1980s. Today, churches maintain counselling centres, provide free testing, organize support and care for AIDS orphans and advocate for universal access to antiretroviral drugs.

Despite the churches' efforts, prejudice and hostility toward those living with AIDS or HIV still persists, even if they have subsided somewhat. Matters of sexuality, particularly moral views on sexual orientation and the use of condoms, have led to serious and nearly irreconcilable differences of opinions among all confessions. One of the greatest ecumenical tasks in the years to come for the EKD, its member churches, and its developmental and mission organizations will be to unite the churches in a common fight against HIV/AIDS.

An ecumenical consultation in 2001 represented a major milestone on the African churches' path towards a constructive approach. At the meeting, the churches committed themselves to: supporting people with HIV; incorporating the issue into church activities; integrating HIV/AIDS into the curriculum of theology programmes; helping women and girls to be strong; teaching men to change their behaviour and to take on responsibility in fighting the epidemic; and supporting effective preventive measures that can save lives.³²

Many partner churches outside Africa have also been involved in AIDS projects, not only in the care of AIDS patients and orphans, but also in education and prevention measures. The impact of HIV/AIDS is most likely to worsen in the decades to come, spreading to countries in areas, including many parts of Asia and Eastern Europe, that have yet to be perceived as crisis regions.

Churches are active in fighting AIDS in a number of different fields. This includes:

- The work of partner churches being supported in many ways by EKD member churches, mission agencies, and church development agencies.

Bavaria's *Mission Eine Welt* ("One World Mission"), for example, supports its partner churches especially on pilot programmes to improve their AIDS work. The Kenya Evangelical Lutheran Church, for one, received support for a home-based care project adapted to local needs. In "Church and Industry against HIV & AIDS," a project of the German state of North Rhine-Westphalia, the Evangelical Church of Westphalia, the Evangelical Church of the Rhineland and the Evangelical Church of Lippe are providing support for local small and medium-sized companies and the tourism industry in South Africa and Namibia to provide HIV prevention, advice, tests and antiretroviral drugs. Partner churches and church organizations are carrying out this work in the affected areas.

- Interreligious cooperation in the fight against HIV/AIDS has increased in many countries in which Christians live together with the adherents of other religions. This cooperation often begins at the leadership level of the religious communities. At times, however, the German churches are still confronted by their partner churches with erroneous views, silence and denial in regard to HIV/AIDS.

A joint declaration by different religious communities was signed and published at the UN Special General Assembly on HIV/AIDS in 2001.³³ Religious leaders released a statement of commitment at the July 2004 International AIDS Conference stating: "HIV and AIDS knows no boundaries. All of our religious communities are living with HIV and

³² Cf. Ecumenical Consultation on HIV/AIDS in Africa (2001). Plan of Action (www.wcc-coe.org/wcc/what/mission/ehaia-html/kenya-plan-of-action-e.html).

³³ Cf. Statement by Faith-Based Organizations facilitated by the World Council of Churches for the UN Special General Assembly on HIV/AIDS June 25-27, 2001, in: *International Review of Mission* 2001 (90) pp. 473-476.

AIDS ... We will not rest until the promise of 'Access for all' and the hope of a world without HIV and AIDS is fulfilled."³⁴

- The EKD and its development agencies support churches around the world in their efforts to anchor the topic of HIV/AIDS in the ecumenical movement.

The *Ethiopian Orthodox Tewahedo Church* (EOC), for example, joined forces with Ethiopian Protestant church leaders in concerted action against the HIV/AIDS epidemic. The *Armenia Round Table Foundation* (ART), which includes Armenian Apostolic, Catholic, and Evangelical churches, has offered seminars on HIV/AIDS for theology students with the support of the Church Development Service of the Protestant Churches in Germany (eed). Future priests learn to work with people who are HIV-positive and their families, to improve HIV prevention and to reduce stigmatization in their congregations.

- The EKD and the church agencies are also active in ecumenical networks involved in a variety of tasks in different regions.

The *Ecumenical HIV/Aids Initiative in Africa* (EHAIA)³⁵ is a joint initiative of African churches, churches and ecumenical partners in developed countries, and the World Council of Churches. The *Brot für die Welt* ("Bread for the World") aid agency of Germany's Protestant churches was and remains central to this initiative. By means of ecumenical exchanges, training events, and publications, the initiative provides churches in Africa with access to information, educational programmes, networks and financing. The initiative has played its part in ensuring that a great number of African churches have become active in HIV/AIDS efforts, introducing HIV/AIDS into the curriculum of their theological seminars and integrating HIV/AIDS into their church liturgies.

The *Ecumenical Pharmaceutical Network* (EPN)³⁶ is yet another example for an ecumenical network. *Brot für die Welt* sponsors the network's German development agencies. The network works to improve church pharmaceutical programmes by providing church health institutions with the training necessary to deal with HIV/AIDS treatment with antiretroviral drugs, and by affording these institutions access to inexpensive quality-controlled medicine.

- The development agencies support churches and civil organizations of the South in their advocacy efforts, which have been increasing in importance over the past several years. Advocacy means working for the disadvantaged and righting unfair structures. Through advocacy, for instance, one can exert influence on the governments of high-prevalence countries, putting HIV/AIDS onto the political agenda, and bringing about the crucial allocation of resources needed to fight AIDS.

In this way, *Brot für die Welt*, for example, has extended its support to the Treatment Action Campaign³⁷ in South Africa, which works for access to AIDS treatment. The EKD

³⁴ Statement of Religious Leaders at the XV. International Aids Conference, Bangkok, July 2004. (http://media.e-alliance.ch/iac2004/docs/stmt_rel_leaders_new.doc).

³⁵ www.wcc-coe.org/wcc/what/mission/ehaia-e.html

³⁶ www.epnetwork.org

³⁷ www.tac.org.za

and its development agencies also support the Ecumenical Advocacy Alliance (EAA)³⁸, in which Protestant and Catholic organizations, including the World Council of Churches and the Lutheran World Federation, are represented. The EAA assists churches and ecumenical institutions in their struggle with HIV/AIDS, which has included work on a 2004 conference that provided a platform for an ecumenical exchange in the field. The EAA has also worked to improve the publicity for the churches' contributions to this struggle so that even secular and international organizations are now able to recognize the churches as important partners in this struggle.

4.3 Partner churches: HIV/Aids in the theology curriculum

HIV/AIDS now has a permanent place in the curriculum of the theology programmes run by several partner churches to train church employees and ongoing theologians. Courses on HIV/AIDS should not merely be offered alongside other courses but the topic should ideally be integrated into the entire study programme. Such a programme should also include special courses on epidemiology, HIV therapies and prevention, sociocultural issues, and other aspects of the crisis.

The Ecumenical HIV/Aids Initiative in Africa (EHAIA) has developed HIV/AIDS curricula especially for Africa that are now being followed at a number of theological training centres. Initiatives such as EHAIA and its counterpart, the *South Asian Ecumenical Partnership Programme* (SAEPP) have the potential to reach smaller churches, churches in remote areas and evangelical churches. It is the task of aid and mission agencies to provide ecumenical programmes such as these, equipped with the resources necessary to meet the high demand for their services. The Association of Protestant Churches and Missions in Germany (*Evangelische Missionswerk in Deutschland* – EMW) supports both formal study in dedicated institutes and “informal” training programmes throughout the world.

In times of HIV/AIDS, added importance is placed on the writings of the Bible, on fundamental theological questions and ethical considerations related to what our purpose and responsibility as human beings should be, influenced by forms of piety and ideas about family life, marriage and sexuality. The training programmes of partner churches in all theological disciplines should thus reflect upon HIV/AIDS as a reality of life, including issues touching on justice, gender and modern technologies.

4.4 AIDS efforts in Germany

Communities of homosexual men and women played a central role in the founding of German AIDS agencies in the early 1980s, beginning with *Deutsche Aids-Hilfe*. These groups have continued to work as advocates ever since, involving themselves in self-help programmes and in the political, social and practical support of those af-

³⁸ www.e-alliance.ch/hiv aids.jsp

ected by the crisis. Germany's churches have learned a great deal themselves from HIV/AIDS and related issues, and particularly from people affected by the disease.

In 1994, the EKD opened its first AIDS pastoral care centre in Hamburg, sponsored by the local church district of the North Elbian Evangelical Lutheran Church.³⁹ The Evangelical Church in Württemberg has also provided AIDS pastoral care since 1994 with study days, worship services and help for immigrants provided by church appointed AIDS counsellors. People who are HIV-positive and others affected by the crisis are also given a place to go with their concerns. This sort of pastoral care and advice, now available in many other EKD member churches, allows people to experience the church in a real way, especially for those outside the church or following other ways of life. Berlin's ecumenical AIDS initiative *Kirche posithIV* is one such centre run by volunteers, some of whom live with HIV/AIDS themselves.

The Ecumenical Advocacy Alliance, a large international network of over 50 churches and Christian organizations, was founded in December 2000 to campaign internationally against silence on the topic of AIDS and to help stem the global epidemic. The German groups involved in this international effort came together in 2001 to form an initiative group encompassing seven Protestant organizations: *Brot für die Welt*; the German Institute for Medical Mission (*Deutsches Institut für Ärztliche Mission – Difäm*); the Church Development Service of the Protestant Churches in Germany (*Evangelischer Entwicklungsdienst – eed*); the Association of Protestant Churches and Missions in Germany (*Evangelische Missionswerk in Deutschland – EMW*); the *Kindernothilfe* children's aid agency; the Northelbian Centre for World Mission and Church World Service (*Nordelbisches Zentrum für Weltmission und Kirchlichen Weltdienst – NMZ*) and the United Evangelical Mission (*Vereinte Evangelische Mission – VEM*).

This initiative group gave rise to *Aktionsbündnis gegen Aids* ("Action against AIDS Germany") with its "Life is a human right!" campaign playing a part in the international social movement to improve the lives of people living with HIV and AIDS.⁴⁰ The campaign's goals include the human right to life and health, the German federal government's provision of additional funding for AIDS prevention and treatment, and a reduction in the price of vital AIDS medications by pharmaceutical companies.

Aktionsbündnis gegen Aids now includes 85 German Protestant, Catholic and secular AIDS and developmental organizations, churches, mission agencies, and other organizations. Over 250 grassroots groups are also involved in the organization, including church parishes, "one world" solidarity initiatives and local AIDS support groups. AIDS support activities at the local parish level often depend on the commitment of individuals and the creation of local network structures in cooperation with the AIDS support groups in the area.

³⁹ Cf. Evangelical Lutheran Church in Bavaria / Diakonisches Werk Bayern: *Ich gehe aufrecht – denn du hast mich berührt. Leben mit Aids*, 2002 (www.diakonie-bayern.de/index.php?id=92 – in German).

⁴⁰ www.aids-kampagne.de/english/index.html

Aktionsbündnis has brought churches closer together with other organizations and local groups active in AIDS issues, and has lent support to cooperation between Protestant and Catholic Christians. It has become a central information outlet for the media, political, industrial and church figures, and anyone interested in the topic. The organization has also received considerable international recognition, and works together with the World AIDS Campaign, the Global Fund, United Nations agencies, and civil and other advocacy organizations.

5 Taking action, healing, hoping

5.1 The church as a community in action

This study demonstrates that HIV/AIDS can only be successfully overcome by redoubling our efforts. While the silence on AIDS has recently been broken, fear, condemnation, stigma and discrimination still persist. In their struggle with the challenges posed by the pandemic, many churches around the world have recognized, with a measure of self-criticism, that they have often been and sometimes still remain part of the problem. Just as many have embarked on a journey to seek an open approach to the topic, and are involved in prevention, patient care and treatment, orphan care, and a commitment to advocate for those affected and marginalized by the crisis.

The EKD Advisory Commission on Sustainable Development shares the opinion of many in the ecumenical movement that the global community of churches, their agencies and individual members bear a particular responsibility, while also representing a great potential for dealing with this scourge upon humanity. This community is well networked around the world, and is active both locally and globally. The churches provide people living with the illness and their families with spiritual solace alongside political and practical diaconal support. And in many countries, churches play a crucial role in the forum of public opinion and in forming society. It is in this context that the outlook on potential action, depicted below, can be regarded as an invitation to the organized churches and each and every church member, and to the German churches and their ecumenical partners in the countries of Eastern Europe and the Global South.

Jesus' message and deeds sought healing in wholeness and the religious and societal integration of outcasts and those facing discrimination. This mission remains unchanged whether for organized churches or for individual Christians. They are called upon to accept people with HIV/AIDS without prejudice, to integrate them and to afford them their own platform and space within the church so as to live without fear. The Commission would like to see the churches and church organizations introduce a policy of non-discriminatory hiring in regard to HIV/AIDS, and to develop guidelines and job programmes in line with this policy. This includes youth and educational efforts that call upon those affected or threatened by HIV/AIDS to take responsibility for themselves within society.

In numerous countries, churches bear the brunt of the health issues involved in the global fight against HIV/AIDS. This burden is particularly large as untreated HIV infections can lead to serious secondary illnesses (e.g. tuberculosis, malaria). The Commission calls upon the churches to work toward the creation of appropriate public structures for the prevention of disease and for the care of those who have become ill. They must, however, prepare themselves to meet the tasks in combating HIV/AIDS that they will face in the public arena for a considerable time to come. The churches must therefore become active in HIV/AIDS advocacy work.

The Commission continues to call for the Evangelical Church in Germany to remain steadfast in their witness to large corporations and those in political power on the connection between poverty and AIDS, and to speak out for measures that support just and sustainable development, particularly in the areas of health and education. In doing so, the EKD should ask governments and other sponsors to provide the required resources, and to seek solutions to the medical and social problems that have arisen from this pandemic and from secondary illnesses, especially in the countries of Eastern Europe and the Global South. This includes appeals to governments and international organizations to ensure the universal availability of high-quality HIV tests, and to ensure that preventative measures continue to be developed.

The Commission believes that it is the responsibility of each and every individual to support the equal treatment and standing of women, which is of crucial importance in the fight against HIV/AIDS. It is particularly critical in enabling women to decide for themselves when, with whom and under what circumstances they wish to engage in sexual relations. As a means of bringing about change in relations between genders, partner churches should be supported in their efforts to examine gender justice from a theological perspective, and to implement such change at all levels of church and society. This includes the challenge of bringing about the necessary changes in the behaviour and awareness of men in society.

We call upon Christians at all levels of the church to press for the access of people in poor countries to affordable antiretroviral drugs. This is tied closely to the development of medicines appropriate for children and to research on reducing mother-to-child transmission in developing countries.

The Commission asks the EKD to support its development agencies in their cooperation with their partners on advocacy for the introduction social security systems in high-prevalence countries. Such a measure is necessary to ensure the future viability of these societies. Care for orphans and other children and adolescents affected by the crisis is also of particular importance in this regard.

The WCC central committee is considering convening a church leadership summit alongside a youth summit, no later than 2008, to examine our collective response to the pandemic, learn from better practices, and shape the agenda for the ecumenical response to the crisis. The Evangelical Church in Germany emphatically supports these considerations.

The Commission calls for the Evangelical Church in Germany to ask its member churches and congregations not to relax their focus on or commitment to the issue of HIV/AIDS. Instead they should continue to work together with ecumenical partners on improvements in the care for those affected by HIV/AIDS, on ways to protect their rights, and on the dissemination of knowledge and information on HIV/AIDS. This includes support for initiatives such as the *Aktionsbündnis gegen Aids*. The Commission, furthermore, recommends that the EKD request that church mission and development agencies continue to place central importance on their support of AIDS projects and to increase their efforts in this area even further.

5.2 The church as a healing community

The challenges are complex and the task at hand is immense. The path towards alleviation, improvement and healing is a long and difficult one, requiring unlimited patience. And yet, the Christian faith is anchored in hope; we watch and ready ourselves to do what is possible and required both now and in the future. And we do this without fear of difficulties, doing whatever we can to prevent the disease, to combat its terrors and to work against its destructive power.

Of course, discussion among Christians within and between the churches is not without a certain degree of conflict, and particularly on this issue, is weighed down by great differences both in biblically defined positions and in basic ethical values. There are clear differences of fundamental theological importance in regard to reacting or accepting one's fate, sin and punishment, human wrongdoing and its consequences, and in regard to destiny and responsibility. Serious differences exist that, at times, even threaten to undermine the unity of the church. These include basic sexual-ethical values and their consequences in the judgement of differing lifestyles, as well as gender issues, the condemnation of certain sexual orientations, adequate protection from disease and the sensible use of prophylactics. We must understand these differences, live with them, and work on them. In doing so, we must take into account the interactions between basic theological values, a sober view of reality, and the often profound effect that the church has on people through its words and deeds. For now, this translates into a willingness to live among other Christians despite any tensions that may exist, and into a common pursuit of biblical and theological studies as means of deepening our knowledge and of moving towards harmonizing our positions. This is of particular importance in the ecumenical context.

Regardless of their differences, churches are called upon to follow in the footsteps of Christ and, within the community of faith that is the universal church of Jesus Christ, to view AIDS not as an illness affecting "others", but to take on these challenges together and with determination. Theological differences, as important as they may well be, and discussions within and among churches must not present an obstacle in the struggle against the pandemic that is so urgently necessary today.

5.2.1 Taking responsibility with regard to sexuality

Sexuality is a gift of God to humankind. God does not create humans alone but in relation with one another. His is a precious gift, one which enriches our lives. This gift should be embraced in such a way as to preserve the dignity and safety of every individual and the human community as a whole. God grants people the ability to live in relationships and to love each other. He enables people to conduct these relationships in a responsibility before God and for each other. Sexual relations are among the most intimate of human relations, and should thus be conducted in mutual trust

and in respect for one another. Sexuality can invoke the very beauty of life – but also guilt, entanglements and tragedy.

Sexual equality is an integral part of equal rights and of gender equality. Men must not be allowed to treat women as their property, and women are not predestined to be subservient to men. Violence must be excluded from any such relationships. Faith overcomes all taboos that may prevent people from addressing and overcoming violence in relations between men and women. Churches can and will play a role in breaking the silence often associated with this problem and helping those in need.

In the face of the HIV/AIDS crisis, traditional views of sexual ethics must be re-viewed critically to determine whether and to what degree they put lives at risk. In some places, a fear of HIV/AIDS leads to stronger taboos on sexuality, which can then be linked simplistically to moral failure, sin and death. The exercise of freedom with responsibility and a sober view of preventative measures, particularly with a view to condom use, can then be condemned as amoral. But it is precisely at such a point that we lose sight of our Creator's good gifts and the responsibility he places in us for each other.

5.2.2 Reconciliation and participation

Many Christians view HIV/Aids as an issue affecting “others”, a problem of marginal groups that have nothing to do with them. People who are HIV-positive or who are living with AIDS may then have the feeling of being stigmatized, discriminated against, and without a home – within the very context of a Christian community. There have, on the other hand, been helpful moves towards a change in this sort of thinking, a change promoted in the WCC study document and statement on HIV/AIDS, *Facing AIDS – Education in the Face of Vulnerability HIV/AIDS* (1997). The paper develops a vision of a healing community in the face of the threat posed by HIV/AIDS: “The church, by its very nature as the body of Christ, calls its members to become healing communities. Despite the extent and complexity of the problems raised by HIV/AIDS, the churches can make an effective healing witness towards those affected. The experience of love, acceptance and support within a community where God's love is made manifest can be a powerful healing force.”⁴¹ Healing in this context refers to a sense of being cradled by one's faith and the community, and to a reconciliation with the inevitable, even when the body can no longer itself be healed. This form of healing manifests itself in spiritual, social and mental dimensions, fending off all forms of marginalization and stigmatization, and embracing a spirit of community and solidarity.

Only once they have broken their silence on HIV/AIDS and have incorporated HIV/AIDS into their liturgies and sermons can congregations become places in which

⁴¹ World Council of Churches: *Facing AIDS – Education in the Face of Vulnerability HIV/AIDS*, Geneva 1999, p. 36.

people living with HIV/AIDS feel accepted and comfortable with opening up to others. Two publications have made considerable headway toward this goal: the book *Africa Praying*,⁴² which arose from the efforts of the Ecumenical HIV/Aids Initiative in Africa (EHAIA), and which features a comprehensive collection of liturgical texts and sermons on HIV/AIDS suited to a variety of themes and life situations; and *God breaks the Silence. Preaching in Times of AIDS*, a collection published by Mission 21 and the United Evangelical Mission.⁴³

The member churches of the EKD have also been undergoing a gradual rethinking process. The churches and other civil institutions have been coming closer together, through the founding and efforts of *Aktionsbündnis gegen Aids* (“Action against AIDS Germany”). The ability to achieve significant change lies, to a great degree, with those affected by the crisis themselves. If they are not the actual initiators themselves, people living with HIV/AIDS should always at least be involved in processes that lead to a change in the situation. The World Council of Churches (WCC) has thus identified the “greater involvement of people living with HIV and AIDS” as a crucial aspect of its AIDS efforts. Numerous congregations have picked up on this initiative and conduct their own church services to mark World AIDS Day and other such events, with new ways of remembering those who have passed on and of praying together for people with HIV.

Through this process, the churches have been expanding their focus from diaconal projects and pastoral care to matters of ecclesiological importance. Congregations learn to become “churches for the others” and to speak more openly about sexuality and mutual interdependence, integrating these issues into parish life. This has, however, yet to become reality in many German congregations, as many people living with HIV have indeed reported.

5.2.3 The offer of hope

Jesus, accompanied by his disciples, came across one who had been born impaired and – unlike disengaged passers-by who had ignored him – turned to face him (John 9:1). The apostles asked Jesus whose fault the illness was: “Who sinned, this man or his parents?” (John 9:3a) Jesus did not dwell on this question about the past, and distanced himself from the sort of argument that analyzes and discusses human fate from a cool remove. He instead looked to the future, and to the works of God that they might be revealed in this poor soul. (John 9:3b)

What are these works of God? The Creator brings order to chaos and light to the world, and calls into being that which does not exist. He grants people their dignity – a dignity that is indestructible and everlasting.

⁴² Dube, M.W. (Ed.): *Africa Praying. A Handbook on HIV/AIDS Sensitive Sermon Guidelines and Liturgy*, World Council of Churches, Geneva 2003.

⁴³ United Evangelical Mission and Mission 21, *God breaks the Silence. Preaching in the Times of AIDS*, Rheinbreitbach 2005.

What are these works of God? The Saviour is coming, one who is himself the very word of the Creator, who is himself the light and who brings the light (John 1). He invites both the just and the unjust to his table to bring about a healing community; he does not idly pass by the caves of the lepers, but extends his healing power to face the demons and overturns the desperate fate of the ill. His followers see and hear all that he does: "The blind receive their sight, the lame walk, the lepers* are cleansed, the deaf hear, the dead are raised, and the poor have good news brought to them" (Matt. 11:5).

What are these works of God? Jesus calls on his disciples to follow him: They receive from him inspiration and direction, and are granted power and authority; and they are filled with the power of the Holy Spirit. They bear witness to the one who has come for the benefit of us all. His disciples and followers, men and women alike, receive the power of hope, a force intertwined with faith and love. In the light of the coming kingdom of God, witnesses to Christ remain alert with open hearts, and with hands to console and to carry, to share and to heal in unswerving hope.

International links

UNAIDS: www.unaids.org

International efforts

Annual report on the AIDS epidemic, including information on individual countries and continents, presented together with the World Health Organization

UNICEF: www.unicef.org

International efforts

Information on children and AIDS around the world, campaign information

Ecumenical Advocacy Alliance: www.e-alliance.ch/hiv aids.jsp

Information on church actions and campaigns

World Council of Churches: www.oikoumene.org

Information on AIDS from an ecumenical church standpoint

German links

Bundeszentrale für gesundheitliche Aufklärung (Federal Centre for Health Education): www.bzga.de (German and English)

Information on AIDS prevention campaigns

Robert Koch Institute: www.rki.de/cIn_048/EN/ (German and English)

Information on medical matters and on the latest developments in Germany

Aktionsbündnis gegen Aids: www.aids-kampagne.de/english/index.html (German and English)

Information on HIV and AIDS, background information on campaigns

Deutsches Institut für Ärztliche Mission e.V. (German Institute for Medical Mission – DIFÄM): www.difaem.de (German and English)

Advisement, planning, and assistance for health projects in close cooperation with partners on development projects in the areas affected

Deutsche Aids-Hilfe e.V.: www.aidshilfe.de (German only)

Portal for the umbrella organization of German AIDS help groups with links to the individual groups; basic information on HIV and AIDS; brochures available on request

Glossary

AIDS (Acquired Immunodeficiency Syndrome)

Final stage of the Human Immunodeficiency Virus (HIV)

Antiretroviral drugs

Medication that prevents the virus from reproducing

Combination therapy

Treatment with several (at least three) antiretroviral drugs in combination, a method introduced in 1996

Commercial sex worker

Often replaces the term “prostitute” in studies

Epidemic

Unusually high infection rate within a population

Gender

This term also includes the socially and culturally defined roles of women and men.

Gender equality, gender mainstreaming

Gender mainstreaming is the process of assessing the implications for women and men of any planned act with the goal of achieving gender equality.

Generalized epidemic

An epidemic that has spread within risk groups or to over five percent of the general public

Generic drug

Medicines for which patent protection has expired and which is provided under generic names referring to their chemical make-up instead of their protected brand names

Global Fund

The Global Fund to Fight Aids, Tuberculosis and Malaria, called into being by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, is supported by governments, churches and other NGOs, in addition to individual donors.

High-prevalence countries

Countries with a high HIV infection rate in their population

HIV (Human Immunodeficiency Virus)

The virus that leads to AIDS

HIV status

Whether someone is HIV-positive (infected with HIV) or HIV-negative (not infected)

Immune defence

The ability of the body to defend itself against antigens such as bacteria and fungi

Incubation period

The amount of time following an infection that it takes for the first symptoms to appear (outbreak) or for the infection to test positive

Mainstreaming HIV/AIDS

The integration of HIV/AIDS efforts into development work or, conversely, the integration of all sorts of human development programmes into HIV/AIDS projects

Marginalization

The process in which groups of people are excluded (marginalized) by wider society

Malaria

An infectious disease transmitted by anopheles mosquitoes infected with the malaria parasite

Microbicide

Substances that destroy microorganisms, bacteria and viruses

Millennium Development Goals (MDGs)

A list of goals to reduce poverty, hunger, disease, illiteracy, environmental destruction and gender discrimination, established at the UN Millennium Summit in September 2000

Opportunistic infection

Illnesses that are made possible by the weakening of the immune system (e.g. as the result of HIV)

Pandemic

An epidemic that spreads across national borders or even globally

Prevalence

The frequency of an illness among a certain population at a certain time

Promiscuity

Sexual intercourse with (frequently) changing partners without a stable relationship

Safer sex

Sexual practice that reduces the risk of infection with a sexually transmittable disease (esp. HIV/AIDS) by preventing seminal fluid, vaginal fluid, blood and traces of blood from entering into the body of one's sexual partner

Treatment literacy

Knowledge concerning protection from infection and available treatment

Tuberculosis

An infectious bacterial disease, this is now the most common opportunistic infection in Africa

UNAIDS (Joint United Nations Programme on HIV/AIDS)

The United Nations coordination programme for the fight against HIV/AIDS, UNAIDS emerged from the Global Programme on HIV/AIDS of the World Health Organization in 1996

Voluntary Counselling and Testing (VCT)

HIV testing with both pre-test and post-test counselling sessions

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