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PROJECTS

Klaus Fleischer et al.

Responses of the Catholic Church to HIV and AIDS in Africa: Lessons learned

An international field study by African and German theologians and health workers

German Bishops' Conference Research Group on International Church Affairs (ed.)

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A research project of the German Bishops' Conference Research Group on International Church Affairs

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Responses of the Catholic Church
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- Mr Paul Sagna, Director of SIDA Service in Senegal and a member of SECAM HIV Steering and Advisory Committee

Foreword

On behalf of the German contributors to this report, I wish to express our deep respect and gratitude to all our African partners and friends with whom we have worked intensively on this project, which brings together the disciplines of theology and medicine. We have argued, followed up, agreed, disagreed and finally produced this report. It is thanks largely to our African colleagues that this book has been published, and we are deeply grateful to them for the enthusiasm, commitment and diligence which they have brought to this project.

We have particularly good memories of the outstanding spirit of joint commitment which marked the appraisals at diocesan level, and later the conferences in Frankfurt am Main and Addis Ababa. The contacts made during these meetings are still continuing. For any shortcomings in this report we offer our sincere apologies. We hope, however, that this report leads to an ongoing and productive dialogue between theologians and health professionals in Africa and Germany on the topic of the HIV epidemic.

Finally, the German researchers and authors would like to sincerely thank the German Episcopal Conference and its Research Group on International Church Affairs for having been chosen to undertake this project. We are all deeply concerned about the HIV epidemic and committed to continue doing everything in our power to bring it to an end as soon as possible.

Professor Dr Klaus Fleischer

Study coordinator

Acronyms

AAC	Anti AIDS Club
ABC	Abstinence, Being faithful, Condom use
ADCS	Adigrat Diocese Catholic Secretariat (Ethiopia)
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
BCC	Behaviour Change Communication
CADECOM	Catholic Development Commission in Malawi
CAFOD	Catholic Agency for Overseas Development (UK)
CFSC	Centre for Social Concern (Malawi)
CHAZ	Churches Health Association of Zambia
CMAZ	Churches Medical Association of Zambia
CMMB	Catholic Medical Mission Board (USA)
CPT	Co-trimoxazole Preventive Therapy
CRDA	Christian Relief and Development Association (Diocese of Emdibir, Ethiopia)
CRS	Catholic Relief Services (USA)

CUEA	Catholic University of Eastern Africa
DACC	District AIDS Coordinating Committee (Malawi)
DATF	District HIV/AIDS Task Force (Zambia)
DHO	District Health Office (Malawi)
DHO	Diocesan Health Office (Zambia)
DREAM	Drugs Resource Enhancement against AIDS and Malnutrition
ECM	Episcopal Conference of Malawi
ECUSTA	Ethiopian Catholic University of St Thomas Aquinas
ECS	Ethiopian Catholic Secretariat
EIFDDA	Ethiopian Interfaith Forum for Development, Dialogue and Action
FBO	Faith Based Organization, e.g. churches
GKKE	Gemeinsame Konferenz Kirche und Entwicklung (Joint Church and Development Conference)
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
IGCM	Institute for Global Church and Mission (Germany)

INERELA+	International Network of Religious Leaders living with or Personally Affected by HIV and AIDS
JCTR	Jesuit Centre for Theological Reflection (Zambia)
MA	Missionaries of Africa
MCP	Malawi Congress Party
MMM	Medical Missionaries of Mary
MI	Medical Mission Institute (Germany)
NAC	National AIDS Council (Zambia)
NAC	National AIDS Commission (Malawi)
NACP	National AIDS Control Programme (Malawi)
NAPCP	National AIDS Prevention and Control Programme (Zambia)
NASC	National AIDS Surveillance Committee (Zambia)
NGO	Non-governmental Organization
OMCA	Orthodox, Muslim and Catholic Unity to Safe Life (Ethiopia)
OSSA	Organization for Social Services for AIDS (Ethiopia)
OVC	Orphans and Vulnerable Children
PAC	Public Affairs Committee (Malawi)

PACO	Pastoral Activity Coordination Office, Emdibir (Ethiopia)
PEPFAR	President's Emergency Plan for AIDS Relief (USA)
PLHIV	People Living with HIV
PLWHA	People Living with HIV & AIDS
PMTCT	Prevention of Mother to Child Transmission
SACBC	Southern Africa Catholic Bishops' Conference
SDCO	Social and Development Coordination Office (Ethiopia)
SECAM	Symposium of Episcopal Conferences of Africa and Madagascar
SJ	Society of Jesus
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
Trocaire	Official Overseas Development Agency of the Catholic Church in Ireland
UNAIDS	Joint United Nations Programme on AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

ZAS	Zambian Association of Sisterhood
ZEC	Zambia Episcopal Conference

Glossary

catechist: a lay person or Religious who teaches Christian faith, doctrine and morals

congregation: 1. a group of people belonging to a religious order (see below); 2. a group of people assembled for religious worship

formation: formal training as a priest or Religious in spiritual disciplines for a period of time, during which the person concerned may adapt to a particular way of religious life and develop a sense of belonging

incidence: the number of times something happens or develops, or the rate at which something occurs. HIV incidence usually means the percentage of the population (15-49 years) that becomes infected with HIV over a one-year period.

pastoral agent: a priest, Religious or catechist, or other person doing pastoral work for the Church

prevalence: the degree to which something is prevalent; *especially*: the percentage of a population that is affected with a particular disease at a given time. HIV prevalence is, unless stated otherwise, the percentage of the population between 15 and 49 that is infected with HIV at a given point in time (see also incidence)

religious order: a Christian movement guided by a particular spirituality and living according to a certain discipline

Religious: a woman or man belonging to a religious order or congregation, and bowed by canonical vows

Sister: term of address for a Religious woman who belongs to a congregation

woreda: a district, or third-level administrative division in Ethiopia.

Executive summary

Since the early years of the HIV epidemic, Catholic institutions in sub-Saharan Africa have responded by providing information, treatment, care and support to those infected and affected. Between 2010 and 2013, three interdisciplinary teams carried out field research to document and analyse the responses of the Catholic Church to the HIV epidemic in three African countries: Ethiopia, Malawi and Zambia. They focused in particular on how programmes initiated and run by the Catholic Church have assisted people living with HIV and AIDS (PLWHA), their families and groups in all sections of society in these three countries.

Church programmes in each of these countries have made uniquely valuable contributions to national responses to the HIV epidemic. These include, for example, the provision of medical treatment and nursing care, home-based care and social support, pastoral and spiritual care, voluntary counselling and testing, education and prevention initiatives, support for orphans and vulnerable children, and campaigns to reduce HIV-related stigma and discrimination.

These services have been provided to people of all faiths, with a high level of dedication and technical competence. Particularly prominent in the provision of these services have been congregations of women Religious in collaboration with volunteers (including many non-Catholics) mobilised, trained and supported by the Church. These services have played an important role in recent successes in the field of HIV control, including reductions in new HIV infections and HIV-related deaths in all three countries. In many places, especially in rural areas, the Church is the only institution providing HIV-related health services and social support to the local population.

The two teams that conducted in-country research for the report also looked into the question of how the Church sees itself in relation to the HIV epidemic. They concluded that, although the Church provides numerous HIV-related services, it often perceives itself as an external agen-

cy untouched by HIV, rather than as an organisation which is itself affected by the HIV epidemic. Even discussion of HIV infection among priests and Religious is often considered taboo. In the course of the research for this book, not a single priest or Religious woman or man living with HIV in the three countries could be interviewed, although several people acknowledged that they knew one or more.

The research teams suggest that the church-going faithful and the general public increasingly disagree with the taboo status of HIV and AIDS within the Church. Many Church-going Catholics do not perceive HIV infection as a barrier for clergy and Religious to play an active role in Church life in general and in pastoral care in particular. Despite – perhaps even because of – their HIV-positive status, they are well placed to render service in the cause of the Gospel. Moreover, through much improved health care – especially the availability of antiretroviral therapy – the health status of HIV-infected people has improved enormously. These days, an HIV-positive priest or Religious woman or man can work well under physical stress, and may even be a great asset for an HIV programme providing pastoral care.

The research teams also discussed the issue of what constitutes an "HIV-sensitive Church". The team working in Zambia came up with the following definition:

An HIV-sensitive Church is a Church:

- that talks freely about issues of HIV and AIDS
- that wants HIV and AIDS to be incorporated in all the activities of the Church
- where people can give testimonies
- where they accept seminarians who are HIV-positive to go on with their formation and do not withdraw them from the seminary
- where priests care for each other and do not discriminate against those infected

– where people accept that anyone can get the virus
– where we mainstream issues of HIV and AIDS in all our programmes, not just waiting for annual World AIDS Day, and where we integrate HIV and AIDS issues in our homilies, workshops, wedding ceremonies and Church programmes.

One of the most fiercely discussed topics in the meetings carried out by the research teams was that of discordant couples, i.e. couples in which one partner is HIV-positive and the other negative. This is a challenging issue because it concerns the use of the condom, which fulfils two functions at the same time: the prevention of contraception, which is contrary to Catholic moral doctrine; and second, protection of the HIV-negative partner against HIV infection. In general, four types of advice are given by Church leaders:

1. Sexual abstinence so the non-infected partner does not become infected.
2. Condom use.
3. Allowing married couples to decide according to their consciences what they consider to be the correct behaviour.
4. No advice; married couples are referred to a medical expert, such as a doctor.

The diversity of these responses indicates the presence of a moral dilemma, which urgently needs to be addressed.

International Catholic agencies such as Caritas, Catholic Relief Services, CAFOD, Misereor, missio, Trocaire and the Medical Mission Institute have provided substantial financial and technical support to HIV programmes carried out by the Church. Yet this support has also had a downside, namely, the creation of donor dependency. When, in the mid-1990s, the donors sharply reduced their support for HIV programmes, the recipients were unprepared. Many Catholic HIV programmes had to

sharply reduce the scale and scope of their activities, or stopped completely.

The report makes five specific recommendations to the global Catholic Church, namely:

1. That theological reflection on ethical and other dimensions of HIV and AIDS be enhanced at every level of theological teaching and research. The issue of HIV and AIDS should be addressed as one of integrated development and global justice, as well as a holistic approach of moral theology towards understanding human sexuality as a gift of God.

2. That the situation of discordant couples, also addressed by the Fathers of the Second Special Assembly of the Roman Bishops' Synod for Africa, as well as pastoral and ethical support for discordant couples, may be studied by an interdisciplinary and international body, in order to give clear guidance for the people concerned and in order to avoid conflicting messages.

3. That the formation of pastoral agents of the Church, especially in Major Seminaries, may systematically include capacity building on medical, ethical and pastoral knowledge and skills in the field of HIV and AIDS.

4. That the situation of HIV-positive priests and Religious men and women be taken seriously, so that a spirit of welcoming may be fostered by addressing the issue of HIV-related stigma within the Church; so that support groups for infected and affected pastoral agents may be encouraged; that on this issue a systematic networking of religious orders and congregations, including the "International Network of Religious Leaders living with or personally affected by HIV and AIDS" (INERELA+), be put in place.

5. That the Universal Magisterium of the Catholic Church serve the local churches and their magisteria, so that in accordance with the principle of subsidiarity, specific problems that arise in the local context may be addressed and solved at the local level, and that the magisterium of the bishops in various cultural contexts be strengthened.

The report concludes that, despite recent successes in global HIV control, HIV and AIDS are still of major concern in many parts of the world, especially in sub-Saharan Africa. It would therefore be disastrous if international, national and community responses to the challenges of the HIV epidemic were now to slacken. Constant and untiring commitment to HIV prevention, care and support remains of paramount importance. For the Catholic Church, however, caring for people living with or affected by HIV should not be simply a charitable act, but a mission for social justice.

1. Study background

The engagement of German Catholic institutions in efforts to respond to the challenges of HIV and AIDS in Africa stems back more than twenty years. Misereor and the Medical Mission Institute in Würzburg recognized the possible magnitude of the new epidemic and sought ways to assist local churches in Africa. Ecumenical discussion inspired this engagement through, for example, the ”pharma dialog” of the Joint Church and Development Conference (GKKE) with the pharmaceutical industry active in the production of antiretroviral drugs (ARVs).

In 2006, the Commission for International Church Affairs of the German Episcopal Conference undertook a journey to South Africa. The purpose of the visit was to meet, face-to-face, with women and men living with HIV. The visit also aimed to learn how clergy and lay people in the local Church reacted to the plight of these people, their families and the various groups in society. Based on reports from a broad spectrum of affected persons, as well as Caritas and diocesan groups from all over South Africa, the group explored ways to define the responsibility of the Church and to develop appropriate forms of assistance from the countries of the global North. Six German bishops, accompanied by theological and health experts, under the leadership of Archbishop Dr Ludwig Schick, took part in the journey. Out of this profound experience, the Commission decided to set up a research project entitled “Lessons learned from the response of the Catholic Church to HIV and AIDS in Africa”. The Commission had a very wide remit, covering theological, ethical and pastoral questions, as well as curative and preventive health issues – all from an African perspective. African theologians and health researchers, therefore, were to be invited to develop questions, assisted by a team from Germany.

The study was inaugurated on 15 March 2010, with a budget of €198,000. It was led by the theologians Professor Dr Albert-Peter Rethmann from the Institute for Global Church and Mission (IGCM), Sankt Georgen, Frankfurt am Main, and his co-worker, Dr Gregor Buß, along with Dr

Marco Moerschbacher from missio Aachen. Public health input was provided by Professor Dr Klaus Fleischer, Dr Klemens Ochel, and Dr Piet Reijer from the Medical Mission Institute in Würzburg (MI).

The MI set up a literature database and developed the first research procedures, while the IGCM in Frankfurt am Main took care of the financial management of the project.

A selection of research sites had to be made, taking into account the research capacity, and the time and funds available. The following criteria were used in this selection process: high number of people living with HIV; long-standing efforts in HIV prevention, medical and pastoral care; involvement in international dialogue on social affairs with church-related agencies in Germany; and readiness to participate in the research. Four Catholic dioceses and three seminaries were selected for the study, as follows:

- Ethiopia: the Dioceses of Emdibir and Adigrat as focal points, and the major seminaries in Addis Ababa and Adigrat,
- Zambia: the Diocese of Chipata as focal point,
- Malawi: the Archdiocese of Lilongwe as focal point, including the major seminary.

In June and July 2010 the two German research teams started the field work: Dr Ochel and Dr Buß in Ethiopia, and Dr Reijer and Dr Moerschbacher in Zambia and Malawi. They met and engaged with local African researchers. Consensus was reached on the detailed topics, the methods and the time frame for the study.

It is often said that the Catholic Church takes a "holistic" approach to the HIV epidemic, as opposed to the "mechanistic" and "one-sided" approach of national and international HIV agencies. It was decided, however, not to focus the study on this issue. First, there is no agreed definition of a specifically "Catholic" and "holistic" approach; and second, it is doubtful whether this terminology can be applied to whole regions

where the HIV epidemic is highly differentiated and the level of public awareness is extremely variable. There is, however, a generally agreed objective of assisting men and women living with HIV, their families and groups in all sections of society. To study how the church achieves this or fails to do so is, therefore, a more practical approach, different from that of WHO or narrow national goals.

The study followed approved scientific criteria, with detailed documentation of the enormous variety of answers in the semi-structured interviews of individuals and groups, their answers in case studies, and background interviews with bishops and rectors of major seminaries and other religious institutions. The strength of the study is that the voices of individuals living with HIV, and those engaged in providing them with care and support, were clearly heard. The mandate for the study came from African Church leaders, but was taken up enthusiastically by the German bishops.

Finally, the study proved to be a good example of applied research, engaging and training both senior and junior African researchers in structured field work. This led to a broad range of information about how to proceed in specific life situations. The main weakness of the research is that the examples given cannot be regarded as representative of the whole of sub-Saharan Africa, which is a vast region with huge regional and national differences.

In June 2012, all the researchers met for a three-day conference in Addis Ababa to present their findings under the joint chairmanship of Bishop Tesfaselassie Medhin from Adigrat, Ethiopia, and Auxiliary Bishop Dr Hans-Jochen Jaschke, representing the German Bishops' Conference. The African researchers were accompanied by their bishops. They were joined by two more Ethiopian bishops, as well as representatives of dioceses and church institutions of higher learning - in total, over 50 persons.

During a very intense discussion process the theological, ethical, pastoral, medical, caring and teaching aspects of the study were discussed in detail, and their respective strengths and weaknesses – as reflected in the study – were highlighted. It was agreed that:

- African Catholic clergy and laity are called to deepen their knowledge about – and their engagement in – the ongoing, devastating HIV epidemic, and not to excuse themselves by pushing the matter into the narrow field of health.
- Representatives of the Catholic Church should participate more in local, national and international decision-making about HIV and AIDS, for example, in discussions with traditional leaders or in country coordinating mechanisms.
- Greater emphasis must be given to documentation of the Church's long-standing commitment to assistance for individuals and groups in society that are in need of support. This should include coverage of all aspects of broad-based, church-related HIV and AIDS programmes in the press, radio, television and social media.

The participants of the conference in Addis Ababa suggested discussing the findings of the study in local conferences at various diocesan levels, especially with those who did not take part in the research project. In addition, appropriate learning materials should be developed for the training of priests, religious women and men, and the laity. E-learning, combined with hands-on experience, was suggested as the most suitable method. Auxiliary Bishop Dr Jaschke and the German researchers were asked to bring these proposals to the forums of German Catholic funding agencies.

2. Church responses to HIV and AIDS in Africa

On a global level the African continent is the most affected by the spread of the Human Immunodeficiency Virus (HIV). More than six out of ten people infected with HIV live in sub-Saharan countries, amounting to a total number of 23.5 million.[1] For adults in Africa the infection is mostly transmitted heterosexually. Women are much more affected than men. Children are infected mainly during pregnancy and delivery, and through breastfeeding. In Africa 3 million children are currently living with HIV.[2] For the 17 million African children below the age of 17 who have lost one or both parents the future looks bleak. The issue of exactly why the HIV epidemic has assumed such immense magnitude in Africa cannot yet be answered.

In the late 1980s, church-related health and social services in Uganda were already responding to the ravages of "Slim" disease. The Irish Sisters of the Medical Missionaries of Mary, who headed the Kitovu Catholic Hospital in Masaka, in southwest Uganda, reported how AIDS had already killed large parts of the adult population in this region. There was very little effective medication available to the Sisters and their medical and nursing personnel to treat the symptoms, to ease suffering and to allow people to die with dignity.

Due to the vast numbers of infected and affected people, home-based care programmes staffed mainly by lay volunteers were established. One of the largest programmes in Africa was developed by the Catholic Diocese of Ndola in the Copperbelt Province of Zambia. Soon it became clear that not only AIDS patients were in need of care and support. The entire family was vulnerable. The couple had to be counselled on the importance of testing for HIV infection and protecting the uninfected

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1 UNAIDS (2011), *Global Fact Sheet*, www.unaids.org.

2 Ibid.

partner from infection. Children and adolescents needed information, education, care and support. They had to find ways of becoming an "AIDS-free" generation. Priests and Religious were – and still are – called to offer pastoral and spiritual support to infected and affected persons and their families.

During a conference at the Vatican in 1989, John Paul II encouraged health workers to help and invoked Church relief organizations to show active solidarity with people either infected or affected by the HIV epidemic. He also emphasized prevention through the promotion of human values. The German Bishops' Conference commented on this phenomenon for the first time in 1997, and portrayed AIDS as a pastoral task of the Church. These comments, however, focused less on the global challenges and more on the local ones. Following intense reflections, many Bishops' Conferences in Africa sent pastoral letters and explained the seriousness and intensity of this problem. They encouraged people to change sexual behaviour, denounced other causes for the spread of the disease, asked for political and social commitment to prevent or overcome stigma and discrimination, and they also called on people to pray for the affected.

The impact of church-related social and health services is hard to measure. Based on a survey of Bishops' Conferences, the Pontifical Council has calculated that 20–40% of people living with HIV in Africa are cared for in church-related facilities and programmes. Although this figure cannot be verified exactly, all the international agencies and governments involved in HIV and AIDS-related work acknowledge that the performance of the Church in the field of HIV and AIDS care, treatment and support has been well above average, and continues to be so. Although Church health and social services have made a very substantial contribution to public welfare in the field of HIV and AIDS, these services have received little support from international public donor agencies, such as The Global Fund to Fight AIDS, Tuberculosis and Malaria, which was founded in 2002. The following factors have played a decisive role in this:

– The achievement by Church-related stakeholders is insufficiently documented.

– The use of resources by Church agencies often lacks transparency.

– Approaches by the Church in the field of prevention are seen as at variance with scientific evidence.

– The comprehensive, value-oriented approach of Churches is hard for secular bodies and individuals to understand and accept.

– The Church leadership ignores the fact that some Church representatives are also living with HIV.

3. Hypothesis and methodology

3.1 Hypothesis

The main hypothesis of this study is that, in the Catholic Church, the huge body of practical experience of responding to the HIV epidemic over the past 30 years has not yet been sufficiently included in the formation and training of priests, Religious and the laity. In many fields and areas of training and skills building, ethical, moral and pastoral concerns in relation to HIV and AIDS need to be widened and deepened. Just as in the fields of health and social development, where the HIV epidemic has led to great advances in knowledge and practice, so in the fields of theology and ethics new ground must be broken to respond effectively to the challenges of the HIV epidemic. A proper theological and ethical reflection on HIV and AIDS will focus on structural issues, cultural factors and individual ethical issues. The HIV epidemic needs to be viewed, not in isolation, but as a challenge to the Church, particularly in relation to the pastoral, theological and ecclesiological aspects of the epidemic.

3.2 Central questions arising from the hypothesis

- To what extent do Church interventions contribute to sustainable solutions, for example, in the fields of prevention, treatment and care?
- What are the strengths and weaknesses of church-based involvement in HIV-related activities and programmes?
- What type of assistance with regard to HIV and AIDS do the Church and Church-related institutions need for their personnel (especially pastoral workers)?

3.3 Methodology

This study describes the development of Church-based responses to HIV and AIDS in three countries – Ethiopia, Malawi and Zambia. It does so

through the medium of interviews and case studies. The phases and methods of the project were as follows:

1. Study and analysis of national and international scientific and theological reports and studies (as of March 2010)
2. Development of a frame of reference (including a questionnaire) for the field study, to commence in September 2010; initial field trips for team building and distribution of tasks, development of study tools, formation of the research teams:
    a. Team Ethiopia: Birkinesh Banbeta and Berhane Kidane (Ethiopia), Gregor Bußß and Klemens Ochel (Germany)
    b. Team Zambia-Malawi: Leonard Chiti SJ and Aaron Yambani (Zambia), Jos Kuppens MA und Jacqueline Mpanyula (Malawi), Marco Moerschbacher and Piet Reijer (Germany).
3. Field study: interviews in the form of semi-structured individual interviews and focus group discussions, study and discussions on ethical case studies.
4. Evaluation meetings in the dioceses in early 2011.
5. Study week with all participating researchers at the Institute for Global Church and Mission, Frankfurt am Main, Germany, July 2011.
6. Introduction and discussion of initial results during a three-day conference with Church leaders from study dioceses and representatives of the German Bishops' Conference, in June 2012, in Addis Ababa, Ethiopia.
7. Documentation of the most significant parts of the study in a comprehensive report.
8. Report presentation to the Research Group of the German Bishops' Conference on International Church Affairs, December 2013.
9. Report presentation to the Commission for International Church Affairs of the German's Bishops' Conference, May 2014
10. Presentation of the study in the Diocese of Chipata and the Archdiocese of Lilongwe, May 2014

4. Focus countries and dioceses

4.1 Ethiopia

4.1.1 HIV in Ethiopia

Since the reporting of Ethiopia's first HIV case in 1984 and first AIDS case in 1986, the HIV epidemic has spread rapidly throughout the country and has evolved into a generalised epidemic. AIDS is now the leading cause of morbidity and mortality among adults in Ethiopia.[3]

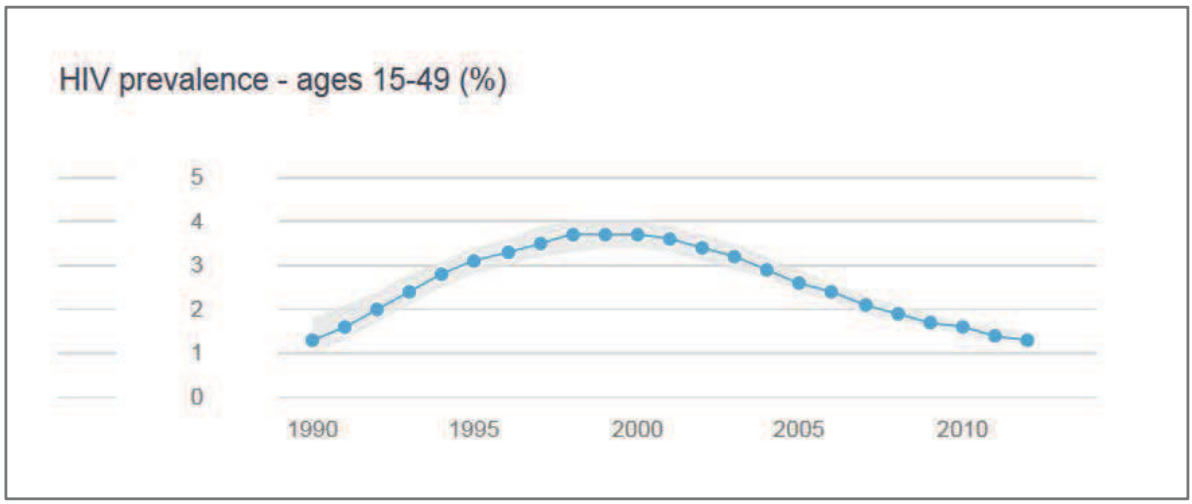

Figure 4.1: HIV – prevalence (%) in people aged 15 to 49 from 1990 until 2012.[4]

Adult HIV prevalence was estimated by UNAIDS to be between 1.4% and 2.8% in 2009 and between 1.2 and 1.5% in 2012.[5] The last available single

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3 Hladik, H.I. (2006) "HIV/AIDS in Ethiopia: where is the epidemic heading?", *British Medical Journal – Sexually Transmitted Infections*, Volume 82 (Suppl. 1) ,pp. 132 – 135.

4 UNAIDS (2012) *AIDS Info UNAIDS*. Available at: http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/ [Accessed: 24 April 2014]

5 Federal HIV/AIDS Prevention and Control Office, Republic of Ethiopia (2010), *Report on Progress towards Implementation of the UN Declaration of Commitment on HIV/AIDS*, Addis Ababa: Federal Democratic Republic of Ethiopia. Available at:

point estimate exercise, done in 2007, projected urban and rural prevalence at 7.7% and 0.9% respectively for 2009. At this point in time prevalence was 1.8% for males and 2.8% for females, and women accounted for 59% of the HIV-positive population.[6] There were an estimated 130,000 new HIV infection (57% female) and 45,000 AIDS-related deaths (57% female) in 2009. The total estimated number of HIV-positive pregnant women and annual HIV-positive births in the same year were 84,000 and 14,000 respectively.

Traditionally, most at-risk population groups, such as sex workers, uniformed forces, long-distance drivers, never-married sexually active females, discordant couples, migrant labourers, cross-border populations and in-school youth (particularly in tertiary education) are increasingly at risk of HIV infection. There is a data gap to accurately measure the recent spread of HIV in these groups and their potential role in spreading the epidemic further within the general population.

http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/ethiopia_2010_country_progress_report_en.pdf [Accessed: 24 April 2014]

6 Ibid.

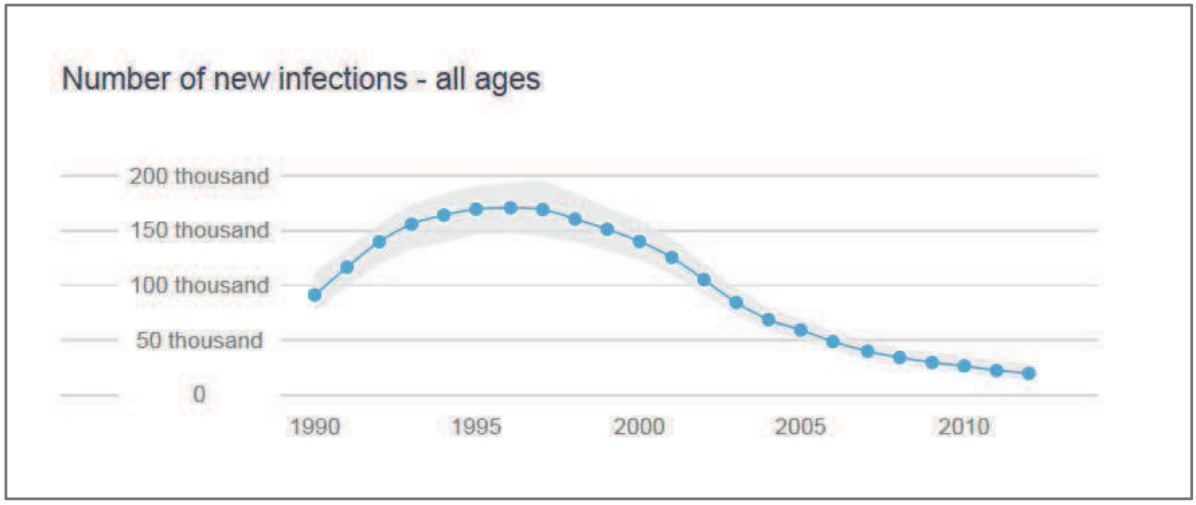

Figure 4.2: Number of new HIV infections in Ethiopia from 1990 until 2012.[7]

The HIV epidemic in Ethiopia peaked in the mid-nineties and started to decline in major urban areas in 2000, while stabilizing in rural settings (see Figure 4.2).

There were an estimated 47,000 deaths due to AIDS in 2012 (see Figure 4.3). The number of AIDS-related deaths would have been much higher if it had not been for the free ART programme, which has been scaled up by the government, in collaboration with development partners, since 2005.

[7] UNAIDS (2012) *AIDS Info UNAIDS. Available at: http*://www.unaids.org/en/dataanalysis/datatools/aidsinfo/[Accessed: 24 April 2014]

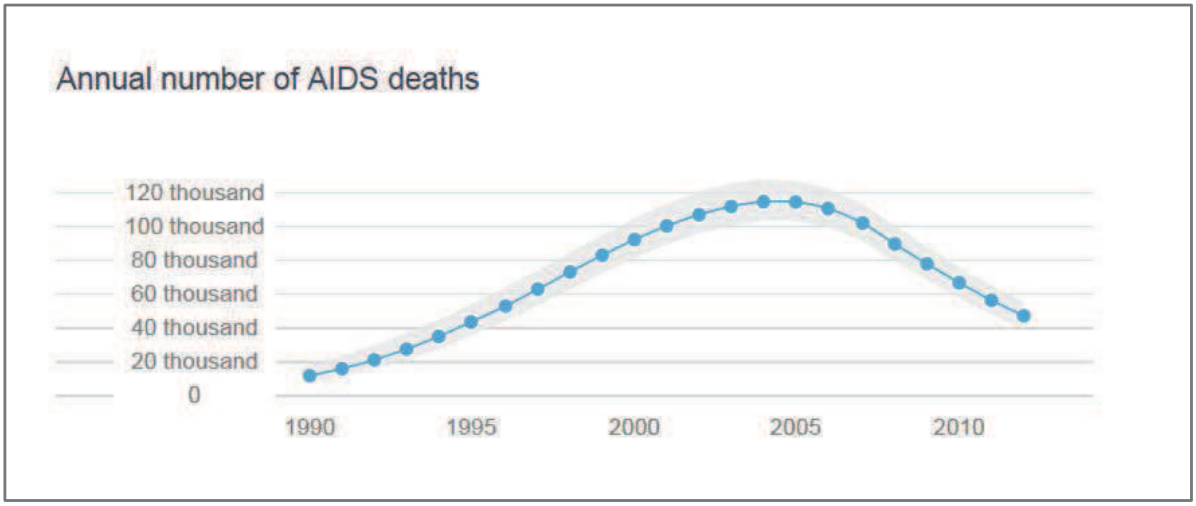

*Figure **4.3:** Annual number of HIV-related deaths in all ages in Ethiopia from 1990 until 2012*[8]

The estimated national adult HIV incidence of below 0.1% translates in approximately 20,000 new HIV infections annually. In 2012, approximately 760,000 people were living with HIV. Out of the estimated 5.4 million orphans living in Ethiopia, 900,000 were orphaned due to AIDS.

[8] Ibid.

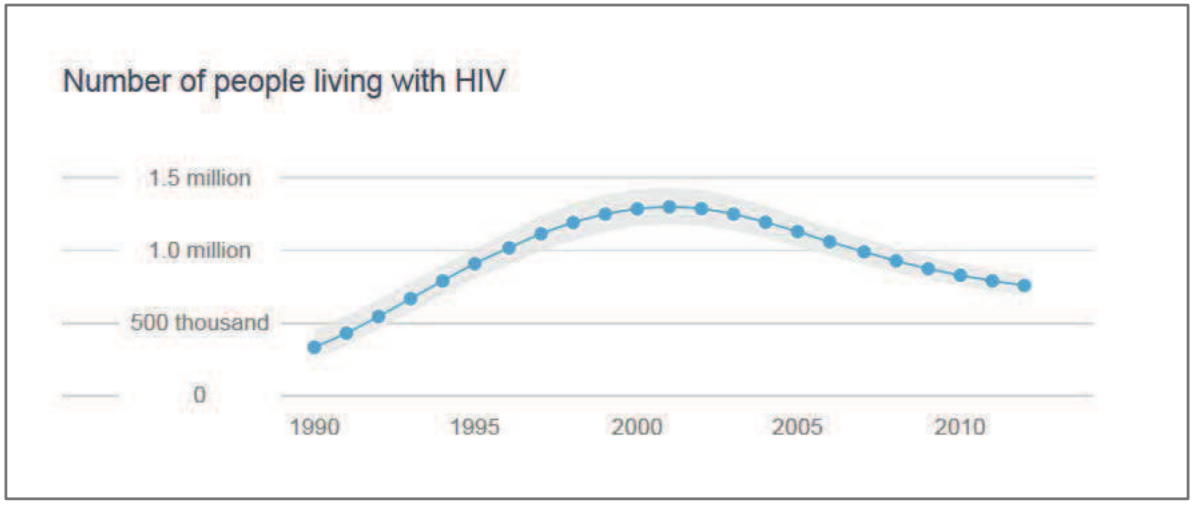

*Figure **4.4:** Number of people living with HIV in Ethiopia from 1990 until 2012*[9]

Addis Ababa and four regions of Amhara, Tigray, Oromia, and the southern region of Ethiopia– together account for 93.4% of the total number of people living with HIV (PLHIV) in the country. Across all regions, females are more affected than males in both urban and rural areas.

In summary, the determining factors that drive the epidemic in Ethiopia are:

– Practice of multiple sexual partnerships.
– Early initiation of sexual practices. The proportion with sexual debut before the age of 15 among the 15-19 years old boys and girls is high, and significantly higher among girls (11.1%) than boys (1.7%).
– Low and inconsistent condom use.
– Intergenerational and transactional sex.
– Repeated episodes of STIs, low treatment-seeking behaviours for STIs and poor quality of STI care services.

[9] Ibid.

– Mobility/migration of population.

– Some emerging behaviours that place individuals and communities at greater risk of acquiring and transmitting HIV infection in the country. These are injecting drug use, substance abuse/dependency, anal sex and men having sex with men.

– Unprotected sexual intercourse among discordant couples.

– The emerging epidemic pattern among couples of reproductive age, together with low uptake of Prevention of Mother to Child Transmission (PMTCT) services (40% in 2012), means that vertical transmission continues to contribute significantly to the spread of HIV.

4.1.2 The Church's response

In December 2002, the Catholic Bishops of Ethiopia published a pastoral letter, "The Church We Want To Be".[10] It contained elements for a common vision of the pastoral action of the Catholic Church in Ethiopia. The following pastoral priorities were identified:

– Training Resource People and Capacity Building.

– Pastoral Service to the Youth.

– The Family Apostolate.

– On-going Catechesis.

– Animation of the Lay Ministry.

– Promoting a greater knowledge of the Bible.

– Measures to be taken concerning HIV and AIDS.

– Encouraging Ecumenism and Inter-religious dialogue.

– Improve quality of education.

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[10] Mata, L. (2008) *Dossier of the Ethiopian Catholic Church*, Vatican City: Agencia Fides.

– Researching new approaches to evangelisation.
– Draw up National Pastoral Guidelines.

The government acknowledges the role of religion and faith communities in Ethiopian society. The government cooperates in mainstreaming HIV and AIDS within faith-based organizations (FBOs) as a key strategic move in the fight against the epidemic. EIFDDA (Ethiopian Interfaith Forum for Development, Dialogue and Action) has been active in the battle against HIV and AIDS. Special focus is given to reducing stigma, denial and discrimination and to care and support to orphans and vulnerable children through assistance by various donors, including the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The Government notes in official reports that the widely advertised ”ABC” slogan (Abstinence, Be faithful and use of Condoms) to prevent HIV transmission is also guiding the prevention programmes of the Ethiopian Orthodox Church, the Islamic Supreme Council and other faith-based organizations.[11] However, faith communities and their leaders remain largely opposed to condom use.

It was not until the late nineties that most faith communities developed structured and extensive anti-AIDS programmes. In 1998 the Ethiopian Orthodox Church began to train its 500,000 priests, as well as preachers and Sunday school students, to become communicators and counsellors on HIV and AIDS. The results of an interdenominational training programme involving Orthodox, Catholic, Protestant and Muslim leaders in HIV and AIDS epidemiology, prevention, counselling, care and support were used to revise training and counselling materials and programmes.[12] The programme has been considered successful overall, although its implementation has been impeded by the sensitivity of the

11 Ibid.
12 Belachew, A. & Seyoum, E. (2000) “Building support among religious leaders for HIV/AIDS program in Ethiopia”, International Conference on AIDS, Durban (Abstract no. TUPeE3883).

subjects of HIV transmission, condom use and traditions prohibiting religious leaders from discussing sexuality with their congregations.

The Catholic Church in Ethiopia has actively participated in the control and prevention of the spread of HIV infection since the epidemic was detected in Ethiopia in 1986. It has 67 health institutions (clinics, health centres and hospitals) and over 80,000 students in its educational institutions, which include elementary schools, high schools and a nursing college. It is a founding member of an inter-religious organization, the Organization for Social Services for AIDS (OSSA). It is engaged in the provision of psychosocial services, financial and material support to the infected and affected, support to children orphaned by HIV, information, education and communication programmes, voluntary counselling and testing services, and other programmes.

HIV and AIDS prevention, care and support services have been offered in the different dioceses of the Ethiopian Catholic Church since 1988. A coordination office was established at the Catholic Secretariat in March 2001. A church policy on HIV and AIDS that addresses pastoral ministry and employees' welfare, and which seeks to reduce stigma and discrimination of PLHIV, has been developed. Most Ethiopian Catholic Church institutions also have a programme for education of employees about HIV and AIDS. The Church's work on HIV and AIDS is also integrated into the work of other programmes, such as development and Catholic youth education programmes.

Home-based care is implemented by Medical Missionaries of Mary (MMM) in Addis Ababa, Daughters of Charity in Addis Ababa, Mekele and Medhin Social Centre. Bushilo Major Health Centre is also set to resume its work in home-based care. The Missionaries of Charity have homes in different parts of the country, which also care for PLHIV. These homes do not serve PLHIV exclusively, but assist all homeless people who are in need of support. In Addis Ababa, the Missionaries of Charity have a home for children living with HIV who have lost their family support. Most local churches also support PLHIV and their families in an

informal way. Management of STIs is routinely integrated with the clinical services of Catholic health institutions. Diagnosis and management of HIV and AIDS-related opportunistic infections is becoming increasingly challenging for most Catholic health institutions.

The church also offers voluntary counselling and testing (VCT) in its health institutions and uses it as an entry point for prevention as well as a strategy to improve care and support. Most of the health institutions receive the required testing materials through collaboration with the local government. However, getting a continuous supply of testing equipment and reagents is becoming increasingly difficult. Stigma and discrimination are also hindrances for the effectiveness of VCT. In addition, most Catholic health institutions need more trained counsellors and laboratory technicians.

The intensification of education and awareness creation on HIV and AIDS in rural areas is one of the Church's key programmatic involvements. This is done using its health institutions and schools. In most rural parts of Ethiopia, patients are accompanied by relatives or neighbours when visiting health institutions. Using this opportunity, most Ethiopian Catholic health institutions have health education sessions for clinic visitors. HIV and AIDS/STIs is one of the topics addressed in such sessions, typically 20-30 minutes long.

The Church seeks to make its schools a supportive environment for children orphaned by HIV and AIDS. A number of schools organize periodic competitions about HIV and AIDS for students, using drawings, essays and poems. Such events are used to motivate students to participate in AIDS prevention and control-related activities. The Ethiopian Catholic Church also supports government and public schools in communicating about HIV and AIDS. This includes training and supervising student peer educators, organizing and training Anti-AIDS Club members, and provision of health education materials. The Medical Missionaries of Mary in Addis Ababa reach the out-of-school youth through Anti-AIDS clubs and peer educators. This is further strengthened through house-to-house

education and use of peer counsellors. Their orientation often focuses on ways of prevention and transmission of HIV and AIDS, and includes counselling, education about sexuality, and other locally relevant issues. The church produces its own information, education and communication materials, which conform to the norms and values of its social teachings. The church promotes abstinence and does not support the use of condoms.

Different types of interventions are used by a few HIV and AIDS programmes to enhance the incomes of PLHIV and their families, through revolving funds and grants. The perception of individuals that the Church is a provider hinders the performance of income generation initiatives.

A review of the Church's HIV and AIDS programme was conducted in 2001, as a background to develop an HIV and AIDS policy and strategic framework. The field visit was undertaken from June to September 2001 by the HIV and AIDS coordinator. In 2002, the Ethiopian Catholic Secretariat was directed to formulate a policy on gender, HIV and AIDS, health, emergency, development, education and peace and justice.

The Church is faced with the following challenges as it carries out its work:

- Capacity building
- Stigma and discrimination of PLHIV
- Increasing numbers of children orphaned by HIV and AIDS
- Provision of VCT services to rural Ethiopia
- Understanding and dealing with factors that aggravate the vulnerability to HIV infection among different risk groups
- Engendering openness to discussions on sex and sexuality among adolescents and couples and high levels of poverty.

4.1.3 Diocese of Emdibir

The Diocese of Emdibir started HIV and AIDS activities in the 1990s. The health institutions started awareness creation and VCT at Attat Hospital. By 1997, the Church was actively involved in HIV and AIDS activities. Priests received special training in the seminaries. HIV and AIDS was part of their teachings to the youth and during homilies.

Donors were willing to support the planned activities. The Christian Relief & Development Association funded workshops for the faithful in parishes. Trained professionals from different Catholic health institutions were invited from time to time to teach the people, and special attention was given to the youth. Whenever there was a spiritual programme, HIV was on the agenda. *Let us protect ourselves from HIV and AIDS by keeping the laws of God* was the title of one of the workshops prepared for the youth. In addition, care and support for the infected and affected was part of the activities. The health institutions offered health education to create awareness about the epidemic and to protect the infected and the affected from stigma. VCT services, symptomatic treatment and (before the introduction of ART) palliative care were also provided, especially at Attat Hospital. This was the only hospital serving the people in the area. Priests went to the houses of the sick and gave spiritual, psychological as well as material support. The lay volunteers cared for the sick in practical ways.

Different institutions are still working actively with OVC, both affected and infected.

There was no interfaith or interdenominational cooperation at first. Each religion and Christian denomination covered the issue separately. Now EIFDDA at national level, in cooperation with the Global Fund, stimulates an interfaith approach.

The HIV and AIDS activities of the eparchy are implemented according to the government's policy and they are an integral part of the Zone's

HIV task force. The programmes are supervised by the government and reports are submitted to them. HIV and gender are mainstreamed in all activities of the diocese. The diocese's Religious and clergy received basic training.

Today the diocese has a health and HIV and AIDS unit, which includes an HIV and AIDS Desk. This unit coordinates the work of the health institutions of the diocese. The diocese follows the national HIV and AIDS policy. Flyers, posters and other IEC materials are prepared during workshops so that information is given to the people in an appropriate way.

The diocese receives some government support, such as test kits. As there are not many NGOs in the area, cooperation with other organizations has not been possible, though there is some cooperation with a local NGO called Zema Sef in the field of training.

4.1.4 Diocese of Adigrat

The Catholic Diocese of Adigrat is now 175 years old. It covers the whole region of Tigray and part of the Afar Region, in total an area of approx. 132,000 km^2.

The diocese, with 32 parishes and three outstations, has a Diocesan pastoral and social development activities coordinating office, six health centres, 15 kindergartens, 26 primary schools, two non-formal schools, three colleges, one vocational school, one major seminary, 13 male and female Religious and diocesan formation houses, three homes for the destitute cared for by the Missionaries of Charity, and five promotion centres for women. There are 10 Religious congregations working in the diocese.

The Adigrat Diocese Catholic Secretariat (ADCS) is a non profit-making church organization, established to respond to the spiritual and physical needs of all people regardless of age, sex, ethnicity, religion, political

affiliation and race. ADCS promotes integral human development through effective coordination and implementation of pastoral, social and development activities in a sustainable way. It focuses on the poorest of the poor, and supports their empowerment for self-reliance, guided and inspired by Gospel values such as love, respect for human dignity, justice, solidarity, and subsidiarity, common good and respect for positive values of cultures. Currently, ADCS runs 49 educational institutions ranging from kindergartens to technical and vocational colleges, with a total of 12,000 students.

Tigray has 46 woredas, 12 urban and 34 rural, with a population of about 4.4 million (51% female). In 2005, the number PLHIV in Tigray was estimated to be 89,000, with over 35,000 OVC. In comparison with other regions, Tigray is more affected by HIV and AIDS because of displacement, war, poverty and lack of education.

ADCS is highly involved in the response to HIV and AIDS by providing comprehensive interventions such as behaviour change communication, VCT services, and care and support for people infected and affected since the year 2001.

The first comprehensive HIV and AIDS Prevention, Care and Support project proposal was submitted to Caritas Germany for funding in April 2003. Caritas Germany assisted the diocese in programme development, with assistance from the Medical Mission Institute in Germany. The finalised project was funded by Caritas Germany. The diocese was able to cooperate with other international partners such as Trocaire, CAFOD and CRS. The latter had a focus on work with the ADCS branch in Mekele.

During the implementation of its HIV and AIDS programme, ADCS recognized the importance of developing a five-year strategic plan covering the period 2007–2011. In 2008, ADCS established an HIV and AIDS mainstreaming committee chaired by the Secretary General.

4.1.5 Appraisal of the response of the Catholic Church

The Catholic Church in Ethiopia has recognized and acknowledged HIV and AIDS as an important part of its ministry since the late eighties. Its response started from decentralised institutions. It took more than one decade to see initiatives of structured integration and generalization, or policy development.

The appearance of patients in advanced stages of infection and in severe clinical conditions made Church health institutions react. They responded first by home-based care and deployed a palliative care model. Very often these health institutions were run by international congregations and religious communities, which were sensitized about HIV and AIDS by the experience of related congregations and institutions working in other parts of Africa.

In the early years of the AIDS epidemic in Ethiopia, the response of the Church was initiated by health institutions and was deeply shaped by compassionate care and support. The response also aimed at overcoming stigma and discrimination, as many patients looked for care in institutions run by clergy because they had experienced rejection elsewhere.

In its socio-pastoral ministry the Catholic Church has always focussed on marginalized and poor parts of the community. Thus the care and support services were more of a charitable and social nature, rather than moral education. This led to tolerance of problematic gender norms and cultural behaviours favouring risk of exposure to HIV, in particular for women. Reduced availability of skilled technical staff in coordination structures led to insufficient documentation. Even today, the socio-pastoral leadership of the Church cannot provide indicators of performance or service coverage.

In terms of prevention, the involved congregations favoured information about the disease, in contrast to indigenous Religious and clergy, who spoke predominantly about moral misconduct, or HIV being God's sanc-

tion for sin. The latter attitude is still found in interviews today, although not in the majority of cases.

As in other parts of Africa, the Catholic Church in Ethiopia had tolerated specific social and cultural behaviours such as initiation rites, gender determining roles, and traditional behaviours that led to partner exchange, all of which are known to be cultural factors driving the HIV epidemic. The reasons for this tolerance, denial or ignorance are not clear. Yet it is important for the Church to examine why so many clergy and Religious still focus on morality rather than culturally determined behaviour as the main reason for partner exchange leading to HIV transmission. It took nearly the whole decade of the 1990s before the Catholic Church in Ethiopia started to develop a broader and comprehensive response to the HIV epidemic, based on the social and moral teachings of the Catholic Church. In certain dioceses, these responses to HIV were gradually integrated into other socio-pastoral activities. Certain individuals and congregations were key to this development.

At the beginning of the millennium the HIV programmes of the Catholic Church in Ethiopia were mainly vertical. This was in keeping with the model favoured by external donor partners, especially Catholic Relief Services (CRS), the Trocaire-CAFOD Partnership and Caritas Germany. By the middle of the decade, however, the integration and coordination of Church-provided HIV services had become an issue. This was due, in part, to the decision of international donor partners to withdraw support from the health sector – not just in Ethiopia, but elsewhere as well. Thus the Catholic Church became remarkably strong in service coverage at community level, but weak in networking above the level of the diocese. This led to a deterioration in the leading role previously played by the Catholic Church in the health sector.

Although networking bodies were set up, the Catholic Church has not been represented in these bodies by qualified persons with the mandate to promote decision-making and commitment by the Ethiopian Catholic Bishops' Conference. On the other hand, the Ethiopian Catholic Secre-

tariat (ECS) initiated a process of policy development and mainstreaming of HIV. The ECS was assisted in this process by external partners. In contrast with the Catholic Church in some other African countries, the resulting policy documents are exemplary. This process has led to the mainstreaming of HIV-related activities and initiatives, for example, the development of HIV workplace policies and diocesan pastoral plans.

At local and regional level, the Catholic Church is a welcome partner in official HIV programmes. Constant dialogue and participation in meetings take place at these levels. However, the services of the Catholic Church are not mentioned in official reports, and very few – if any – financial resources are shared with Church programmes. This may be due, at least in part, to the shortcomings of Catholic Church institutions in properly and scientifically documenting their work and analysing their performance.

The health institutions of the Catholic Church provide every infected and affected person with the best available care and support services. However, the personal attitudes and moral assessments of staff in these institutions often focus solely on individual ethics, and ignore the wider social and ethical dimensions affecting the lives of their patients. Stigma and discrimination against people living with HIV are still only partially addressed. Good mechanisms for training and updating Religious, clergy and lay people on HIV and AIDS do exist, but the materials available still fail to address theological and socio-ethical issues in sufficient depth.

One distinctive aspect of the response of the Catholic Church in response to the HIV epidemic in Ethiopia has been the Church's role in promoting inter-faith dialogue, in particular with Orthodox and Muslim faith communities. This dialogue, however, seems to be focused more on the level of the diocese than on the level of the Bishops' Conference.

In conclusion, it can be said that the response of the Catholic Church to HIV in Ethiopia has been marked by three main features. During the 1980s until the mid-1990s, the Church's response to the HIV epidemic

was provided by Catholic health institutions, led mainly by international congregations. The decline in support for the Catholic health sector from international donors sparked off community support and capacity-building measures, more policy making at local levels, as well as some cautious networking and rather timid pastoral initiatives. The socio-political context starts from the fact that the Catholic Church is a small faith community. The autonomy of each diocese has resulted in an under-representation of the Catholic Church in the national bodies which decide on access to international solidarity funds. This is despite the fact that, in some parts of the country, Catholic health institutions provide a significant amount of HIV-related services.

4.2 Malawi

4.2.1 HIV in Malawi

"Malawi's first AIDS case was reported in 1985. In response, the government implemented a short-term AIDS strategy (including blood screening and HIV education programmes), and in 1988, created the National AIDS Control Programme (NACP) to co-ordinate the country's AIDS education and HIV prevention efforts. Some have argued that these measures did little towards controlling AIDS in Malawi, and that it was not until 1989, when a five-year AIDS plan was announced, that the government began to show any real commitment towards tackling the problem."[13]

Malawi is severely affected by the HIV epidemic. Since 1990 it has been in the top ten of highest HIV prevalence countries in the world. HIV prevalence was highest between 2000 and 2003, running at 13.8% of the

[13] AVERT (2014) *HIV and AIDS in Malawi*. Available at: http://www.avert.org/aids-malawi.htm#contentTable0 [Accessed: 24 April 2014]

adult population (15–49 years), and was reduced to 10.8% in 2012 (see Figure 4.5).[14]

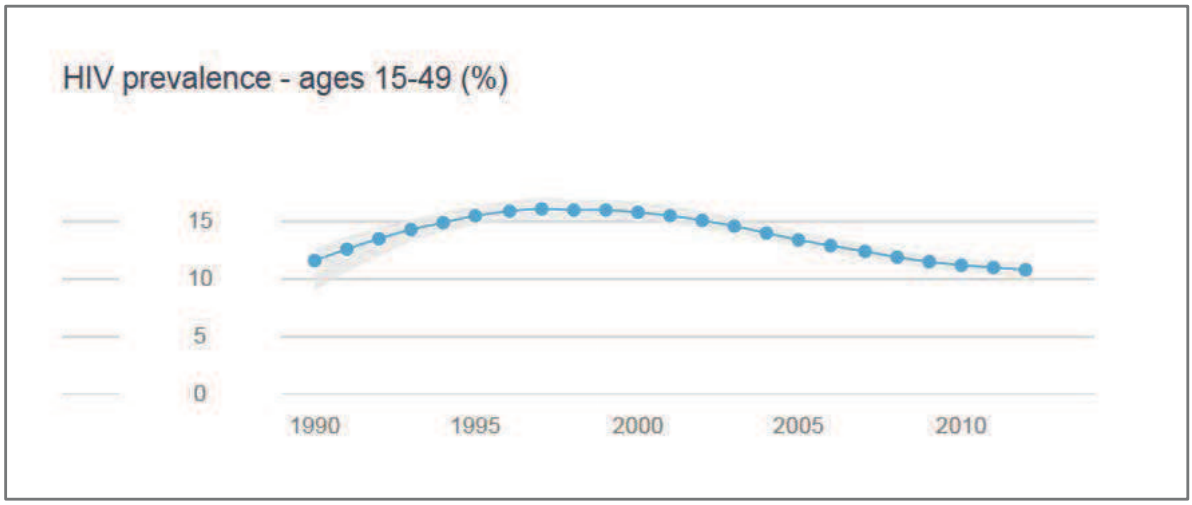

Figure 4.5: HIV prevalence (15–49 years) in Malawi, 1990–2012

In 2006, there were an estimated 1,100,000 PLHIV in Malawi, a number that has been till 2012 (see Figure 4.6).

[14] UNAIDS (2014) *AIDS Info UNAIDS. Available at:* http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/ [Accessed: 24 April 2014]

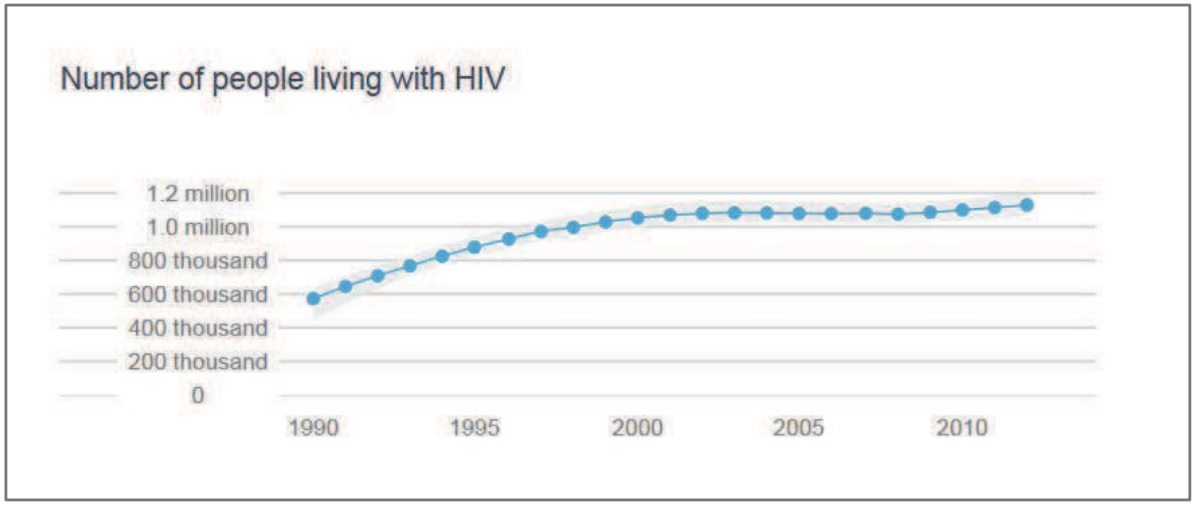

Figure 4.6: Number of PLHIV in Malawi, 1990–2012

Although the number of PLHIV is stable, the annual number of new infections has been reduced by almost 50% in the last decade (see Figure 4.7). The incidence of HIV infection peaked between 1996 and 1997 at 1.9%, and by 2011 had fallen to 0.5%.

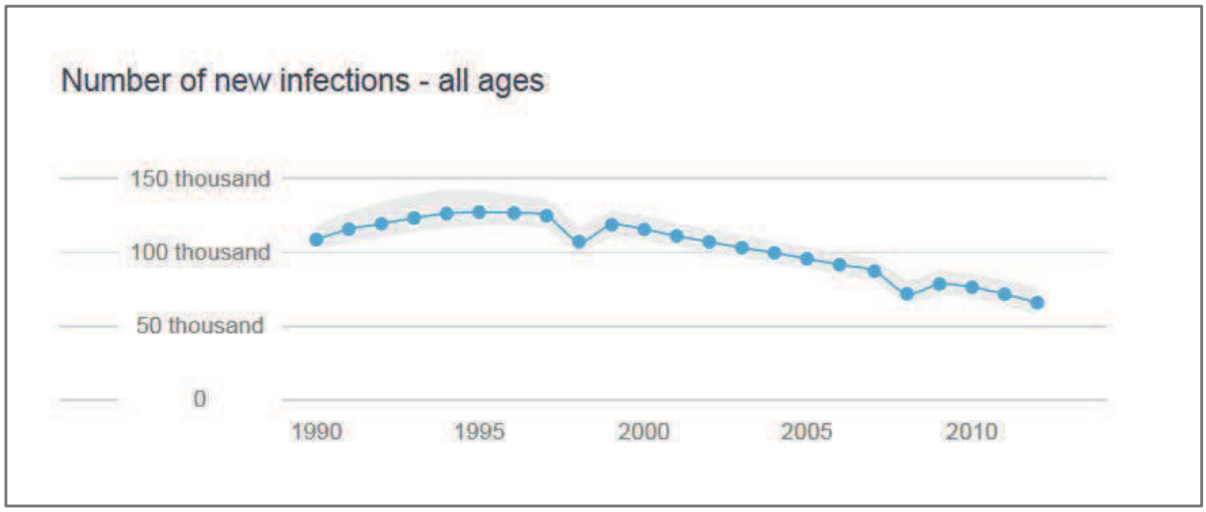

Figure 4.7: Number of new HIV infections in Malawi, 1990–2012

The more or less stable number of PLHIV and the declining incidence is explained by the reduction of the number of people dying due to AIDS-related conditions. The annual number of deaths due to AIDS-related

conditions increased from 14,000 in 1990 to 77,000 in 2005, but by 2011 it had fallen to 44,000 (see Figure 4.8).

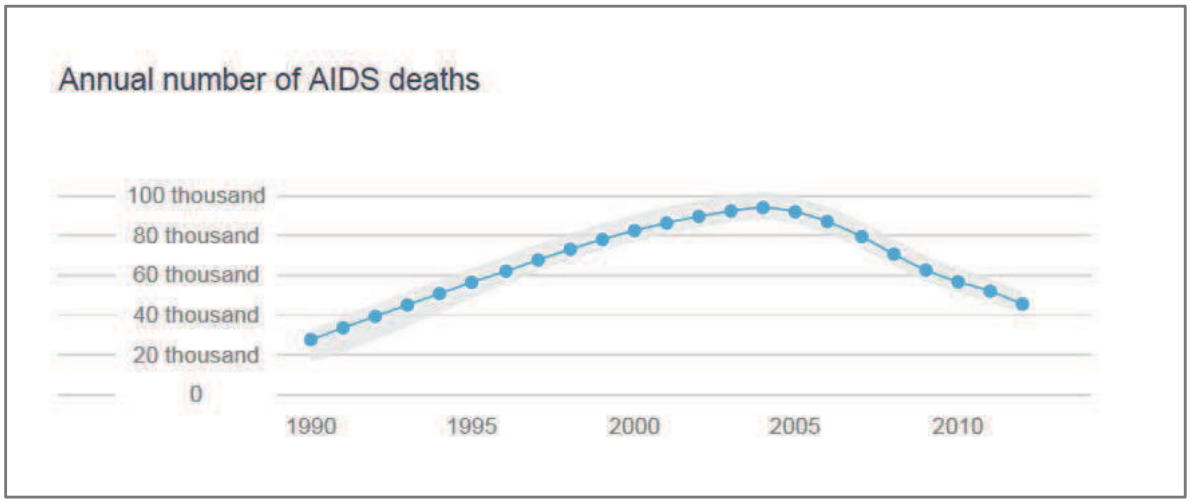

Figure 4.8: Annual number of deaths due to AIDS-related conditions in Malawi, 1990–2012

The main reason for the reduction in AIDS-related deaths is the increasing number of people who receive antiretroviral therapy (ART). In 2012, 69% of those eligible for treatment according to the National Treatment guidelines received ART. However, only 36% of children (0–14 years) who were eligible received ART.[15]

Between 50% and 74% of pregnant women received Prevention of Mother to Child Transmission (PMTCT) treatment in 2011. This is expected to increase to over 90% in future years. Malawi was one of the first countries in Africa to introduce the new WHO guidelines on treating HIV-infected pregnant women. This will contribute to reducingof the number

[15] UNAIDS (2013) 2013 progress report on the Global Plan, towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. Geneva: UNAIDS. Available at: 2013 progress report on the Global Plan, towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive [Accessed: 24 April 2014]

of new-borns with HIV infection to less than 2% of all babies born to HIV-infected women.

The HIV epidemic has taken a heavy toll of parents in Malawi: 12.4% of all children under the age of 18 have lost one or both parents. Approximately 60% of orphans have lost their father, 17% have lost their mother and 23% have lost both parents.

4.2.2 The Church's response

The Church in Malawi has a crucial "watchdog" role, helping to keep the government of the day in check, and holding it accountable to the country as a whole, including poor, marginalized, vulnerable and voiceless people. The churches as a whole exert a powerful influence on both the people and the State. For example, Malawi's re-democratization journey started with a Lenten Pastoral Letter, *Living Our Faith,* written by Catholic Bishops in March 1992. The letter was read in all Catholic churches throughout the country and sparked a chain of events, culminating in 1994 in the downfall of the once-mighty Malawi Congress Party (MCP), which had ruled the country for three decades, and the re-introduction of multiparty democracy.

The churches are closely in touch with people at grassroots level. As the former Chairman of the Public Affairs Committee, Fr Boniface Tamani once put it, "Our task is facilitated by the fact that we have a podium every Sunday, whereas other organizations have to struggle to get authorisations and resources to organize meetings." On 31 October 2010, the Episcopal Conference of Malawi (ECM) astutely articulated the populace's concerns over the current socio-political and economic issues in a Pastoral Letter entitled, *Reading the Signs of the Times.* From the pastoral perspective, the ECM has developed its own HIV and AIDS policy. Through this policy, the ECM seeks to "serve its constituency adequately and to be able to contribute to the national response strategical-

ly, premised on the principles of Catholic Social Teaching and the gospel values, medical ethics and health guidelines."[16]

Through the initiative of the ECM, home-based care programmes were spread widely down to parish level in all the dioceses throughout the country. On the first Sunday of Advent the Catholic Church commemorates World AIDS Day and has a message read in all churches throughout the country.

The ECM Strategic Plan for 2004–2009 recommended that issues pertaining to human health and HIV and AIDS be separated from other commissions, to stand alone in a fully-fledged separate commission.

In 2004 the Catholic Bishops established the Catholic Health Commission, with the mandate to coordinate health and HIV programmes, to be implemented by all dioceses through Catholic health units and community programmes throughout the country.

4.2.3 The Archdiocese of Lilongwe

Lilongwe diocese is in Central Region, which in 2008 had a population of 5,491,034. It covers the districts of Nkhotakota, Salima, Ntchisi, Dowa, Mchinji, Lilongwe and a large part of Kasungu.

In 1992 the Archdiocese of Lilongwe joined the rest of the Catholic dioceses in Malawi in the fight against HIV and AIDS, with the mission "to reduce the impact of HIV and AIDS in Malawian communities by harnessing the peoples' potential: this will be through mobilizing sustainable community responses to prevent the spread and mitigate the impact of HIV and AIDS on the infected individuals and affected children and families." The Home Based Care Programme of the Archdiocese of Lilongwe was first implemented as a pastoral programme, which was initi-

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16 Episcopal Conference of Malawi, *HIV and AIDS policy 2008-2011.* Lilongwe: Episcopal Conference of Malawi.

ated by Catholic Sisters as part of their activities to alleviate the pain and suffering of people infected and affected by HIV and AIDS.

The Programme was housed under the umbrella of the Catholic Development Commission in Malawi (CADECOM) to oversee the implementation of HIV and AIDS as well Home Based Care (HBC) activities. At the time, there was no direct relationship between HBC and the health facilities. The main focus and target of the HBC programme was to care and support chronically ill people in their communities. It also attended to the needs of orphans, the elderly and youth with regard to HIV and AIDS. In short, it implemented activities to mitigate the impact of HIV and AIDS and to reduce the spread of HIV. The HBC Coordinator was responsible to the Diocesan CADECOM Director.

The Catholic Health Commission of Lilongwe Archdiocese operates directly under the Archdiocese, which has been implementing health services for as long as it existed. There have been tremendous developments within the Archdiocese that have transformed the delivery of health services since it started implementing health services programmes.

As a diocese, Lilongwe did not develop an HIV Policy, but is currently in the process of developing one. However, there is a strategic plan for the health commission, which ran from 2009–2011. The main players at diocesan level are CADECOM, the Health Commission, pastoral agents, priests, Religious, and organizations such as the HBC programme and the Justice and Peace Commission.

The Health Commission trained groups to keep memory boxes but the challenge is a lack of follow-up. On the diocesan level, the Church collaborates with the District AIDS Coordinating Committee (DACC) and the District Health Office. The government funds PMTCT projects for mothers and under-five clinics. The Church is also collaborating with other organizations such as Drugs Resource Enhancement against AIDS and Malnutrition (DREAM).

Donors such as Catholic Relief Services, the National AIDS Council, CAFOD, UNICEF, the Rose Foundation and Kindermissionswerk provide funds for various projects.

The Commission also receives technical support from ECM. The overall experience with donors has been good; however, donor money is earmarked for specific projects, and as a result there is very little room to respond to emerging issues. There is also a perception from the donors of wanting to see immediate results, and that the help provided will completely eradicate the problem.

As a pastoral approach, the diocese has been conducting on-going training for the clergy; sometimes research persons, and experts in the field of HIV and AIDS are invited to give talks. In the major seminary HIV and AIDS is also addressed as a topic in bioethics.

There are six Catholic hospitals and three Catholic health centres in the diocese. All are involved in one way or another in HIV and AIDS activities. The HIV and AIDS activities performed in the diocese include:

Prevention

HIV prevention activities include:

- Information and education on HIV and AIDS.
- Voluntary Counselling and Testing.
- Prevention of Mother-to-Child Transmission.

Medical care services

These services include activities through the home-based care programmes and the health facilities, including:

- Care and support of PLHIV and OVC through home based care groups in the parishes.
- Antiretroviral Therapy (ART).

- Co-trimoxazole Preventive Therapy.
- Treatment of opportunistic infections.
- Hospice services (palliative care).
- Treatment of Sexually Transmitted Infections.

Non-medical care services

These services include:

- Counselling (psychosocial, pastoral, spiritual).
- Capacity building among health workers and lay persons on HIV and AIDS.
- Food aid, nutrition support and training.
- Provision of safe drinking water.
- Provision of clothing and other material support to PLHIV and OVC.
- Skills training for volunteers.

Advocacy and networking

The diocesan facilities collaborate with one another, but there is relatively little collaboration and networking with other organizations in the area. The DREAM Centre has special advocacy programmes, for example, to improve the communication skills of prisoners and elderly people. Some health facilities have outreach activities to sensitise the community on HIV and AIDS and to encourage people to go for HIV testing.

4.2.4 Appraisal

The diocesan Health Coordinator assessed the diocesan activities as follows: "We came into the situation with enthusiasm because there was funding but now most of it has ceased. This has meant a marked decrease in activities. So one may say that the initial dependence on outside funding decreased creativity. Donors did not help beneficiaries to start relying on their own resources."

The pastoral secretary observed: "There is a reduction in numbers of bedridden patients, probably due to wider access to ART. This has led to complications. While patients were sick they lost their jobs, but now they have recovered they cannot find work. As pastoral secretary, my perception of the condition has changed. When I was in the seminary I was judgemental because I thought people were being reckless. But now I see that the problem is much more complex.

"The fact that fewer people are bedridden has enabled the Health Commission to divert funds to other programmes, especially to orphans and vulnerable children. Pastorally we promote a change of attitude and we wish to educate the people. I have become more involved. The loss of friends, relatives and clergy due to the pandemic has caused this. So too the loss of powerful personnel, whether in government or in the Church. The pandemic has also loaded us with more responsibilities, especially for orphans and widows."

The CADECOM home care programme was a well-funded national programme, but it has lost most of its funding since the large-scale introduction of ART. Most of the tasks of the home care programme, namely, provision of care and support to sick PLHIV, are now viewed as far less important.

The diocesan health facilities – including ART clinics and PMTCT services – are included directly in national health services, without any involvement of the diocese.

4.3 Zambia

4.3.1 HIV in Zambia

Zambia was one of the first sub-Saharan African countries that faced an HIV epidemic. The first reports on the presence of HIV-infected people date from as far back as 1984, and there is strong evidence that HIV infection was already present in the country before the 1980s. Within two

years after the first case was detected, the National AIDS Surveillance Committee (NASC) and the National AIDS Prevention and Control Programme (NAPCP) were established to coordinate HIV and AIDS-related activities. In the early stages of the epidemic much of what was known about the prevalence of HIV was kept secret by the authorities under President Kaunda. Senior politicians were reluctant to speak out about the growing epidemic, and the press did not mention AIDS[17]. The President's announcement in 1987 that his son had died of AIDS was a notable exception. It was significant, however, that the President's announcement about his son was made in Canada and the information was not made public within Zambia.

Zambia has one of the highest burdens of HIV in the world. HIV prevalence among adults aged 15–49 years peaked at 14.9% in 1993, and by 2012 had fallen to 12.7% (see Figure 4.9). AIDS-related deaths continue to be one of the main causes of death: in the year 2012 an estimated 30,000 people died of AIDS-related diseases.[18] In 2012, Zambia had an HIV incidence[19] of 0.8%, and an estimated 56,000 new HIV infections. In 2012, a total of 1.100,000 people were living with HIV in Zambia.

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17 AVERT (2012) *HIV and AIDS in Zambia.* Available at: http://www.avert.org/hiv-aids-zambia.htm#contentTable0 [Accessed: 24 April 2014]

18 Most data on HIV are from the UNAIDS web-site:http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/ [Accessed: 24 April 2014]

19 "Adult (15–49 years) incidence: To calculate the adult HIV incidence, the estimated number of adults (15–49 years) newly infected with HIV in 2009 was divided by the 2009 adult population (15–49 years) not infected at the start of 2009", from: UNAIDS Report on the Global AIDS Epidemic|2010. Geneva: UNAIDS. 2010, p.79. Available at: *www.unaids.org/documents/20101123_GlobalReport_em.pdf*. [Accessed: 24 April 2014].

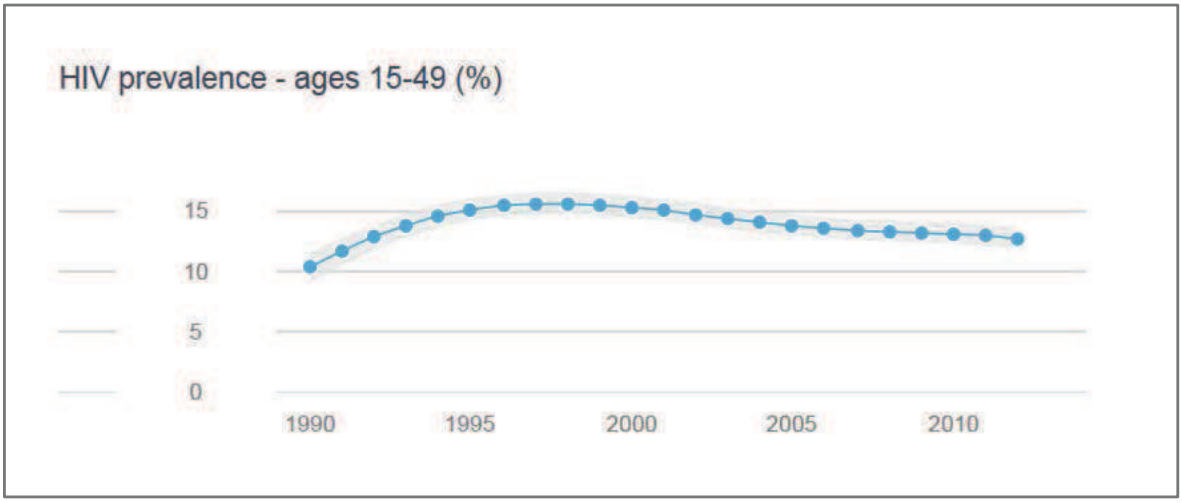


Figure 4.9: HIV prevalence (%) in Zambia, 1990–2012

The number of new infections was highest in the years 2001–2003, with an estimated 110,000 new cases annually. By 2012, this had been reduced by over 50% to an estimated 56,000 (see Figure 4.10).

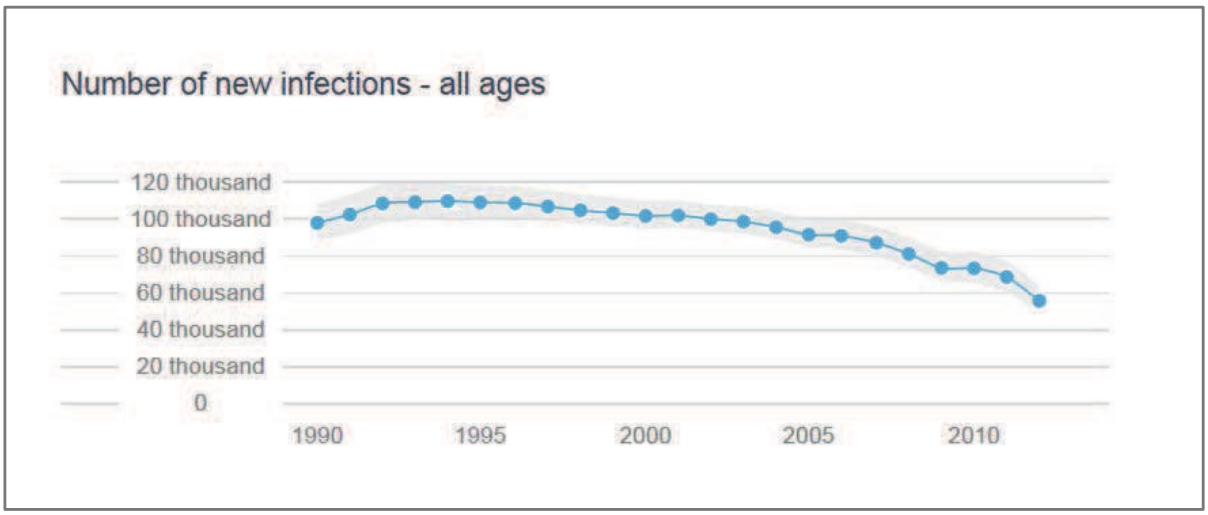


Figure 4.10: Number of new HIV infections in Zambia, 1990–2012

Although the number of new infections has been brought down by over 50%, the total number of PLHIV in Zambia is steadily increasing. In 1990 there were an estimated 540,000, while in 2012 this was 1.1 million (see Figure 4.10).

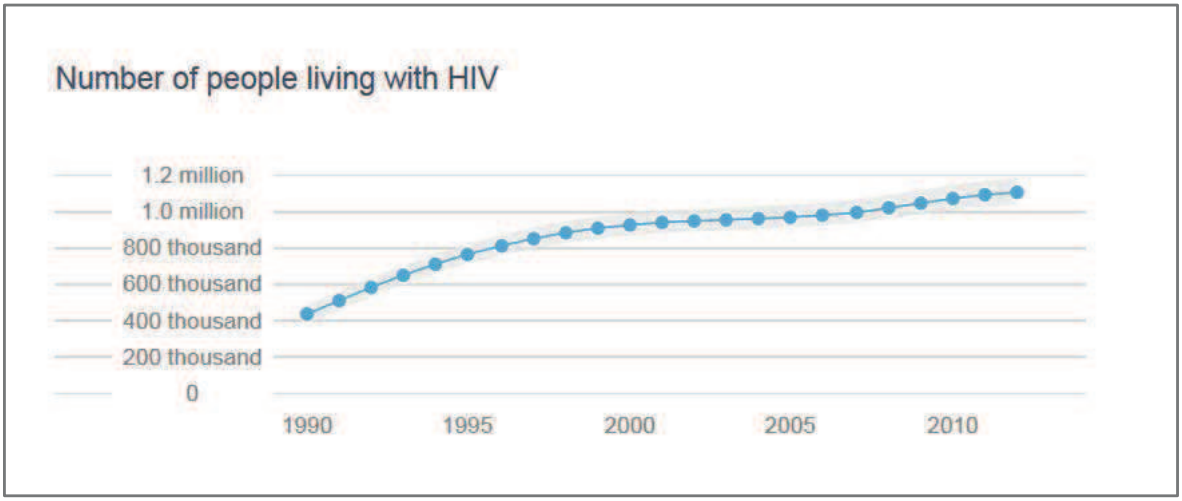


Figure 4.11: Numbers of People Living with HIV in Zambia, 1990–2012

At first, the conclusions that can be drawn from Figures 4.8, 4.9 and 4.10 (above) may appear to be contradictory.[20] How can the number of people infected grow steadily, while the number of new infections drops rapidly and at the same time the prevalence declines only slowly? First of all, the population of 7.9 million in 1990 increased to around 13 million in 2010. This explains why, between 1990 and 2011, the total number of people living with HIV nearly doubled, while prevalence declined by a small amount. At the same time, while the number of new HIV infections fell by 50% between 1990 and 2010, the prevalence of HIV fell by only 2.5 percentage points. This is simply because, since the widespread availability of ART, HIV-positive people are living much longer. This is borne out by the decline in AIDS-related deaths from 74,000 in 2003 to 30,000 in 2012 (see Figure 4.12).

[20] See the glossary for definitions of terms “incidence” and “prevalence”.

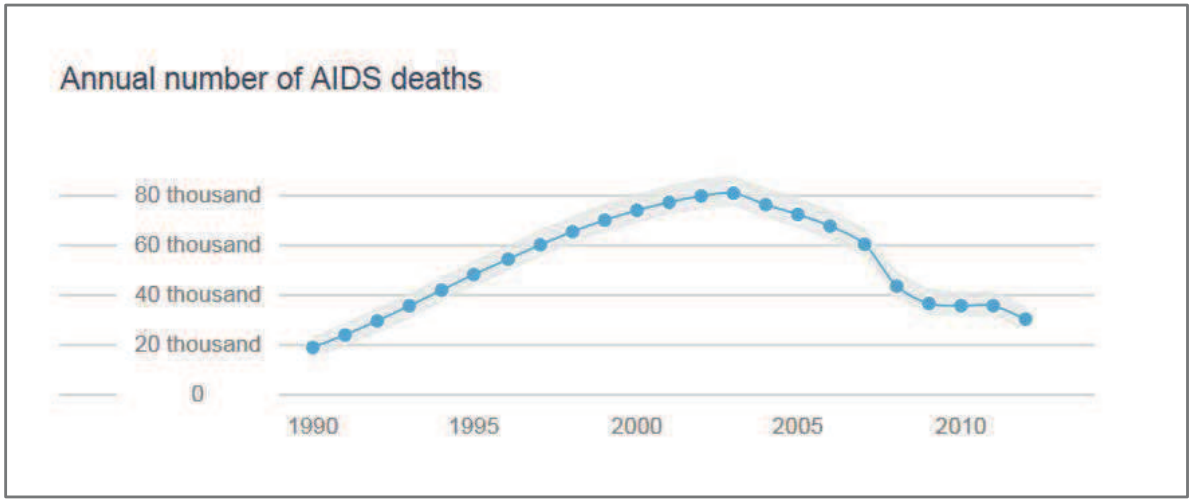


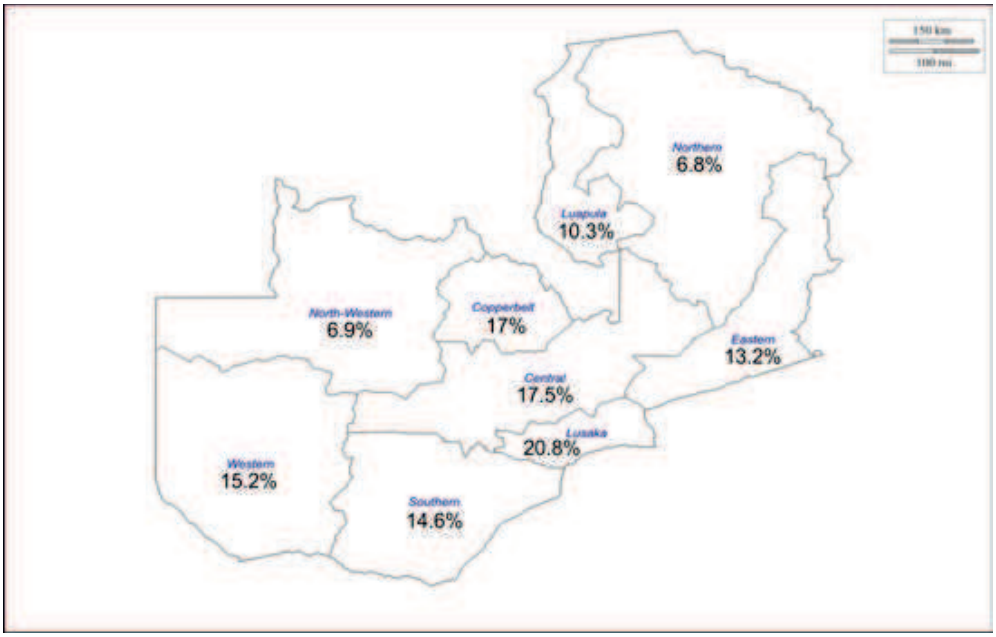
Figure 4.12: Annual number of AIDS deaths, 1990–2012

Over 80% of all PLHIV in Zambia who, according to national guidelines, are in need of ART, are now actually receiving the medication. Zambia is one of only a few countries in sub-Saharan Africa with such a high ART coverage.

HIV prevalence rates, however, vary considerably, between different age groups, between men and women, and between different parts of the country. There is a stark difference between rural and urban areas, with the lowest prevalence being 6.8% in Northern Province and the highest 20.8% in Lusaka Province (see Map 1.2).[21]

[21] Maps and data reflecting Muchinga Province are not yet available and therefore have not been depicted in this map.

Map 1.2: HIV Prevalence rates per Province in 2007



Source data: GRZ, 2010
Source outline map: d-maps (http://d-maps.com/carte.php?lib=zambia_map&num_car=26231&lang=en)

The HIV epidemic is clearly having a huge impact on Zambia. It is affecting not only the health of individuals, but also the welfare and well-being of households, communities and ultimately entire societies.[22] The epidemic strikes the economically productive members of society. As such,

22 Barnett, T. & Whiteside A. (2002) *AIDS in the twenty-first century. Disease and globalization*. Basingstoke & New York: Palgrave Macmillan.

it is not surprising that it brings with it profound social and economic consequences.[23]

4.3.2 The Church's response

Background

The Catholic Church has been involved in health care delivery in Zambia since almost immediately after missionary activities started towards the end of the 19th century. Protestant missionaries also started health care services at around the same time. Initially, most of this faith-based health work was on a modest scale – small clinics or health posts at parish level. Several of these, however, grew over the years and, with the assistance of doctors, nurses and midwives from abroad, hospitals were founded. Most of these institutions are still operational. They include, for example, Monze Mission Hospital, Minga Mission Hospital, Our Lady's Hospital, and St Theresa's Hospital. Until Zambia achieved Independence in 1964, these and other faith-based health institutions were the main providers of health care in the country. Even today, in rural Zambia over 50% of health care services are still provided by faith-based organizations.

In the 1970s, the various churches active in the provision of health care in Zambia formed their own association, the Churches Medical Association of Zambia (CMAZ), later renamed the Churches Health Association of Zambia (CHAZ). The CMAZ established a good working relationship with the Zambian Government, and in 1972 the first Memorandum of Understanding regulating the support of the Zambian Government to Church health facilities was signed. Today, faith-based institutional health services are fully integrated into the national health care system. The Zambian Government is responsible for the payment of all running

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[23] D'Adda, G., Goldstein, M., Zivin, J.G., Nangami, M., & Thirumurthy, H. (2009) *ART Treatment and Time Allocation to Household Tasks: Evidence from Kenya*. Oxford: Blackwell Publishing Ltd.

costs, including staff salaries. The role of the Church is the management of the facilities and financing part of some capital projects.

The National Health Department of the Episcopal Conference

"The Catholic National Health Department is an administrative organ of the Zambia Episcopal Conference (ZEC), whose principal function is to carry out the aims and objectives of the ZEC for health. It is responsible for linking up Catholic dioceses, parishes and communities in regard to coordination, policy issues, and development of community-based health and related programs. The Health Department was established in 1996 and operated as a desk up to February 2005, when the Bishops elevated its status to a department. One of the reasons for elevating the desk to a department was to make the response by the Catholic Church to HIV and AIDS and health issues more effective and coordinated."[24]

Responses to the HIV epidemic

The first responses by Catholic organizations to the HIV epidemic in Zambia were by Catholic hospitals in various parts of the country, starting in 1985/86. The dioceses and the Episcopal Conference were not yet involved, or were involved only marginally. CMAZ (later CHAZ) provided these Catholic hospitals with advice and also became a channel for financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

From 1990 onwards, initiatives in parishes – and later on in dioceses – developed in response to the HIV epidemic, in particular to provide assistance to PLHIV. The Archdiocese of Lusaka, the Diocese of Ndola[25] and the Diocese of Livingstone were the first to develop a diocesan re-

[24] Zambia Episcopal Conference (n.d.) Available at: http://www.catholiczambia.org.zm/index.php?option=com_content&view=article&id=63:health-dept&catid=54:health-depart&Itemid=93 [Accessed: 24 April 2014]

[25] Documented in Blinkhoff, P.; Bukanga, E.: Syamalevwe, B. and Williams, G. (1999) *Under the Mupundu Tree*) Book and DVD. Oxford: Strategies for Hope. Available at, http://www.stratshope.org/

sponse. This response concentrated on care and support for PLHIV in their homes, as hospitals were not able to offer continuous support. These initiatives – known as "home-based care" or "home care" – grew over the years into large programmes. By 2005, the diocesan programme in the Archdiocese of Lusaka had over 15,000 PLHIV registered; in Ndola, the diocesan programme had approximately 14,000 PLHIV registered. Home care programmes were eventually established in all dioceses throughout the country, and the Zambia Episcopal Conference has been involved in these programmes since 1996. Most of these home care programmes also gave assistance to orphans and vulnerable children (OVC).

In most dioceses home care was part of the pastoral department. In Ndola it was part of the health department. The services offered by the various home care programmes varied a lot, depending on the availability of external funding, since neither the Episcopal Conference nor the dioceses were able to support these programmes financially.

Most of the home care programmes have also been involved in creating awareness about HIV and AIDS. In addition, local initiatives for the prevention of HIV were developed, for example, school programmes. Youth Alive Zambia – an HIV prevention programme for children and youth – was started in the Archdiocese of Lusaka, and was later established in the other dioceses. However, due to lack of funding, the organization is no longer active in most places.[26].

The Catholic Church's National Health Department produced a document entitled "The Catholic Health Policy Document" to provide guidance to the dioceses, health facilities and parishes.

Various religious orders opened hospices to assist PLHIV in their last period of life. All but one has closed after the wide-scale introduction of ART.

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[26] Youth Alive Zambia (2014). Available at: http://www.youthalivezambia.org/

4.3.3 The Diocese of Chipata

Chipata Diocese follows the boundaries of Zambia's Eastern Province. In 2010 it had an estimated population of 1,707,731, growing at an annual rate of 2.7%[27]. The Catholic Diocese of Chipata was established at first as an Apostolate Vicariate in 1937, and in 1959 became the Diocese of Fort Jameson. In 1968, after the name of the town changed from Fort Jameson to Chipata, the name of the diocese changed as well. The diocese now consists of 23 parishes, served by 51 priests and 184 male and female Religious.[28]

HIV prevalence among adults aged 15–49 in Eastern Province is estimated at just over 10%. As elsewhere in Zambia, the prevalence is not equally distributed. Chipata District has an estimated HIV prevalence of over 20%, while Nyimba and Petauke districts are believed to have prevalence below 8%. (It should be noted that these data, derived from the 2007 Health and Demographic Survey, are based on very small sample sizes. More recent data were not available.)

There are three key institutions in the forefront of combating HIV in the diocese. These are the Diocesan Health Office (DHO), the National AIDS Council (NAC) and the Churches Health Association of Zambia (CHAZ). These institutions work directly with beneficiaries and administrators of diocesan HIV and AIDS programmes.

The Catholic Diocese of Chipata implements its HIV and AIDS programmes directly through home-based care groups in parishes, and indirectly through Caritas Zambia. There are four Catholic mission hospitals

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27 Republic of Zambia Central Statistical Office (2011) Zambia *2010 Census of Population and Housing*. Available at: http://unstats.un.org/unsd/demographic/sources/census/2010_phc/Zambia/PreliminaryReport.pdf [Accessed: 24 April 2014]

28 Diocese of Chipata Information up to April 2007 from http://www.catholic-hierarchy.org/diocese/dchpt.html [Accessed 24 April 2014]

working in partnership with government and one in partnership with the Anglican Church as well as government.

The Diocese communicates through the DHO with the home-based care groups, which are responsible for managing HIV and AIDS-related activities at parish level. The Diocese also implements HIV and AIDS programmes through Youth Alive and Caritas Zambia. Both are autonomous institutions and operate independently of the DHO, although they are under Catholic administration. Both Caritas Zambia and Youth Alive Zambia are responsible for their own resource mobilisation. The DHO reports to the Diocesan administration through the Pastoral Coordinator. Of the 24 parishes in the diocese, the DHO has been providing resources to only 15.

Prevention and education

These are carried out through eight different activities, namely:

- Information, Education and Communication (IEC)
- Behaviour Change Communication (BCC) at parish level
- Peer education
- Voluntary Counselling and Testing (VCT) in the four Mission hospitals and two parishes (Mphangwe and Petauke)
- Prevention of Mother-to-Child Transmission (PMTCT) in the four Mission hospitals
- Life Skills Education by Youth Alive in Chipata town
- Information sharing, other than medical counselling and education
- Provider-initiated testing and counselling (hospitals only).

These services are embedded mainly in the established home-based care activities at diocesan level. Some common practices that people interviewed felt contributed to the HIV and AIDS pandemic were polygamy, early marriages and poverty compounded by illiteracy.

Many people interviewed stated that these practices, which are common in many parishes, are major factors in the spread of HIV and AIDS. Some parishes have taken specific measures to address some of these issues. Chadiza parish, for example, made it mandatory that, for a marriage to be blessed in Church, the bride should be at least 18 years old and the bridegroom at least 20 years old.

Three religious congregations running the Mission hospitals in the diocese offer a wide range of prevention and education programmes. These are Minga and Lumezi Mission Hospitals, run by the Kilimanjaro Sisters; Muzeyi Hospital, run by the Sisters of Charity of Ottawa; and Kanyanga Hospital, run by the Missionary Sisters of the Immaculate Conception.

Medical treatment

Unlike prevention and education, the diocese has a well-structured and widespread treatment mechanism through the Home Based Care programmes at parish level. These activities include:

- Health maintenance: for example, nutritional rehabilitation, hygiene and vaccination of infants and pregnant women
- Prevention and treatment of opportunistic diseases and other HIV-related conditions
- Symptomatic treatment
- Specific treatment with antiretroviral therapy
- Palliative care.

The extent to which these activities are available, however, differs from one parish or institution to the other.

Non-medical care and support

Non-medical care and support offered in the diocese includes:

- Social care such as food aid, financial support and livelihood support

– Legal assistance, for example, workplace rights, and legal aspects of family life especially heritage rights
– Pastoral care, prayer, spirituality
– Special programmes for women and children (especially orphans and vulnerable children).

Networking

There are several other organizations providing HIV and AIDS-related services in Chipata Diocese. These include, for example, World Vision, Care International and Diakonia. Some Catholic organizations are very effective at networking. Youth Alive and Caritas Zambia, for example, both have a seat at the District HIV and AIDS Task Force.

The research for this study found that some places had multiple programmes running in the same catchment area. For example, the district of Minga has three home-based care programmes – one organized by Care International, one by World Vision and one by the Catholic parish.

4.3.4 Appraisal

As in many other countries in sub-Saharan Africa, during the two decades between 1985 and 2005 the care and support of PLHIV and of orphans and vulnerable in Zambia was organized mainly by the churches, in particular the Catholic Church. The Zambian government tried to establish home care programmes through health centres, but this failed. It was not until the introduction of ART in 2005 that this situation began to change.

There is no generally accepted definition of "home care" or "home-based care". In some places home visits to PLHIV and their families by an untrained volunteer can be called "home care". In other places, such visits may carried out by trained health workers who have access to drugs and food aid. It is not possible, therefore, to determine whether all diocesan-run home care programmes have been equally effective.

The larger home-based programmes, such as those in Lusaka and Ndola, which received donor funding, were able to treat opportunistic infections, including tuberculosis, in the home environment. Other programmes, however, were not able to offer even the most basic drugs or any material support at all. Nevertheless, the programmes that were badly-funded were marked by great compassion; through counselling and prayer, the volunteers have helped people to live with the reality of HIV infection. In Chipata Diocese, the limited funding available for the home care programme was provided entirely by foreign donor organizations.

The funding for programmes that supported orphans and vulnerable children was highly variable. Some of the programmes were able to assist children to go to school, while others lacked funds for this purpose.

The availability of ART, starting in 2005, brought about a dramatic change in the lives of PLHIV and their families. Home care programmes have enabled thousands of people to access ART, and nowadays it is rare to encounter PLHIV with symptomatic HIV infection. With 80% of people in need of ART receiving this treatment, Zambia has one of the highest levels of ART coverage of any country in sub-Saharan Africa. The contrast with the nineties, when in many communities a bed-ridden person living with HIV could be found in every tenth house, is striking.

Several home care programmes have changed their focus, for example, to concentrate on care and support of orphans and vulnerable children. However, this switch in priorities is problematic, since it has occurred at a time when donor support for such programmes has fallen dramatically. Since 2009, the main response of the Church to the HIV epidemic has been through its health facilities, especially through HIV counselling and testing, the provision of ART and prevention of HIV transmission from mother to child.

These efforts are fully integrated into the national programme and are funded by international organizations such as the Global Fund, the

World Bank and PEPFAR. The Church Health Association of Zambia, of which the Catholic Church is by far the largest member, plays a key role in collaboration with the government and international donors. The four Catholic Mission Hospitals in Chipata diocese are included in these activities.

Pastoral care is meant to be an integral part of home-based care. In Chipata Diocese this lags behind other activities, as most parish home-based care programmes bypass Church structures. The DHO, for example, communicates directly with the parish home-based care volunteers, without contacting the office of the parish priest.

Networking in order to coordinate responses to the HIV epidemic is organized at national, provincial and district levels. Not all this networking is effectively organized. In Chipata Diocese it is well organized in some districts, but not at provincial level. According to the Provincial HIV and AIDS Coordination Advisor for Eastern Province, the Church administration has been quite reluctant to submit progress reports on its activities.

5. Challenges to the church and theology

5.1. Church life and the African reality

In his contribution to a handbook of pastoral theology, the German theologian Karl Rahner highlighted the fact that, in many ethical issues, there is friction between "theoretical" and "real" morality[29]. He explains this as "the difference – and the inequality – between lived morality and proclaimed pastoral morality".[30] Rahner considers this chasm between common practice and taught theory to be a fundamental challenge – not only for discussions about morality and theology, but for actual pastoral care.

Rahner is particularly worried that this chasm will mean that many faithful people will not be able to follow the moral expectations of the Church in their everyday lives: "It may well be that a person accepts the formal authority of the Church regarding conventions. He or she hears and understands a certain statement by the Church, but is unable to implement it in an existential manner".[31] Rahner thinks that such dilemma situations occur, for example, when people are under pressure through collective role models or economic strain.

When looking at the problem of HIV and AIDS, the chasm between "taught" and "lived-out" morality quickly becomes apparent. During discussions in Malawi between representatives of Catholic institutions, this problem was often exposed. One particularly pertinent example is the phenomenon of discordant couples, in other words, couples made up of one partner who is HIV-negative and one who is HIV-positive. In sub-Saharan Africa, one of the main routes of HIV transmission is from one

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29 Rahner, K. (1995) "Theoretische und reale Moral in ihrer Differenz" in: *Selbstvollzug der Kirche. Ekklesiologische Grundlegung praktischer Theologie*, Freiburg: Herder, pp. 233-242.

30 Ibid, page 233.

31 Ibid, page 237.

partner to another within a discordant relationship. Quite often these partners are married couples. If these partners are not abstaining from penetrative sex, the question of how to prevent HIV transmission within such a relationship has to be addressed. Part of the answer is to include good medical care – especially the use of antiretroviral drugs. Nutrition is also an important issue. The issue of condom use, as one of the most important means of HIV prevention, will also have to be considered.

This research study repeatedly touched on these dilemmas. When addressing the topic of discordant couples, one interviewee in a hospital in Malawi said: "I follow my conscience, which is influenced by my faith and my work. I do not follow the rules of the Church or my employer". Other interviewees also responded that one's conscience is the ultimate authority regarding such moral conflicts. A woman from a self-help group in Ethiopia, however, also stated that conflicts of conscience are a great burden for her: "I am aware of the Church doctrine, but I am unable to live it. I know that I have to follow my conscience in the end, but it still bothers me that I am unable to follow the Church doctrine."

The issue of discordant couples is therefore a prime example of the difference between theoretical and practical morality, brought to our attention by Karl Rahner. The specific case described in the research study shows the importance of overcoming the gap between "taught" and "practical" morality. This does not mean that the Church has to adjust to each and every social role model. The Church is challenged, however, to be more sensitive in her teachings. Rahner states that "not everything is possible and ought to be desirable [...] at every moment".[32] Some African Bishops' Conferences have already taken this to heart in relation to the issue of discordant couples. They have advised their believers to protect themselves from infection in such cases.[33] [34]

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[32] Ibid, page 41.

[33] Catholic Bishops of South Africa, Botswana and Swaziland (2001) *A Message of Hope.*

The interviews conducted as part of this study revealed that many African Catholics hardly listen to the Church any longer regarding issues of sexuality and marriage – a phenomenon that has long been familiar to people in Europe. In many cases this is linked to the fact that their reality can no longer be brought into line with the Church's teachings on morality. What Rahner has diagnosed within the European context also applies to Africa: if the Church wants to be heard more regarding ethical issues, she has to strive towards reducing the gap between theoretical and practical views on morality.

5.2 HIV and AIDS outside and within the Church

The research results show that the Catholic Church is one of the main stakeholders in the fight against HIV and AIDS on the African continent. The Church – alongside governmental institutions – is often the main organization that cares most for people who are directly or indirectly affected by the HIV epidemic. In some regions, and especially in remote areas of Africa, the Church is often the only institution providing basic health care. In his book *Light of the World* Pope Benedict XVI has especially emphasized the significance of the Catholic Church in the fight against HIV and AIDS: "The Church does more than anyone else, because she does not speak from the tribunal of the newspapers, but helps her brothers and sisters where they are actually suffering."[35]

Despite the considerable commitment that the Catholic Church shows in the area of HIV and AIDS, the interviews carried out in various African countries as part of this study have clearly shown that the HIV epidemic is frequently regarded as a reality that exists outside the Church. The Church takes care of those infected with HIV, supports orphans and

[34] Episcopal Conference of Chad (2002) Bishops of Chad's Statement on AIDS: N'Djamena: Catholic Bishops of Chad.

[35] Benedikt XVI. (2010) Licht der Welt. Der Papst, die Kirche und die Zeichen der Zeit. Ein Gespräch mit Peter Seewald. Freiburg: Herder, p. 145.

vulnerable children, and carries out HIV prevention activities. Often, however, the Church perceives this commitment as an external service in keeping with the charitable role of the Church, but not touching directly upon the inner self of the Church. Those infected with HIV are frequently regarded as – to use a biblical term – a stranger: "The stranger who sojourns with you shall be to you as the native among you, and you shall love him as yourself;" (Leviticus 19:34) Although the stranger may be certain to receive active help from the Church, he still remains a stranger; he does not really belong.

A second observation which points to the same conclusion is that HIV and AIDS is often regarded as a matter outside the Church. Even discussion of HIV infection among members of the Church, especially priests and Religious, is often considered taboo. It has frequently been reported that cases of HIV-positive priests or Religious are completely unknown, and exist only as rumours, not in reality. It is indeed extremely rare within Catholic circles for a priest or a Religious to publicly disclose his or her HIV-positive status. During the course of this study we did not find a single case of this having occurred in Ethiopia, Malawi or Zambia.

It is still the case that being HIV-positive can be regarded as a valid reason for excluding an HIV-positive person from entry to a seminary or a religious community. This suggests that Church leaders still find it unthinkable for a Catholic priest or a Religious to be HIV-positive. The usual argument in such cases is that such a person is not resilient enough to do service in a parish or a religious community.

The church-going faithful and the general public increasingly disagree with the taboo status of HIV and AIDS. A vast number does not perceive HIV infection as a barrier for clergy and Religious to play an active role in Church life in general and pastoral care in particular. Despite – or perhaps even because of – their HIV-positive status, they are able to render service in the cause of the Gospel. Moreover, the health status of HIV-infected people has also substantially improved, largely because of improved medical care, especially the availability of ART. These days, an

HIV-positive priest can work well under physical stress, and would surely be an asset for any HIV programme in the field of pastoral care. Such priests and Religious women and men are well placed to bear an authentic witness to the Gospel, thus becoming important confidants of people who, like, them, are living with HIV.

Perceiving and accepting HIV as a reality within the Church would mean refraining from the utopian vision of an invulnerable and perfect Church. It could be argued that this would leave room for diseases and weaknesses within the Church. At first glance it might seem that this would restrict or even degrade the Church. Ultimately, however, it is a more accurate portrayal of the everyday reality of the lives of the faithful – especially in sub-Saharan Africa.

This perception of a vulnerable and stricken Church was already aptly described by Fr Teum Berhe, from the Diocese of Adigrat, in Ethiopia, as follows:

"There is no place in the Holy Bible where it says the church is perfect and holy. The Church is sinful, but still forgives the sinner. The Church is wounded, yet heals the wounded. Through the sacraments and prayers, we are striving towards holiness every day. Jesus makes it clear when he says: 'I came not to call the virtuous but to call the sinners'. (...) The problem is, I think, that some people still see priestly celibacy as a shield against HIV, because its main means of transmission is sexual. Priests are not born as priests, but after a long period of formation they become priests. Why are doctors getting HIV infections? Certainly not because of lack of awareness and knowledge.

Underlying the reluctance of religious leaders to publicly disclose their HIV-positive status is their very real fear of stigma and discrimination. Unless HIV-positive religious leaders disclose their status to the media and to the faithful, we cannot expect ordinary people to take a positive attitude. We need a courageous leader saying 'Here I am, just like you.' We need new inspiration that closes the door on stigma and discrimina-

tion. The only answer is a renewed and much stronger sense of mission. We need a new sense of mission; we need suitable missionaries and seminarians."

5.3 Formation of priests and reality in the communities

The above quote by a priest from Ethiopia illustrates the importance of the formation of seminarians in how to deal with HIV and AIDS within the Catholic Church. In many African countries priests are still seen as authorities on moral issues. The formation of priests with regard to issues related to HIV and AIDS is therefore extremely important.

This research study has shown that the sensitization of the new generation of priests on issues concerning HIV and AIDS has improved considerably in recent years. For instance, the Major Seminary in Ethiopia uses a multi-volume handbook covering medical and pastoral aspects of HIV and AIDS during the formation of future priests. The principal of the seminary states that it is possible to include the issue of HIV and AIDS in the curriculum, but it has to be adapted:

"Recently the Ethiopian Catholic Secretariat produced a huge module of HIV components to be used as part of the curriculum for training priests. We find it very difficult to use all of its contents, since we already have a lot of topics to cover as part of the curriculum of the university to which we are affiliated. But after looking at it in detail, we found that, directly or indirectly, most of the contents are already included in our courses. Sex and sexuality, for example, comes up in moral theology; behavioural change comes into psychology; counselling comes into pastoral theology, and so on. So what we are trying to do is to integrate or mainstream, our courses in such a way that the HIV issue is fully addressed."

The integration of questions on the topic of HIV and AIDS into the curriculum of the Seminary gives reason to hope that the priests of this diocese will be better prepared in future when they are confronted with issues related to HIV and AIDS in their communities. The study inter-

views revealed, however, that an alarming amount of work still remains to be done. More and more Church faithful refrain from addressing their parish priests on issues such as HIV and AIDS and – most especially – on the issues of sexuality and marriage. Such matters are normally taboo during conversations with the clergy. There can be many reasons for this, but one is certainly that they do not consider the clergy to be competent partners in such a dialogue. They would rather consult a physician, who would at least be able to answer their medical questions.

Yet HIV and AIDS cannot be reduced to medical issues alone. For many people, moral and spiritual issues are just as important. The gap which has opened up between the members of the parish and the parish priest regarding the issues of family and sexuality must be closed. Perhaps the hesitant, rather insecure way in which the topic of HIV and AIDS has been addressed is an indication that issues of sexual morality are not yet discussed with sufficient openness within the Church. One of the interviewees from Malawi also made a wish in this respect, namely, to have an "HIV-sensitive Church", which allows its members to address sexual matters in an open way.

The chasm between priests and parishes also has another dimension. Despite the fundamental importance which priests have in parish leadership, it would be short-sighted to leave the overall responsibility to them. The everyday tasks that priests have to deal with are quite numerous and sometimes very complex. If they were expected to deal with all these issues on their own, they would quickly become over-burdened. The laity is also challenged when dealing with HIV and AIDS. The laity, however, has already taken the initiative and founded self-help groups, home-based care programmes and campaigns to reduce stigma. Given the magnitude of the AIDS epidemic in large parts of sub-Saharan Africa, ignoring the potential of the laity in the fight against HIV and AIDS would be short-sighted in the extreme. An interviewee in Malawi underlined this point by pointing out that Africa simply did not have enough priests for an effective response to this challenge: the laity should be involved much more in the Church's response to the HIV epidemic.

5.4 Church and cooperation

One main challenge for the commitment of the Catholic Church regarding HIV and AIDS is dependency on funds, equipment, medical supplies and staff from abroad. This basic problem was highlighted by almost all interviewees, and a detailed discussion is also included in chapter 6.5 of this report. This is certainly a considerable challenge. It is intensified even more when church-related organizations and initiatives regard themselves as individual players that cannot be – or do not wish to be – integrated into larger networks. Comments in many questionnaires revealed that cooperation with other initiatives or organizations could still be expanded in Church circles.

The scope of activities carried out by the Church in the fight against HIV and AIDS may be impressive, yet it is quite astonishing that the Church often still perceives herself as an individual actor. Surprisingly enough, this applies not only in relation to government institutions or to secular NGOs, but also within the Church herself. For example, in Adigrat, northern Ethiopia, several HIV programmes were founded by the diocese and others religious orders, but with minimal contact amongst these different initiatives. Similar comments were made by interviewees in the other participating countries, for example those from Malawi, where there were complaints about ”a lack of coordination of activities and efforts of HIV and AIDS among different players”.

6. Considerations from a pastoral perspective

6.1 Structure and organization

All dioceses and episcopal conferences in the three countries covered by the research study have pastoral departments or a pastoral coordinator, as well as health offices or desks. From the medical and also from the pastoral perspective, the HIV epidemic is seen as a challenge to be taken up by the Catholic Church. On a practical level, however, the relationship between the medical and the pastoral responses often leaves much to be desired. There is often a lack of coordination between these two approaches. As a result, the efforts being made do not always translate into holistic pastoral care which meets the needs of the intended beneficiaries.

In all the dioceses covered by the research study, the Catholic Church has developed ways and means of addressing the issue of HIV through pastoral agents, often with a special focus on sensitization of the youth. In Chipata Diocese, for instance, every pastoral gathering at parish level includes a special session on HIV and AIDS, including the Church's teaching on abstinence and faithfulness, as well as medical issues.

An important pillar of the Church's response to the challenge of HIV and AIDS is formed by the home-based care groups which are working in most parishes of the dioceses visited. According to the report by the Zambia research group, this home-based care approach can be considered "one of the main successes of the Catholic Church engaged with the HIV and AIDS pandemic". For instance, the number of patients catered for by home-based care groups in the 15 parishes assessed (out of a total of 24) in Chipata Diocese increased from 2,672 in 2007 to 4,080 in 2009. In 2009, 549 caregivers were involved in the home-based care activities, most on a voluntary basis. The findings suggest, however, that this well-established structure of home-based care groups is not always well connected to the overall pastoral work of the parish. Links between parish priests and the home-based care groups in their parishes are not struc-

turally anchored. Moreover, Chipata diocese has no health policy, and the diocesan health office lacks the personnel and funds needed to implement a general pastoral agenda that takes account of HIV and AIDS. As the Zambian research report observes:

"There is no compelling policy for parish leadership to be involved in the fight against HIV and AIDS; the destiny of the fight is left to the jurisdiction of the parish leadership."

The report concludes that the pastoral aspect of the Church's response to the HIV epidemic lags behind, "as most of the respondents had no deliberate programmes to access pastoral services. For example, the diocesan health office communicates directly to the parish home-based care without passing through the parish priest's office." The main activity of the home-based care groups is no longer care for bed-ridden patients, as ARV treatment has greatly reduced that number. On the agenda are rather pre-test and post-test counselling, information and sensitization, material help for the most vulnerable groups, and the information and support needed for people living long-term on anti-retroviral treatment. That is why support groups of people living with HIV constitute another important element of the Church's response to the challenge of HIV and AIDS. These support groups play a key role in fighting stigma and discrimination. They enable PLHIV to come out into the open, to meet regularly, and to help one other to live positively with the virus. As one interviewee from the Archdiocese of Addis Ababa put it:

"HIV and AIDS was believed to be a curse. [...] It was of great help when the affected people came out to tell others their story. An organization of such people was established to appeal to the public to accept the reality. Earlier it was difficult to expose them because of stigma. This was a radical change in the way of thinking."

The research report of Lilongwe Archdiocese indicates that these support groups also mirror the ”female face” of HIV and AIDS, as there are more women than men active in such groups. There are also more female than male volunteers involved in home-based care programmes.

Livelihood support is another important pillar of the pastoral response of the Catholic Church to the challenge of HIV and AIDS, as it contributes towards reducing the socially detrimental effects of stigma. In the Diocese of Emdibir (Ethiopia), Attat Hospital runs a very effective women's support programme with 3,292 women organized in 29 groups. The report explains:

“These women have a revolving fund where they can borrow and engage in small income generating schemes. There are animators from the public health office who meet with them every 2-3 weeks. Health education is a major component of their meeting. This has helped women to overcome their shyness and avoid dependence on men, which has a lot to do with prevention of HIV transmission. They help in the mobile VCT unit which the hospital sends to different villages. In some villages, the women have initiated their own feeding programme for the under-five children, taking turns in cooking the food which they themselves provide. Some have been trained to provide home-based care by professionals who themselves received special training, and provide basic care to bedridden patients in their villages and also teach others to do so. Stigma is becoming history now in the villages where these women are actively involved because they themselves used to fear HIV as a ‘wild animal’.”

The Diocese of Emdibir runs two hospitals and six clinics, which are under the responsibility of the Diocese's HIV and AIDS Desk within the Health Unit. The “Pastoral Activity Coordination Office” (PACO) is responsible for evangelization activities, and works in close collaboration with the Social and Development Coordination Office. These activities are well appreciated by the people, by community and religious leaders, and the Government. The latter, for instance, supports the home-based care groups through kits, training and technical support.

However, the cooperation between pastoral facilities, health institutions and health desks does not always function smoothly, often due to problems with finance. For instance, the pastoral office of Chipata Diocese does not have an external donor, so all funding has to come from the diocesan coffers. The major costs are linked to transport. Lack of transport facilities makes the work of pastoral coordination very difficult. The office tries to negotiate with other departments for the sharing of transport as a cost-saving measure. However, as the Pastoral Department relies mainly on external funding from Caritas, the organogram of the diocese, where Caritas comes under the Pastoral Department, does not seem to be operational.

6.2 Culture-sensitive Church and theology

One major challenge in the response of the Catholic Church to the HIV epidemic is the cultural background of the people involved. As several interview partners emphasized, the African approach to disease in general – and to HIV in particular – is often different from the "Western" or medical approach. According to the African approach, disease always has to do with disturbed social relations and cannot be cured without addressing – and overcoming – these disturbances. This means that, for the Church and for theologians in particular, responding to the HIV epidemic also involves dealing with complex questions about African culture.

In Lilongwe Archdiocese, Malawi, local Christian communities introduced the so-called *alangizi* to provide pastoral care for couples and youth. The *alangizi* are Christians assigned by the community to accompany young couples in preparation for marriage, to instruct the youth during puberty, and to provide counselling for couples in general. This is a good example of a pastoral practice which is sensitive to traditional culture and uses one of its institutions, re-framed in the setting of a Christian community, in order to cater for specific pastoral needs, namely, the counselling of youth, young adults and couples.

A context where traditional institutions and mechanisms are still very important for the functioning of society is Ethiopia. The elders are highly respected in this society. As the people listen to them, the Church's health institutions also rely on elders for support on HIV-related issues. In the Diocese of Emdibir, for example, a major step in the prevention of HIV transmission was the fact that the elders in Gurage area reached a consensus that, without HIV test results, engagements or marriage ceremonies would not take place. Some relevant norms of traditional Ethiopian culture (no sex before marriage, no polygamy) are in line with the Church's teachings, but modern urbanization – and especially migration – tends to undermine these norms.

All three research reports on Ethiopia highlight migration as a major pastoral challenge to the Church in Ethiopia. Because of endemic poverty and the loss of social cohesion, migration contributes to the spread of HIV, especially amongst the youth, who are migrating from rural to urban areas looking for jobs. The younger generation is therefore particularly vulnerable to the link between poverty, migration, change of values and the risk of HIV transmission.

The research report on the Diocese of Adigrat highlights an interesting and significant fact, namely, that people with different religious beliefs are united through their traditional culture. When questioned about why people of the different religions and denominations live in harmony with one another, a spokesperson from a local NGO, OMCA (Orthodox, Muslim and Catholic Unity to Safe Life), responded as follows:

"It is the long tradition we have inherited from our great grandparents. As history tells us, Ethiopia was the first country to welcome the Muslim religion and give refuge when the disciples of Mohamed were persecuted, and since then we live in harmony and participate in different social affairs like festivals, funerals and different occasions. Our difference is only our religious practice in our respective worshiping places. Otherwise we have the same culture and socio-economic practices."

According to the Secretary General of Adigrat Diocesan Catholic Secretariat, most people benefiting from the HIV services provided by the diocesan health facilities are non-Catholics. He continued: "I think the secret of our unity was the same tradition, culture and history we share as Ethiopians, which we inherited long time ago."

On the other hand, traditional culture can also play a negative role. The research reports from Zambia and Malawi highlight certain traditional practices which discriminate against women, degrade human dignity and contribute to the spread of HIV. For example, in Chewa culture, on both sides of the border between Zambia and Malawi, the traditional practice of *fisi* requires a young girl, after her initiation ceremony, to have her first sexual intercourse with a village elder. In a similar practice, known as "blanket for the chief", when a chief visits another area he is given a local girl to sleep with.[36]

That these cultural practices still persist, even in Christian circles, could be interpreted as a general lack of an in-depth evangelization since the era of the European missionaries began. Has the Church sufficiently challenged African cultural practices that are against human dignity, in a spirit that is inspired by the Gospel? The research reports from Malawi and Zambia seem to suggest that this has not yet happened sufficiently thoroughly and in a long-lasting manner. A certain dualism – or a gap – between theory and practice seems to persist between, on the one hand, Christian teaching on abstinence and faithfulness and, on the other hand, traditional cultural practices that go against this teaching, and indeed contribute to the spread of HIV.[37] Further investigations are needed to learn more about the actual impact of these cultural practices, and about the stand which Christians take against them. The research

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[36] These and other practices were reported by the interview partners to happen. There is no empirical data, however, to prove that these practices are in actual use or how widespread they are.

[37] Cf. Chiti, L. (2011) "The Church, culture and HIV/AIDS", *JCTR Bulletin* no. 89, pp. 25-26.

report from Zambia furthermore suggests that most people would not follow the Church's teaching and advice to abstain from sex before marriage.

Traditional beliefs can also aggravate stigma and discrimination, as the following statement by a Sister from Adigrat (Ethiopia) suggests: "The issue of stigma and discrimination is still a long way from being overcome, due to cultural beliefs. People easily associate HIV-positive persons with evil deeds and bad behaviour. This is one reason why they are reluctant to disclose themselves and give testimony for others."

Another challenge with regard to culture is the notion of witchcraft, which is often linked to disease and death, and thus especially to cases of AIDS. An informant in Chipata diocese said: "Many people, especially in rural areas, believe that a person cannot just die from a natural disease; death is usually a result of witchcraft. This opinion is sometimes held, even with full knowledge that the deceased was HIV-positive. Witchcraft would always come into the picture."

There is a lasting tension between traditional and modern understandings of HIV, and awareness programmes have to take this into account. In addressing HIV, the "technical" explanation of how it is transmitted is insufficient. From the traditional African perspective, the important question is: who is responsible for it? This is a delicate issue, difficult to address but never to be bypassed. It also translates into competition between traditional healers and modern medical treatment. Especially in rural settings, a solution to a health problem would first be searched for from a traditional healer, and only if these attempts fail, would Western medicine be addressed for help. In the case of HIV infection, however, early detection and treatment are of capital importance.

When asked if one of his patients wanted to quit ART and go instead to a traditional healer, a social worker in the Diocese of Emdibir replied:

"I would tell a patient who wants to quit ART the problems that will arise if ART is stopped. I would tell him/her that he/she can take the ART with traditional treatment as long as what he/she takes is something that doesn't contain strong drugs. Most of the time people want to go for Holy water and that doesn't cause any problem if taken with ART."

A holistic pastoral approach by the Church has to take into account the different concepts of sickness, and has to address the healing of the whole person in his or her social environment. Such a pastoral approach should be able to act as a bridge between the traditional and the modern views on sickness and healing. As the pastoral coordinator of Chipata Diocese put it: "Our mission is to instil hope."

6.3 Pastoral agents

On a general note, it was observed that activities in response to the challenge of HIV and AIDS bring together lay people and priests, or religious men and women, because the virus cuts across all layers of society and the Church. The responses must therefore also be cross-cutting.

There is a growing awareness in the dioceses of the three countries that pastoral agents, as they are constantly confronted with issues on HIV and AIDS, need to have a solid training in both the medical and the psychological aspects of the disease. Courses on HIV and AIDS are integrated into seminary formation, and special retreats, as well as events like World AIDS Day, are used to create awareness and sensitivity on questions related to HIV and AIDS.

The research report from the Diocese of Emdibir reminds us that priests are key persons for awareness-raising. In 1997, for example: "The priests got special training in the seminaries about the issue, and HIV and AIDS was part of their teaching to the youth and during homilies … The priests themselves are taking the issue seriously and put in a lot of effort to create awareness among the faithful." Training and awareness creation on HIV and related issues are of paramount importance in Ethiopia, where

priests play a key role in society. Their authority is respected and their word is listened to, in a similar way to the word of elders. But efforts to incorporate components of HIV and AIDS into the formation of priests at major seminaries have encountered difficulties, as the Rector of a seminary in the Diocese of Adigrat points out:

"The Ethiopian Catholic Secretariat produced a huge module of HIV components to be used as one part of the curriculum, but we find it very difficult to use since we already have a lot of demands from the university to which we are affiliated."

Although pointing in the right direction, these efforts are, however, not sufficient. They indicate a lack of knowledge and insufficient sensitivity by some pastoral agents, whether they be priests, Religious or lay pastoral workers, or volunteers involved in home-based care groups.

At the level of the Episcopal Conference, the officer in charge of the Ethiopian Catholic Secretariat's AIDS Desk believes that, on the whole, priests and Religious are not sufficiently sensitive on matters related to HIV. This is mainly because, during and after their formation, insufficient time is devoted to this issue. This is also the reason why, he believes, unlike Protestant and Orthodox clergy, Catholic priests and Religious in Ethiopia do not disclose their HIV-positive status and "do not share their experiences".

The pastoral coordinator of Chipata Diocese identifies a "lack of trained chaplains" as the root of the problem. He advocates for greater HIV sensitivity as part of the priestly vocation, and also in the training of priests. This is also reflected in the answers given by parish priests to a question posed during the research about an HIV-positive woman whose husband refuses to use condoms. As mentioned in the research report from Lilongwe Archdiocese, the clergy preferred to refer her to marriage counsellors or medical personnel for advice and help on this issue. In other places priests who were asked for advice on condom use by discordant couples tended to refer people to doctors or other medical personnel for

advice. The same group of parish priests interviewed in Lilongwe indicated that the Church does not speak much about HIV and AIDS, and that very little is being done for the clergy. They felt that this was a major gap in the Church's response to this important issue. One Religious sister put it bluntly: "I do not feel equipped with the necessary tools to deal with HIV and AIDS."

The question of including issues related to HIV and AIDS in the formation of pastoral agents remains one of the main challenges in the response of the Church in the dioceses that participated in this study.

6.4 Stigma within the Church

One crucial point in this field is the issue of stigma within the church towards HIV-positive priests as well as Religious women and men. A lot of silence and denial seem to persist. In the research report from Lilongwe Archdiocese, Malawi, one parish priest referred to the challenge as follows: "It is a delicate issue which affects us psychologically, especially seeing fellow priests getting sick."

The research report from Addis Ababa could not address this issue, as people were not available for interview or refused to answer sensitive questions. The programme coordinator of the orphanage, "Missionaries of Charity – Gift of love", confirmed: "There are no reports of HIV-infected priests, religious or catechists." Various attempts in the Diocese of Chipata and beyond in Zambia to interview an HIV-positive priest or religious person failed. Their notion of an HIV-sensitive church would be of great interest for further pastoral planning.

The interviews with rectors and seminarians from the Major Seminary in Addis Ababa about the non-admission of an HIV-positive candidate showed that there is an issue about HIV-positive priests and other pastoral agents. The main reason for his non-admission was given as "physical fitness". Yet a conclusive reason could not be given as to why a candidate infected with, say, Hepatitis B would be treated differently from the HIV-

positive candidate. One seminarian put it as a rhetorical question: "Does the actual health status of the candidates allow to us assume that they are not able to fulfil the tasks of a priest?"

Nowhere during the research was it clearly expressed that an HIV-positive priest or a Religious person can give great encouragement to the HIV-positive faithful and that the Church welcomes them. However, the Secretary General of Adigrat Diocesan Catholic Secretariat, in Ethiopia, shed some light on this issue when he explained the meaning of the expression "an HIV-wounded Church":

"Priests are not born priests, but become priests after a long period of training. ... It is the fear of stigma and discrimination which prevents HIV-positive religious leaders from disclosing their status. Unless religious leaders disclose their HIV-positive status to the media and to their faithful, we cannot expect ordinary people to do so. We need a courageous religious leader to say: 'Here, I am like you!' This would help to close the door on stigma and discrimination. This is a mission for which we need fitting missionaries and seminarians."

According to the pastoral coordinator of Chipata Diocese, the fact that the bishop encouraged his priests to go for HIV testing and to talk about the issue with one another has helped them to tackle stigma around the issue of HIV-positive priests and religious persons. All over Zambia, recent seminars on HIV and AIDS, sponsored by the US-based aid organization, Catholic Relief Services (CRS), were held at religious formation houses and have contributed to increased awareness within Religious congregations of HIV-related stigma and discrimination.

The reluctance to admit HIV-positive seminarians and aspirants to religious life is also mirrored in the general acceptance of mandatory testing before admittance. There was only one mention, in the Malawi research report, of the mandatory HIV test before admission as being discriminatory. In fact most respondents do not find this discriminatory. Admission of HIV-positive candidates has been discussed, for instance, by the Zam-

bian Association of Sisterhood (ZAS) since 2009, but without reaching a conclusion or making a recommendation. Every congregation decides autonomously. For instance, the Jesuits and the Missionaries of Africa accept candidates with Hepatitis B, but do not accept HIV-positive candidates.

The national Episcopal Conferences in the three countries have recommended workplace HIV and AIDS policies, and the Ethiopian Bishops' Conference has developed such a policy, but there are no such policies being implemented in the dioceses or in most of the Church institutions. In Chipata Diocese, Zambia, a workplace policy including HIV and AIDS has been worked on but without reaching a concrete result so far. Health institutions of Lilongwe Archdiocese made a challenging assertion, namely, that HIV-positive Religious and clergy are not ready to come into the open and that this leads to unnecessary deaths. The same report confirms that priests do not speak about HIV and AIDS in the presence of HIV-positive priests. In response to the question of what to do if a member of a religious order, or a fellow priest, is HIV-positive, the response was: "We tolerate one another, but in a segregating way."

The lack of coherence in dealing with the issue of HIV and AIDS within the Church, and in the Church's public statements, can also be felt in the following statement from the Malawian research report, on what an "HIV-sensitive Church" would look like, namely, a Church "where they accept seminarians who are HIV-positive to go on with their formation and do not withdraw them from the seminary, where candidates to sisterhood should also be allowed to continue, where priests care for one another and do not discriminate against those infected, and where people accept that anyone can get the virus."

To some extent, the Church has learned how to address the issue of HIV and AIDS in her pastoral work and in her public statements, but seems to be slow in accepting and dealing openly with the fact that pastoral agents themselves are also affected and infected. As one health worker in

Malawi put it, "The fact that people are not able to say that they are HIV-positive shows that they are discriminated against."

6.5 Donor dependency

Finances are one major problem with which the local churches in Ethiopia, Malawi and Zambia have to struggle. All the dioceses depend heavily on foreign funding for their health and development work – not only for their HIV programmes. Self-sufficiency is far from being achieved, and endeavours towards it are hampered by the economic weakness of the surrounding societies. Money from donor organizations is linked to the donors' policies, which can be subject to change and which sometimes lack continuity. The National Pastoral Secretary of Malawi stated: "There is a donor dependency, but we do not know how we can manage without donor aid."

For instance, the "Healthy Choices Project" in the Archdiocese of Addis Ababa focussed specially on marginalized areas and their inhabitants, who were provided with material help along with awareness programmes. This was funded for three years by Catholic Relief Services and Caritas Italiana. The staff allowances paid through this programme, however, raised the financial expectations of staff working in these sorts of projects. The Catholic Secretariat of the Archdiocese sums up this mentality with the astute comment: "Generally, people associate HIV and AIDS programmes with money." The funds for this programme ran out in 2010, but new donors have not yet been identified.

The General Secretary of Adigrat Diocesan Catholic Secretariat in Ethiopia is also critical of the way HIV projects have been funded, and has suggested radical changes: "In some cases, the amounts of money the so-called partners announce and the amount that reaches us are incomparable. Not even half of it reaches the targeted beneficiaries. Some remains, in one way or another, with the partner organization in the donor country. Or they come with their own people, and a huge amount is consumed by these expatriates. The salary of just one expatriate could

have covered the cost of more than ten experts here. So for me it is the system that creates this problem, and unless the system is changed nothing can be done."

The problem of financial discontinuity also applies to the home-based care programmes in parishes of both Chipata Diocese and of Lilongwe Archdiocese. In 15 out of 24 parishes in the Diocese of Chipata, home-based care programmes used to be sponsored by the US donor organization, Catholic Relief Services. This funding has stopped, and the home-based care programmes have had to continue on a smaller scale, mostly on a voluntary basis or supported by local resources. The Bishop of Chipata confirms that the local people take a very negative view of this kind of donor behaviour, namely, funding for a limited period of time and then leaving without ensuring any kind of sustainability.

In Lilongwe Archdiocese, Malawi, all 35 parishes used to run home-based care programmes, sponsored by CAFOD and CRS. After the donor funds finished, only 8 parishes managed to continue their home-based care programmes with local resources. The main problem is finding and paying for qualified personnel. In the research report for Lilongwe Archdiocese, Malawi, the Diocesan Health Coordinator, the Diocesan Pastoral Secretary and the National Pastoral Secretary sum up the situation as follows:

"Basically the organization has done well; previously ... home-based care was in all the parishes. We came into the situation with enthusiasm because there was funding, but now most of it has ceased. This has meant a marked decrease in activities. So one may say that the initial dependency on outside funding decreased creativity. Donors somehow did not help beneficiaries to start relying on their own resources."

High staff turnover is a major problem, linked to finance. In Chipata Diocese, Zambia, the Diocesan Health Office is not paid for by the diocese. The Office depends entirely on foreign funding. A few years ago, one whole building was set up to provide offices for several health ser-

vices, including offices for home-based care and for youth awareness programmes. The funding stopped, and now only a few rooms in the building are still being used. In the Diocesan Health Office of Lilongwe Archdiocese, the salaries of most staff are paid for by international donors. Only a minimal staff is sustained by contributions from the diocesan-run hospitals.

Even on the national level of the Episcopal Conference of Malawi, the National Health Secretary is not paid for by the Episcopal Conference, but is dependent on funding from abroad. This means that activities are not determined solely by the Health Secretariat or by the Episcopal Conference, but – at least in part – by foreign donor agencies. Currently, funding comes from the Global Fund, through the National AIDS Commission. The post of National Health Secretary is the only one of three currently filled. The two other posts – one in charge of home-based care programmes and one in charge of the Church's health institutions – have had to be cut due to lack of funds.

The problem of donor dependency heavily affects networking between the various institutions involved, especially between the pastoral and the medical level. Moreover, a stable and appropriate monitoring and evaluation structure cannot be set up under these circumstances.

The research report from Lilongwe confirms the lack of personnel in the office of the Health Commission, as well as the "need to further strengthen coordination of health activities in the diocese. There is a need to continue these activities and they should be linked to that of the pastoral department, which should coordinate all different departments ..., creating a synergy between them."

The problem of financing the structures of the local church is not addressed in a satisfactory manner by pastoral theology and ecclesiology. The former "mission churches" in Africa have been Africanised to some extent, yet the question of finances has not yet found an answer within local contexts. The long-lasting dependency on Western donor organiza-

tions still hampers creative attempts towards self-sufficiency. As the National Pastoral Coordinator points out in the Lilongwe research report: "Somehow, the church does not start looking for alternative funding as long as outside funding comes." The economic situation of most African countries renders the question even more acute. What does it mean to be "Church" in the context of widespread poverty and deprivation?

A Church working as an NGO in the area of HIV and AIDS has to meet expectations which might not be in accordance with her own self-perception. As expressed in the Malawian research report, this also applies to collaboration between Church and State. Health services in Malawi are, to a great extent, provided by the Church, while it is primarily the Government's responsibility to provide for health institutions. What does it mean to be "Church" in a context where the State does not assume its tasks and responsibilities?

The problem of the sustainability of HIV-related programmes arises in all the dioceses under consideration. The evaluation of work at the diocesan level from the pastoral and health perspective in Lilongwe highlights the different perspectives of donors and recipients: "Donor money is earmarked for specific activities with a lot of do's and don'ts. ... Donors think that if they help you today it ends the problem in a couple of years. But since this is mostly not the case, it is difficult to sustain our interventions."

The advice of the General Secretary of Adigrat Diocesan Catholic Secretariat in Ethiopia is therefore of relevance elsewhere as well:

"If we still depend on parents, on benefactors and projects, I do not think we will go very far. So the question is how to prepare ourselves, how to capacitate ourselves with the money which might stop tomorrow. We need to work on this strategy very well. Whatever money we receive, whatever development we do and whatever work we do, it has to have a double edge: first, immediate support, no matter what sort of support we

offer; and second, what we do should not be simply a relief or support for the moment but has to have a long term plan."

The recommendation then, which is also that of the Malawian research report, is to include local income generating activities in every project "for helping HIV and AIDS-infected and affected, so that they may help themselves".

6.6 "An HIV-sensitive Church": Quotations

Some quotes of the interview partners about what an HIV-sensitive Church in their view looks like, or should look like:

"For me, to be a HIV-sensitive church is to give hope, to promote life and not to discourage people who are already discouraged, have lost hope and expect death." (Catholic Sister, Adigrat, Ethiopia)

"An HIV-sensitive Church is:

- one that cares, protects life and renders spiritual and material help
- one that cares for the sick, supports them physically and mentally
- one that is concerned with people's lives and respects human beings
- one that talks about HIV and AIDS
- one that is realistic about the practical situation
- one that is open to talk about HIV and AIDS among Christians and religious."

(Report from Zambia)

"An HIV-sensitive Church is a Church:

- that talks freely about issues of HIV and AIDS
- that wants HIV and AIDS to be incorporated in all the activities of the church

– where people can give testimonies

– where they accept seminarians who are HIV-positive to go on with their formation and do not withdraw them from the seminary

– where priests care for each other and do not discriminate against those infected

– where people accept that anyone can get the virus

– where we mainstream issues of HIV and AIDS in all our programmes, not just waiting for annual World AIDS Day, and where we integrate HIV and AIDS issues in our homilies, workshops, wedding ceremonies and church programmes."

(Report from Malawi)

7. Ethical perspectives

Before analysing some ethical aspects of HIV and AIDS, three preliminary remarks have to be made. First, Catholic moral teaching must acknowledges the challenges that result from the HIV epidemic. This is particularly true for those challenges in relation to issues around morality and ethics. Catholic theology has to find suitable responses to these complex questions, as many faithful are affected by HIV and AIDS in their daily lives. They are expecting answers to their questions.

Furthermore, the care of the sick, the poor and the vulnerable forms an essential nucleus of Christian faith. Jesus himself says that he has been sent to proclaim the Good News to the poor (Luke 4: 18-19), because "it is not the healthy who need a doctor, but the sick" (Matthew 9:12; Luke 5:31). Thus, as Pope Benedict XVI wrote in his exhortation, *Africae Munus*: "In the spirit of the Beatitudes, preferential attention is to be given to the poor, the hungry, the sick – for example, those with AIDS, tuberculosis or malaria – to the stranger, the disadvantaged, the prisoner, the immigrant who is looked down upon, the refugee or displaced person."[38] (cf. Matthew 25:31-46).

The second preliminary remark is a reminder that Catholic moral theology and social ethics relating to HIV and AIDS are under enormous pressure as a result of people's expectations. Here again, a passage from *Africae Munus*: "The problem of AIDS (...) is an ethical problem. The change of behaviour that it requires (...) ultimately involves the question of integral development, which demands a global approach and a global response from the Church."[39]

As Pope Benedict emphasizes, HIV is not only a medical, but at least as much an ethical challenge. It is about human behaviour and – as we well

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38 Benedict XVI (2011) *Africae Munus*, No. 27.

39 Ibid, No. 72.

know from personal experience – established behaviour patterns are difficult to change. What makes these changes even more difficult – and Pope Benedict refers to this as well – is that HIV and AIDS are a global challenge.

Only if mankind faces this problem in a collective manner can it be eradicated. The world is completely interconnected through economic relations, trade, patent rights, the Internet and social media. Consequently, an answer to the challenge of HIV and AIDS can be found only from a global perspective. All other efforts to come up with answers will be in vain. In this respect, the Catholic Church may be able to use her centuries-long experience of thinking and acting on a global scale.

The third preliminary remark concerns the human being, who is at the centre of each and every attempted response. In terms of theological ethics, personal well-being and the protection of life are regarded as the highest aim when dealing with the problem of HIV and AIDS. Therefore, as Agbonkhianmeghe E. Orobator has correctly commented: "The discourse on the morality of HIV prevention should be conducted primarily as a discourse about people rather than a polemic over prophylactic devices".[40]

Such an approach also represents a paradigm shift, as occurred during Vatican Council II. The Council Fathers emphasized particularly that, within Catholic moral doctrine, the focus is on the whole person, not just on a person's individual activities. This is reflected in the principle:

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[40] Orobator, A. E. (2006) "Ethics of HIV/AIDS Prevention: Paradigms of a New Discourse from an African Perspective", in: Hogan, L. (Ed.) (2006), *Applied Ethics in a World Church*, Maryknoll, NY: Orbis Books, pp. 147-154.

"Human activity must be judged insofar as it refers to the human person integrally and adequately considered".[41]

When dealing with ethical questions, these three preliminary remarks should be borne in mind, especially the third one, namely, dealing with the well-being and the protection of the human being as a whole. This should serve as a guideline for the remarks that follow.

7.1 HIV as punishment from God?

The responses to the question of whether HIV could be seen as a punishment from God were various. A vast number of interviewees replied that they would say no. At the same time, however, they also said that such beliefs are still widespread. In Zambia, for example, one respondent said: "People say it is a punishment from God. For me it is not. It is something human beings brought about due to their carelessness." In response to this question, many respondents in Ethiopia mentioned the story about the man who had been born blind (John 9:1-3). When asked by his disciples what sin had caused this man to be blind, Jesus replied that the man's blindness was not due to any sin by him or his parents. The respondents interpreted this story to mean that, in our present context, a person with AIDS may not be regarded as having been punished by God.

7.2 Reasons for the spread of HIV

In order to approach the theological and ethical aspects of the HIV epidemic, it was quite helpful to consider the question of the reasons for the spread of the disease. The responses as a whole can be divided into two categories. First and foremost, the immediate causes of the epidemic

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[41] Vatican Council (1965) *Schema constitutionis pastoralis de ecclesia in mundo huius temporis: Expensio modorum partis secundae* (= Schema for the pastoral constitution on the Church in the modern world). Vatican City: Typis Polyglottis, pp. 37-38.

were seen as the misbehaviour – or at least the risky behaviour – of individuals. Responses commonly referred to unprotected sexual intercourse, multiple sexual relations, or simply ignorance. Sometimes the lack of maturity, in the spiritual sense, was mentioned as well. These are basically individual ethical issues. On the other hand, the root causes of the epidemic were seen as unjust social and economic structures, such as lack of education, poverty, forced migration and the unfair treatment of women.

7.3 Discordant couples

One of the most fiercely discussed issues, especially in the Ethiopian context, was that of discordant couples. The discussions about the case studies revealed that this is an issue that cannot be answered so easily. The responses vary considerably. In general, however, four types of responses can be identified for discordant couples:

1. Sexual abstinence so the non-infected partner does not become infeced
2. Condom use
3. Allowing married couples to decide according to their consciences what they consider to be the correct behaviour
4. No advice; married couples are referred to a medical expert, such as a doctor.

The diversity of responses indicates that we are dealing with complex moral questions. Especially the two different functions of a condom – contraceptive on the one hand, protective on the other – lead to different estimations. As the fourth type of answers shows, some priests and other church members also tried to avoid giving answers at all because they were not sure what to advise in this case. Others also missed a clear guidance by the church on the issue of discordant couples.

Some African Bishops' Conferences therefore tried to give orientation. In October 2002, for example, the Episcopal Conference of Chad stated:

"With regard to the condom, the Church wishes to recall here, through our Bishops, that its use is subjected to the normal moral rules as for the other human acts. The ultimate moral rule is our conscience. It is up to each and everyone of us to train one's conscience and to assume one's responsibility according to the situation in which one finds oneself. Because «no one is bound to do the impossible», spouses cannot be asked to abstain from sexual intercourse; we therefore understand that a person, through love, may be led to use the condom to protect himself/herself or to protect his/her partner. But everybody must understand that the condom does not provide 100% protection and that it does not ultimately solve the real problems raised by AIDS."[42]

7.4 Vulnerability of women

Within the context of discordant couples, the role and position of women has to be addressed in more detail. The case studies demonstrate that women – especially young women – are at much greater risk of HIV infection than men. The situation of women is seen as a big challenge, although there are examples from places like the Diocese of Emdibir, in Ethiopia, where the opposite seems to be the case. As women quite often get married very young or are economically largely dependent on their husbands, they are often not in a position to lead an autonomous life. Due to their precarious living conditions, they can be forced to practise risky sexual behaviour and thus be at greater risk of HIV infection. The study results show that women in particular are in need of an effective response from the Catholic Church in relation to HIV and AIDS. Apart from their personal rights to safety, respect and dignity, women have a particularly key role in protecting family life and also in promoting social cohesion.

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[42] Episcopal Conference of Chad (2002) *Bishops of Chad's Statement on AIDS*.

8. The different levels of response

The presentation of some ethical focal points was able to visualize the complexity of the challenge – including the ethical challenge – of the HIV and AIDS issue. This challenge encompasses all dimensions of human life, starting from personal maturity and the formation of conscience, but also including the position of women in society and the relationship between the sexes, and questions regarding the fair distribution of goods, at either village or global level. A comprehensive response to the HIV epidemic should bear in mind all these dimensions even if, in actual practice, the focus is on certain aspects.

While searching for adequate answers to these and other questions, the Church should not rely on being able to find suitable responses on her own. Rather, the Church has to obtain comprehensive information on a wide range of issues regarding HIV and AIDS. As the example of the discordant couple shows, there are moral conflict situations which are very difficult to resolve.

For all attempts to find responses, it has to be remembered that these are not complex mental acrobatics, but real, live issues affecting the destiny of numerous real people. Ethical responses do not happen in a vacuum or in pure theory, but are meant to lead ultimately to a decent way of living. Each and every ethical reflection thus has to be certain of this link with practice.

This connection to the concrete reality means not only that ethical reflections aim at practical results, but also that they are based on real life. It was therefore necessary for this study to first observe and describe the realities in Africa before attempting to make ethical recommendations.

The search for answers will take place on different ethical levels. We have already identified two categories – the *individual* level and the *social* level. Although these levels share interactions and mutual dependencies, some ethical issues clearly fit into one of these two categories.

Regarding the socio-ethical dimension of HIV and AIDS, yet another categorization becomes evident. Issues such as poverty, education and equal opportunities can be bundled together under the heading of *structural* issues. Issues regarding the significance of certain cultural practices or customs can be categorised as *cultural* phenomena.

8.1 Structural level

On the structural level it is mainly the lack of distributive justice that has contributed to the rapid spread of HIV. Unjust structures, for example in the field of education, food supply, trade, health care, distribution of resources and even patent rights mean that many people in sub-Saharan Africa are deprived of the opportunity to lead an independent life. As Michael Czerny says: ”It might be argued that the most urgent ethical issue arising from the pandemic of HIV and AIDS is the lack of distributive justice. The poorest, most marginalized and oppressed members of society are also most vulnerable to the threat of HIV and the tragic consequences of AIDS”.[43]

For the Catholic Church, caring for people living with or affected by HIV should therefore not be simply a charitable act, but should also be a mission for more justice. Church-related involvement in HIV-related work often lacks a structured and systematic orientation. This is influenced partly by reliance on financial support from abroad. Another contributing factor, however, is the fact that the guiding principle for Church activities is mostly that of charity rather than justice. Bishop Kevin Dowling from South Africa points this out as well: “Faith-based responses must be technically correct and based on sound analysis and scientific research. This is a challenge for faith-based communities because it involves a move from random acts of kindness to

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[43] Czerny, M. (2010) *An African View of Church and HIV,* Interview with Founder of Nairobi-Based AIDS Network Nov 29, 2010 Vatican City: Catholic Radio and Television Network. Available at: http://www.zenit.org/en/articles/an-african-view-of-church-and-hiv [Accessed: 24 April 2014]

structural involvement in processes with the affected people which change the suffering and dehumanisation caused by HIV".[44]

To achieve a more systematic approach to HIV prevention, care and support, certain steps need to be taken. These include, for example, increased professionalism in planning, implementation, monitoring and evaluation, combined with comprehensive coordination of the different initiatives in these fields. In addition, an advanced monitoring and evaluation system, the development of policies and strategic plans, and – most especially – competent education and training of Church staff are absolutely indispensable.

Yet another aspect has to be observed in this context. Increased professionalism can be achieved if the Church makes more effort to network with other organizations. A starting point could be within the Church itself, where diocesan structures already work in collaboration with religious congregations. However, the Church needs to reach out further, and to work more closely with *all* people of good will. Stronger ties should be established especially with the numerous governmental and non-governmental organizations. This will not only save financial and personnel resources, but will also allow a more systematic – and thereby more effective – access to resources. Other stakeholders in the field of health should not be regarded as competitors, but as operational partners.

However, this does not negate the obligation of the Church to adhere to her special profile and mission, and also to introduce this into the public debate. Advocacy on different levels – local, regional, national international – was still new territory for many of our interviewees in Zambia, Malawi and Ethiopia. There were repeated complaints that the engagement of the Church in HIV-related work was not sufficiently acknowledged by the public or by government authorities. On the other hand,

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[44] Dowling, K. (2010) Catholic Social Teaching and the Response of the Church to HIV/AIDS. National Catholic Reporter 8/7/ 2010

there seems to be only limited awareness on the part of these Church agencies that they may require assistance in advocacy work. Thus, the call by SECAM, which was already formulated in 2003, needs to be emphasised even more:

”We are committed to … advocate with government at all levels and with inter-governmental organizations to establish policy priorities that adequately support those affected by HIV and AIDS, that provide access to care and treatment and a life of dignity for people living with HIV and AIDS, and that implement the commitments made at various other inter-governmental meetings.”[45]

Michael Kelly SJ gave a detailed description of what such work could look like at different levels:

“Through health and education programmes, justice and peace commissions and in other ways, the Christian churches work for the realisation of the social and economic rights of the poor. However, there is some room for them to be more forceful in promoting these rights. At the local and national levels, the Churches need to insist in season and out of season on such issues such as the payment of a just wage, employment creation, the availability of housing, provision of safe water and sanitation, social protection measures and accountable governance. At transnational level, the churches should tirelessly advocate for fair trade, responsible care for the environment, international structures that respect poor nations as equal partners with the wealthy, and more equitable sharing of global resources among all peoples of the world.”[46]

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45 SECAM (2003) The church in Africa in face of the HIV/AIDS Pandemic: Plan of Action, Dakar: SECAM.

46 Kelly, M.J. (2010) HIV and AIDS. A Social Justice perspective, Nairobi: Paulines Publications Africa, p. 238.

8.2 Cultural Level

The research results from Zambia and Malawi – and to some extent from Ethiopia as well – revealed that certain cultural patterns and traditions may favour the spread of HIV. Sexual practices or conventions such as *Kusasa fumbi* (cleansing rites for widows) and *Fisi* (forms of sexual initiation of girls) may increase the risk of HIV infection. In most cases women – especially young women – are affected. On a cultural level there is a need to review, from an ethical perspective, which values, practices and conventions contribute to the spread of the HIV epidemic. This is an extremely challenging task, as it should not involve the devaluation of existing positive cultural values, but rather the formulation of culturally sensitive ethics.

In sub-Saharan Africa, initial reflections may focus particularly on female vulnerability to HIV, since women and girls are especially affected by the HIV epidemic. According to UNAIDS:

"More women than men are living with HIV in sub-Saharan Africa, accounting for 59% of people living with HIV (…) In sub-Saharan Africa, young women aged 15–24 years are as much as eight times more likely than men to be living with HIV (…) Studies among women in sub-Saharan Africa show that fear of a partner's negative reaction, including abandonment, violence, rejection, loss of economic support and accusations of infidelity were the most commonly reported barriers to HIV testing and disclosure of HIV status (…) Early marriage is still common worldwide, with young girls often forced into marriage." [47]

This quote shows how difficult it is to improve the situation of women, as there are behaviour and thought patterns that have been in operation for centuries. Even widely promoted HIV prevention strategies such as

[47] UNAIDS Factsheet (2011) *HIV/Aids and women and girls*. Geneva: UNAIDS. Available at: www.unaids.org (Accessed 24 April 2014)

ABC may be of questionable value for many women, as Gillian Paterson notes: "We only need to take a look at the renowned prevention strategy, commonly known under the abbreviation 'ABC', **a**bstinence, **b**eing faithful, **c**ondom use. This strategy evolved from the (currently prevailing) biomedical debate and is a classic example for a mantra claiming general validity, yet in reality it is tailored to an autonomous, adult man from the western hemisphere. Abstinence? In many parts of the world abstinence is not an option for women. Marriage is a cultural necessity, and the same applies for children; early marriage is quite common and often highly welcome; women are economically dependent on their men; and the circumstances of sexual intercourse are usually not controlled by women. Faithfulness? Many women are faithful, but they get infected with HIV by their unfaithful or drug-addicted partners. Condom use? What woman or child has ever convinced a man, against his will, to use a condom?"[48]

Even though Patterson's statements sound somewhat polemical, this is a salient issue in many strategies in the fight against HIV and AIDS. Often, these strategies take insufficient account of the special problems of women. Thus, each response to the epidemic should include at least these two questions: what are the cultural factors favouring this worrying situation of women and girls? Will it be possible to identify beliefs and behaviours in the cultural traditions that could be useful to ensure the special protection of women?

Thus, the Church has the obligation to strongly promote women's rights and to fight against any form of suppression or discrimination. Well-known quotes from St Paul's Letter to the Galatians may serve as a useful orientation: "So in Christ Jesus you are all children of God … There is neither Jew nor Gentile, neither slave nor free, neither male nor female, for you are all one in Christ Jesus. " (Galatians 3, 26–28)

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[48] Patterson, G. (2007) "Der Gender-Falle entkommen. Die Aufdeckung patriarchalischer Strukturen in Zeiten von Aids", *Concilium* 43, (3), pp. 342-352.

Apart from the empowerment of women and girls, which is a moral duty based on their special vulnerability, ethical questions on a cultural level may also be discussed in another way. The effectiveness of cultural thought patterns and conventions shows that an ethical directive will remain unsuccessful if it does not display sensitivity towards these factors. This requires an enculturation of ethical guidelines and moral concepts. Otherwise, African Christians may get irritated as they will be torn between their traditional and Christian beliefs, as well as their moral attitudes, which are strongly influenced by the western world. Paul Chummar points out: "African Christians walk with one foot in African religion and culture and the other in the Church and Western culture (...) People are confused."[49]

Chummar adds that the theological formation in the seminaries intensifies the confusion on moral issues: "The way theological ethics is taught in Africa contributes to this moral confusion. Even institutions specializing in developing an enculturated theology largely teach Western moral theology as if it were a universal theological ethics. This is a form of theological colonialism."[50]

In order to avoid this form of theological neo-colonialism, Chummar recommends the elaboration of enculturated theological ethics. Instead of blindly accepting western thought patterns, Catholic moral doctrine in the African region should more strongly follow local traditions. The following list, which Chummar has put together, shows that there are still many hidden treasures:

- "the principle of life as the greatest gift from God
- the principle of liberation, which serves to free people from every kind of suffering and slavery

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49 Chummar, P.: (2006) "HIV/AIDS in Africa: An Urgent Task for an Inculturated Theological Ethics", in: Hogan, L. (Ed.) (2006) *Applied Ethics in a World Church*, Maryknoll, NY: Orbis Books, pp. 155-162.

50 Ibid.

– the principle of inclusion, which seeks liberation for both the oppressed and the oppressor so that a holistic salvation can take place
– the principle of faith and moral relevance by which universal characteristics in line with the Church's teaching are established."[51]

The more the Church in Africa introduces these ideas into Church moral doctrine, the easier it will be to overcome the chasm between taught theory and common African practice. In many interviews during the research for this report there was annoyance that Church doctrine deviates hugely from the life of the faithful, and that the sermons and recommendations of the clergy are hardly observed any longer. Increased enculturated ethics could counteract what Karl Rahner calls this "difference between theoretical and practical morality", which we have already discussed in Chapter 5.

8.3 Individual level

Ethical issues on the individual level are prominent discussion topics during international AIDS conferences. This may be linked to the fact that ethical issues related to sexual behaviour create heightened interest in connection with the Catholic Church.

The Church's insistence on abstinence and faithfulness is often dismissed by other organizations as unworldly. However, the Church has good reasons to stick to her ideals, not only regarding her own tradition, but also in the light of scientific investigations in connection with the spread of HIV. In 2007, Pope Benedict underlined this in a speech to the Namibian Ambassador:

"The understanding of marriage as the total, reciprocal and exclusive communion of love between a man and a woman not only accords with the plan of the Creator; it prompts the most effective behaviours for

[51] Ibid.

preventing the sexual transmission of disease: namely, abstinence before marriage and fidelity within marriage."[52]

Michael Kelly also thinks that the importance of the ideals of abstinence and faithfulness cannot be valued highly enough: "Ideals can provide (...) tremendous motivating force in the moral sphere. Based on respect for the sacred value of life and the wonder of sexuality created by God, the ideals of abstinence and marital fidelity inspire, motivate and move towards appropriate action."[53]

At the same time, however, everyday experience does not always correspond with these ideals. Indeed, in many cases it cannot. As already mentioned, the example of discordant couples is particularly relevant. In such cases we frequently encounter partnerships that are based on faithfulness. The spouses want to be faithful and want to express their love to each other. However, they have to recognize that the HIV-negative partner is at risk if appropriate protective measures are not taken during sexual intercourse. Thus, one of several moral issues that arise here is the question of condom use.

The issue of condom use is so challenging because the condom fulfils two functions at the same time. First, the condom is used to prevent conception, which is contrary to Catholic moral doctrine. Second, the condom also provides effective protection for the sexual partner against

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52 Benedict XVI (2007) Address of his Holiness Benedict XVI to H.E. Mr Peter Hitjitevi Katjavivi New Ambassador of the Republic of Namibia to the Holy See L'Osservatore Romano. Available at: http://www.vatican.va/holy_father/benedict_xvi/speeches/2007/december/documents/hf_ben-xvi_spe_20071213_namibia_en.html [Accessed: 24 April 2014]

53 Kelly, M.J.: "Some AIDS-Relevant Teachings of Moral Theology in the Field of Sexuality", in: Moerschbacher, M; Kato, J.; Rutechura, P. (Eds.) (2008), A Holistic Approach to HIV and AIDS in Africa, Nairobi: Paulines, pp. 117-128.

HIV infection.[54] These two functions – protection of unborn life and protection of the sexual partner – need to be weighed up in the balance against each other.

As already mentioned, the interviews carried out for this study did not reveal a uniform picture in response to the dilemma of discordant couples. Most interviewees tended to trust the affected partners to reach a responsible decision according to their own conscience. The Bishops in South Africa, Botswana and Swaziland also came to a similar recommendation: "There are couples where one of the parties is living with HIV and AIDS. In these cases there is the real danger that the healthy partner may contract this killer disease. The Church accepts that everyone has the right to defend one's life against mortal danger. This would include using the appropriate means and course of action. Similarly, where one spouse is infected with HIV and AIDS, they must listen to their consciences. They are the only ones who can choose the appropriate means, in order to defend themselves against the infection. Decisions of such an intimate nature should be made by both husband and wife as equal and loving partners."[55]

In their AIDS Statement from 2002 the Bishops' Conference of Chad addressed the use of condoms even more explicitly: "With regard to the condom, the Church wishes to recall here (...) that its use is subjected to the normal moral rules as for the other human acts. The ultimate moral rule is our conscience. It is up to each and every one of us to train one's conscience (...). Because 'no one is bound to do the impossible', spouses

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54 Keenan, J.F. (2010) "HIV/AIDS: The Expanding Ethical Challenge", in: E. Duffy (Ed.) (2010), *Beauty, Truth and Love: Essays in Honour of Enda McDonagh*. New York: Columbia.

55 "Southern Africa Bishops Conference (2001), *A message of hope" from the Catholic Bishops to the people of God in South Africa, Botswana and Swaziland*, Pretoria: St. Peter's Seminary. Available at: http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/southern-africa-bishops [Accessed: 24 April 2014]

cannot be asked to abstain from sexual intercourse; we therefore understand that a person, through love, may be led to use the condom to protect himself/herself or to protect his/her partner. But everybody must understand that the condom does not provide 100% protection and that it does not ultimately solve the real problems raised by AIDS."[56]

Even though the use of condoms is important for the prevention of HIV transmission, it should not be forgotten that this is not the only issue for debates on sexual ethics. Catholic theology has to focus increasingly on a new perception of human sexuality as a whole, embedded in the wider context of human loving, life-giving and flourishing, rather than focusing simply on the condom debate. As Archbishop Schick stated in a newspaper interview, what needs to be internalized especially in church circles is that sexuality is not something "dirty" or "sinful", but it is basically "a gift from God"[57].

As the Irish moral theologian Enda McDonagh explains, sex is part of God's Divine Plan of Creation for humans to be sexual beings: "In one Genesis account (Genesis 1:27), when God created humanity, 'in the image of God he created them; male and female he created them'. For love and companionship, for life-giving and co-creating, this gift of sexual duality was given to humans as images of God. … A Christian theological view of sexuality has no place for the 'sex is dirty' syndrome."[58]

In order to avoid the taboo on discussion about sexuality in general – and HIV and AIDS in particular – within the Church, it would be desira-

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56 Episcopal Conference of Chad (2002) *Bishops of Chad's Statement on AIDS*. N'Djamena: Catholic Bishops of Chad.

57 Das Gupta, O. & Drobinski, M.: "Sexualität ist von Gott geschenkt". Interview with Archbishop Schick, in: Süddeutsche Zeitung, 3rd September 2012. Available at: http://www.sueddeutsche.de/politik/interview-mit-bamberger-erzbischof-schick-wenn-der-papst-verhoehnt-wird-verletzt-das-unsere-seele-1.1456907 [Accessed: 24 April 2014]

58 McDonagh, E. "Theology in a time of AIDS" in: Gill, R. (Ed.) (2007), *Reflecting Theologically on AIDS. A Global Challenge*. London: SCM Press, pp. 43-59

ble to deal with these issues openly. A more positive view of sexuality, as called for by the Bishops' Conference of Chad, would certainly be a substantial – perhaps even a decisive – step forward: "Sexuality therefore participates in our fulfilment as men and women. The Church looks positively on sexuality, which it views as a task to accomplish, a responsibility to assume."[59]

[59] Episcopal Conference of Chad (2002) *Bishops of Chad's Statement on AIDS*. N'Djamena: Catholic Bishops of Chad.

9. Lessons learned and visions upheld

9.1 Key issues

This three-country research project has identified the following issues as of key importance on the way to an HIV and AIDS-sensitive Church:

- Despite recent successes in global HIV control, HIV and AIDS are still of major concern in many parts of the world, especially in sub-Saharan Africa. However, responses to HIV need to strive for a truly holistic model.
- It is vitally important to break the silence about HIV and AIDS within the Church, including among Religious and clergy.
- The Church hierarchy should be empowered to address issues related to HIV and AIDS in the sense of *Africae Munus*, for example, by developing a realistic strategy for the Symposium of Episcopal Conferences of Africa and Madagascar (SECAM).
- There is a need for better appraisal of human sexuality.
- Structural and culturally based violence and practices, especially against women, must be urgently addressed.
- The Church at all levels requires a more systematic approach, especially:
  - Better networking with all partners
  - Better coordination and cooperation in pastoral, human development, charity and emergency ministries
  - Improved planning and implementation for greater sustainability of programmes, including applying for public funds.
- A more intense and continuous dialogue with the scientific community is needed, especially to:
  - Bridge the gap between theology and pastoral formation

  - Strengthen capacity building on all levels: diocesan, regional and international.

– Responsibilities should be shared with other faith communities, civil society and the general public in order to improve advocacy and develop common good practices.

– The Church in affluent countries should address issues of global justice, especially if unsustainable economic policies create vulnerable conditions in low income countries.

– The Church, as a community of believers committed to health and healing, can promote a community dimension of health, from a local up to a global scale.

9.2 Recommendations at the level of the Universal Church

Pope Francis has explained the role of the Pope as a vocation in terms of being a "protector", who understands power as service. In his homily at the inauguration of his papal ministry on 19 March 2013, he said:

"Let us never forget that authentic power is service, and that the Pope too, when exercising his power, must enter ever more fully into that service, which has its radiant culmination on the Cross. He must be inspired by the lowly, concrete and faithful service which marked St. Joseph and, like him, he must open his arms to protect all of God's people and embrace with tender affection the whole of humanity, especially the poorest, the weakest, the least important, those whom Matthew lists in the final judgment on love: the hungry, the thirsty, the stranger, the naked, the sick and those in prison (Matthew 25:31–46)."

Convinced that the Pope's role is also that of the Universal Church in the service of local churches worldwide, the authors of this study come to the following recommendations concerning the Universal Church:

1. That theological reflection on ethical and other dimensions of HIV and AIDS be enhanced at every level of theological teaching and re-

search. The issue of HIV and AIDS should be addressed as one of integrated development and global justice, as well as a holistic approach of moral theology towards understanding human sexuality as a gift of God.

2. That the situation of discordant couples, also addressed by the Fathers of the Second Special Assembly of the Roman Bishops' Synod for Africa[60], as well as pastoral and ethical support for discordant couples, may be studied by an interdisciplinary and international body, in order to give clear guidance for the people concerned and in order to avoid conflicting messages.

3. That the formation of pastoral agents of the Church, especially in Major Seminaries, may systematically include capacity building on medical, ethical and pastoral knowledge and skills in the field of HIV and AIDS.

4. That the situation of HIV-positive priests and Religious men and women be taken seriously, so that a spirit of welcoming may be fostered by addressing the issue of HIV-related stigma within the Church; so that support groups for infected and affected pastoral agents may be encouraged; that on this issue a systematic networking of religious orders and congregations, including the "International Network of Religious Leaders living with or personally affected by HIV and AIDS" (INERELA), be put in place.

5. That the Universal Magisterium of the Catholic Church serve the local churches and their magisteria, so that in accordance with the principle of subsidiarity, specific problems that arise in the local context may be addressed and solved at the local level, and that the magisterium of the bishops in various cultural contexts be strengthened.

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60 Synod of the Bishops II Special Assembly for Africa (2009), "… this Synod proposes: … a pastoral support which helps couples living with an infected spouse to inform and form their consciences, so that they might choose what is right, with full responsibility for the greater good of each other, their union and their family." (Propositio 51). Available at: http://www.vatican.va/roman_curia/synod/documents/rc_synod_doc_20091023_elenco-prop-finali_en.html [Accessed 24 April 2014]

9.3 Responses of the Catholic Church in Africa

It would be a mistake to generalise findings and statements about Church responses to the HIV epidemic for the whole of Africa. Just as there are differences in the epidemic itself in terms of onset, vulnerable groups, response capacities and actual responses, so dioceses, regions and national units also differ with regard to culture, ethnicities, history, faith traditions and the enculturation of faith responses to the epidemic. Any statements made in this section about the Church response to HIV and AIDS in Africa relate to Africa-wide or regional organizations such as SECAM and to the actual public health facts about the spread of the HIV epidemic in sub-Saharan Africa. Every statement in this section should be cross-checked against historical developments and actual situations.

Some African bishops, such as bishop Hugh Slattery of South Africa, attended a Vatican AIDS Consultation in Rome in 1987, and were inspired by this event. This was followed by World Church responses such as the commitment of CAFOD in United Kingdom, and the joint initiative of the German agencies Misereor and the Medical Mission Institute, to establish a working group on HIV and AIDS and International Health. In sub-Saharan Africa, dioceses and national episcopal entities began to integrate HIV and AIDS activities into their health, educational or social desks. In the early 1990s, funding was scarce and national coordination staff were employed part-time. Funding for projects was also scarce. HIV and AIDS coordinators were not specially trained, and carried out mainly administrative tasks, such as accessing HIV testing or hygiene equipment. There was little deepening of socio-pastoral and theological reflection, and virtually no policy making. The Medical Mission Institute provided a number of policy documents on topics such as voluntary testing and counselling, home-based care, care for orphans and vulnerable children.

Starting in the late 1990s, AIDS desks were separated from health and other departments, and became independent units within the socio-pastoral activities of the Church. This was very often related to the avail-

ability of external funding, especially from Catholic organizations in Western Europe and North America. Some Bishops' conferences, such as the SACBC, were concerned about the mainstreaming of HIV and AIDS, and linked these units directly to the secretariat. Others left these units at the same organizational level of other departments, so mainstreaming of HIV and AIDS activities did not happen. As financial support for HIV and AIDS programmes increased, there were greater claims for professionally qualified staff. This led to the establishment of diocesan HIV and AIDS strategies and even national HIV and AIDS policies, as in the case of the Ethiopian Catholic Church.

In the 1990s, study days and seminars on HIV and AIDS were organized for high-level Church leaders at their request. These events were often facilitated and supported by Mgr. Robert Vitillo of Caritas Internationalis and Sr Maura O'Donohue of CAFOD. By the late 1990s, when the response of the international community to the HIV epidemic had increased substantially, in particular through the establishment of UNAIDS, Catholic organizations started to question the importance they had given to the epidemic. Organizations in Europe began reducing their support for HIV and AIDS programmes, arguing that financial commitments to treatment programmes, for example, would overstretch their capacities. At the same time, US organizations such as CRS and CMMB applied for – and received – government funding for substantial HIV and AIDS treatment programmes. To be considered for government funding, these Church entities first had to apply for NGO status, which was by no means a simple and straightforward process.

Since the start of the new millennium, individual bishops and bishops' conferences have testified more frequently to the realities of HIV and AIDS. All have been deeply concerned by the death toll and the other effects of the epidemic, although in fact the number of new infections was starting to decline in many countries. Homilies and pastoral letters encouraged the faithful to re-establish broken relationships and to provide care and support to people living with HIV. At the same time, while analysing the root causes of the spread of HIV, Church hierarchies often

spoke about the crisis of traditional values and about problematic individual behaviour in relation to the moral teachings of the Church. The recommended solution offered to those affected by these issues was to return to Christian values.

Two realities have been overlooked in this discourse. First, many people are forced by economic, social, cultural or political pressures into risk behaviour which they cannot avoid. And second, many socio-pastoral workers, Religious and clergy are themselves living with HIV. They have not yet been allowed, however, to live openly with HIV in the service of the Church. The only Bishops' Conference that has reflected on HIV infection and the priestly life is that of Senegal.

In 2003, SECAM, while meeting in Dakar, Senegal, approved an action plan on the HIV epidemic. This plan, however, lacked any strategic orientation and the resources needed for implementation. In November 2011, the Church's response to HIV and AIDS was part of the post-synodic Apostolic Exhortation, *Africae Munus*. The main focus of of this document was the provision of care services, in particular health care: "In the spirit of the Beatitudes, preferential attention is to be given to the poor, the hungry, the sick – for example, those with AIDS, tuberculosis or malaria – to the stranger, the disadvantaged, the prisoner, the immigrant who is looked down upon, the refugee or displaced person (see Matthew 25:31–46). The response to these people's needs in justice and charity depends on everyone".

9.4 The Catholic Church in Germany and HIV and AIDS

Since the start of the new millennium, the number of new HIV infections and of AIDS deaths worldwide has steadily diminished, year by year. However, the total number of people living with HIV is still increasing. It would therefore be disastrous if international, national and community responses to the challenges of the HIV epidemic were now to slacken. Constant and untiring commitment to HIV prevention, care and support remains of paramount importance.

The Catholic Church in Germany has a special responsibility, based on her numerous connections with African local churches, her long-term experience in the fight against HIV and AIDS, and her financial resources.

In recent years, the focus of activists of the Universal Church in Germany has shifted somewhat away from the HIV tragedy. This study, however, has shown that many issues related to the HIV epidemic have not yet been resolved. This is due, at least in part, to the complexity of the challenges connected to the issue of HIV and AIDS. These challenges are by no means only medical. As Franz Kamphaus has observed: "If the cultural, social and societal contexts are ignored, AIDS cannot be effectively combatted."[61]

This is also the reason why poor people – and in particular poor women – are suffering so much from the direct and indirect consequences of the HIV epidemic. HIV and AIDS should be recognized as an indicator of structural injustice within the cooperation framework of the Universal Church. The Catholic Church in Germany must therefore ensure that the HIV epidemic does not continue to be a disease of poverty. Church-related relief organizations need to use their experience of holistic approaches to health and development in order to contribute to the continuous reduction of the incidence of HIV, especially within poor communities.

Compared to just a few years ago, not only HIV and AIDS but health issues in general seem to have lost their significance in the work of the Universal Church. Although health services in Africa have improved substantially in recent years, a satisfactory level is far from having been achieved. Although there are regional differences, millions of people across Africa still suffer from seriously inadequate medical care.

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61 Kamphaus, F. (2008) "HIV/AIDS und die katholische Kirche" in: *Die Welt zusammenhalten. Reden gegen den Strom*, Freiburg: Herder, p. 128.

In many African countries, the Church still remains an essential provider of health services to the poorest of the poor. Church health facilities constitute a uniquely valuable network – extending even into remote areas – of holistic health care. The withdrawal of support by the Catholic Church in Germany for HIV-related health care, especially in sub-Saharan Africa, would be disastrous. The mission of Jesus "to proclaim the Kingdom of God and to cure diseases" (Luke 9:2) has always been – and remains – the core issue of Christian mission. Even though other challenges should not be neglected, the Church's mission in the field of health should remain paramount.

An additional lesson can also be learned from this study. Often the Catholic Church – even in Germany – reacts to the issue of HIV and AIDS with a kind of speechlessness. Many believers and church-related activists find it difficult to react positively to the issue of HIV and AIDS. This is in stark contrast to the deep commitment and professional competence of Church-related health institutions. Yet when it comes to human sexuality, a strange silence can often be observed. This silence has to be overcome. It will only be possible to help the people affected if this issue is addressed openly. The Catholic Church is often regarded as a moralising and didactic institution with regard to issues of sexuality. The Church needs to take to heart the words of Pope Francis: "A beautiful homily, a genuine sermon must begin with the first proclamation, with the proclamation of salvation. There is nothing more solid, deep and sure than this proclamation. Then you have to do catechesis. Then you can draw even a moral consequence. But the proclamation of the saving love of God comes before moral and religious imperatives. Today sometimes it seems that the opposite order is prevailing."[62]

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62 "A Big Heart Open to God". Pope Francis' interview with Antonio Spandaro SJ, 19 September 2013. Available at: http://www.thinkingfaith.org/articles/20130919_1.htm [Accessed 24 April 2014]

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