

**A Review and Appraisal of the Progress made
towards the implementation of the UNGASS
Declaration of Commitment to combating
HIV/AIDS and WCC Work Place Policy by the
Churches.**

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EXECUTIVE SUMMARY

The AIDS pandemic has taken a tremendous toll on people worldwide and has reached critical proportions. An estimated 4.9 million people were newly infected with HIV in 2005, and more than 41 million people are currently living with HIV. More than 25 million people have died of AIDS over two decades. Recognising the sheer size and gravity of the AIDS crisis, 189 member states of the United Nations at the twenty-sixth United Nations General Assembly Special Session (UNGASS) in 2001 unanimously adopted and signed a "Declaration of Commitment" an epic international pledge to substantially increase both resources and attention to fighting HIV/AIDS.

Churches and (FBO) around the world facilitated by the World Council of Churches (WCC) also made commitments to join the fight against HIV/AIDS in line with the UNGASS DoC by putting forward their resources and collaborating with governments and non government associations. The moral and spiritual influence of religious leaders in all communities was offered, to decrease the level of stigma and discrimination, vulnerability of people for responding to HIV/AIDS and to contribute to the highest level of care and support that is attainable. Over the last five years, there has been a tremendous spurt in the faith community's engagement with HIV at a visible level and numerous efforts have been made to address the problem. The list of promises made, both as countries at the international level and as faith communities, is a long one. This survey addresses the question: "Are we keeping our promises?"

The Health and Healing Program of the World Council of Churches commissioned this study to identify, measure and analyze the level of commitment of Faith Based Organizations in combating HIV and AIDS and also to scrutinize the steps taken by Faith Based Organizations in keeping the promises they made. A questionnaire was designed and developed by the WCC in collaboration with UNAIDS, World Health Organization and the Ecumenical Advocacy Alliance and was based on the main indicators of leadership, public mobilization, prevention, treatment and care outlined in the UNGASS DoC. Stakeholders for the study were identified ranging from church leaders, lay people and people living with or affected by HIV or AIDS.

The first phase of the study was conducted at the WCC's Ninth Assembly in Porto Alegre, 14-23 February, where questionnaires were distributed to church leaders to evaluate and and AIDS. This was followed by an online survey of a sample of other stakeholders for feedback on the role played by their FBOs and leaders in the fight against HIV and AIDS, the attitudes of members towards people living with HIV, and the services available for people living with or affected by HIV or AIDS.

Two hundred and ninety four (294) respondents from FBOs representing eighty-eight (88) countries responded to the survey. Thirty-two percent (32%) of the respondents were from Africa. Sixty (60) respondents identified themselves as National religious leaders, 22 identified as regional religious leaders, 62 identified as ordained members and 67 identified themselves as lay members.

The findings are expected to play a major role in shaping a systematic, efficient and effective strategy for Christian FBOs to more successfully handle the HIV/AIDS crisis. The study will encourage Christian FBOs by recognising their excellent work and, hopefully, also bring in a measure of accountability and galvanise, energise and mobilise inactive Christian FBOs to start taking active steps to keep their promises.

BACKGROUND

THE HIV/AIDS EPIDEMIC

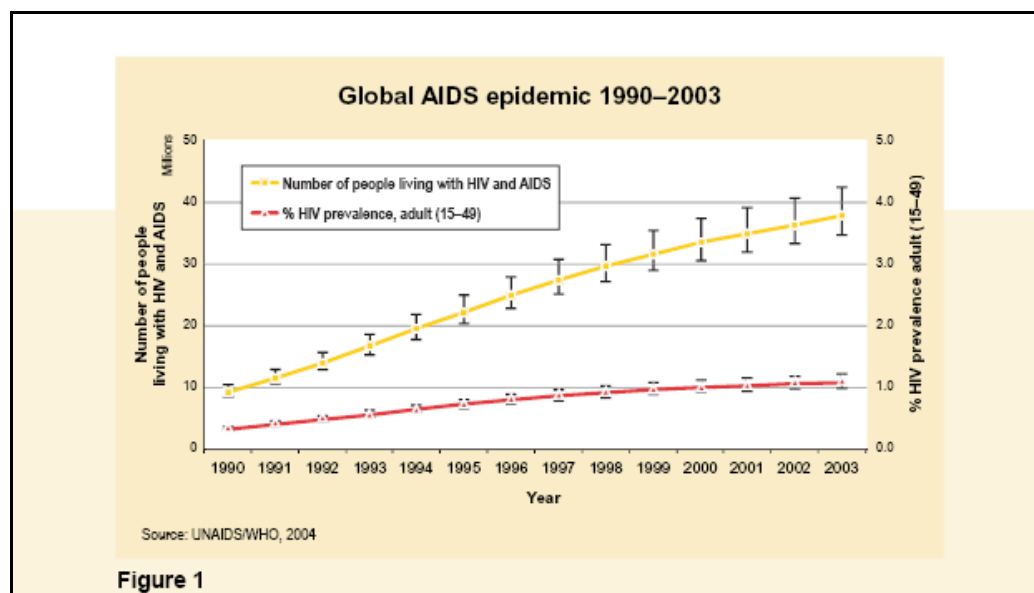
"The global HIV/AIDS epidemic is an unprecedented crisis that requires an unprecedented response. In particular it requires solidarity -- between the healthy and the sick, between rich and poor, and above all, between richer and poorer nations. We have 30 million orphans already. How many more do we have to get, to wake up?"

– Kofi Annan, United Nations Secretary General

The HIV/AIDS pandemic has reached critical proportions and continues to escalate worldwide at the rate of 14,000 new infections per day, with nearly half of these infections in the 15-24 age-group. On a global scale, in 2004, 39.4 million people were living with HIV/AIDS (PLWHA), 4.9 million people were newly infected with HIV/AIDS and there were 3.1 million AIDS deaths.

HIV/AIDS is not only affecting health but also social and economic progress in countries by affecting the most productive part of the population (adults in their prime), increasing poverty, robbing children of their parents, robbing families of their breadwinners, contributing to chronic food shortages, and reducing life expectancies by decades..

For



example, many countries in southern Africa are facing a growing crisis of human resource capacity. Skilled staff essential for the provision of vital public health services have been lost to the AIDS epidemic and Sub-Saharan Africa with the highest HIV prevalence in the world is facing its worst crisis with 12 million AIDS orphans who have lost one or both parents to AIDS

With this in view, in June 2001, 189 Member states unanimously adopted and signed the Declaration of Commitment (DoC) to fight HIV/AIDS at the twenty-sixth United Nations

General Assembly Special Session (UNGASS). This was the first time that the General Assembly acknowledged the enormity of the HIV/AIDS crisis and declared its commitment to overcoming the Global HIV/AIDS epidemic. (NAT, 2004). The DoC reflected the global consensus among all the nations for achieving the Millennium Development Goal of “Halting and beginning to reverse the HIV/AIDS epidemic by 2015” in a structured and systematic manner.

UNGASS 2001 AND THE DECLARATION OF COMMITMENT

□ **BACKGROUND TO UNGASS 2001**

The first major AIDS Conference in the South was held in July 2000, in Durban, South Africa. This conference highlighted the problems Sub-Saharan Africa and other low-income countries face in tackling the HIV/AIDS epidemic. This was immediately followed by a resolution passed by the UN Security Council recognising the threat posed to international and regional stability by HIV/AIDS and a call for further action on HIV/AIDS prevention and care went out. (U.N.S.C, 2000 and , this was again reiterated at the Millennium Summit in September 2000 where the General Assembly voted to have an emergency special session to tackle the HIV/AIDS problem. (G.A.Resolution, 2000). Following the Millennium Summit, with only 9 months preparation time, UNAIDS organized the UNGASS on HIV/AIDS. This was the first conference dedicated exclusively to HIV/AIDS and also the first UN conference to explicitly involve civil society groups in the entire process. (Roseman and Gruskin, 2003).

UNGASS saw the emergence of four groups among the member states that joined together to negotiate on the majority of the issues. The Rio Group, comprising of several Latin American Countries was led by Chile, the European Union (EU) group was led by Sweden and the South African Development Community (SADC) was led by Zambia, they firmly supported the women’s and girl’s rights in relation to sexual and reproductive health matters on HIV/AIDS prevention and treatment. These groups also strongly rooted for the need of affordable drugs for HIV AIDS treatment and for the development of indigenous pharmaceutical industries in developing countries; strongly voiced their stance on the need for strong language on sexual and reproductive health rights and the rights of access to all individuals to sexual health information and services.. Other countries like Australia, Senegal, Canada, New Zealand and Lichenstein joined with the above-mentioned three groups in their stance and also in support of the rights of vulnerable and at risk populations. However the fourth group comprising of Islamic states and headed by Egypt opposed these stances in the debates and objected strongly to any language openly addressing the vulnerability of gay and bisexual men to HIV infection. The Vatican showed their willingness to ensure progress on negotiation and did not take their usual negative stance on the inclusion of language on reproductive rights, access to contraception and adolescent sexuality. The US however was quite conservative; they advocated for abstinence and sidelined other HIV/AIDS prevention methods like sex

education and reproductive rights.. The World Council of Churches also participated in UNGASS 2001. A plenary presentation was made by Dr. Christopher Benn, who stated the church's commitment to work cooperatively with all PLWHA and people including other religious communities, community based organizations, governments and UN agencies in responding to HIV/AIDS. He offered the resources the churches have in the community: their local community presence, influence, spirit of volunteerism and genuine compassion facilitated by their spiritual mandate. He reiterated that governments could not achieve the goals set out alone but will have to co-ordinate with UN organisations, civil society, and NGOs including faith-based organisations to tackle the HIV/AIDS problem effectively and decisively¹.

There was a call for civil society participation by UNAIDS at UNGASS, however civil society was met with many obstacles. Few countries (only 41 countries out of 189) included the civil society's voice in their delegation and even fewer took into consideration: gender, PLWHA and the youth viewpoints. Attempts were made to keep out gay, bisexual and transgendered groups from negotiations, which led to difficulties in actual input from these groups.

The Declaration was formulated following this session and was the result of the above-mentioned negotiations and compromises between member states, civil society and NGO's.

□ **THE DECLARATION OF COMMITMENT (DoC)**

The DoC addressed the need for global, regional and country level responses to prevent new HIV Infections, reduce the impact of the epidemic and ensure equitable access to treatment and care. It also endorsed the inclusion of civil society organizations, private industry and labour groups, non-governmental organizations and PLWHA organizations. Countries were given the responsibility for the implementation of the DoC in collaboration with UNAIDS and the progress in the fight against HIV/AIDS was measured by the achievement of concrete time –bound targets. The DoC further stipulated that national strategies should aim to address prevention, treatment, care and support; the vulnerability of women and children; the social and economic impact; research and development; monitoring and evaluation. (UNGASS, 2001)

In 2002, keeping with the mandates of the DoC, core indicators were formulated and clearly defined by UNAIDS, its partners and co-sponsors, so as to measure the progress in implementing the DoC. Additionally mechanisms were devised for the collection of information on an on-going basis. Countries were expected to report back to the UNAIDS every two years on these indicators. The core indicators formulated were classed into four broad categories:

- I. National Commitment and Action
- II. National Knowledge and Behaviour

¹ Plenary Presentation at the United Nations General Assembly Special Session on HIV/AIDS By Dr. Christoph Benn representing the Commission of the Churches on International Affairs of the World Council of Churches June 27, 2001 <http://www.ealliance.ch/resources/documents/world/WCC%20Plenary%20Presentation%20UNGASS.doc>

- III. National Impact
- IV. Global Commitment and Action

□ **FOLLOW UP TO UNGASS**

UNGASS 2001 was followed up with another session in 2003 where 103 member states reported back to UNAIDS with details of their success in establishing an enabling policy environment for future progress to follow. (NAT, 2004). Twenty nine reports were received from Sub-Saharan Africa, 21 from Latin America and the Caribbean, 17 from Asia and the Pacific 14 from Eastern Europe and Central Asia, 14 from high income countries and 8 from North Africa and the Middle East. Mostly the National AIDS Committees or equivalent bodies supervised the compilation of these national reports. Over three quarters of the reports contained inputs from three or more government ministries. Roughly two thirds of the reports were prepared with the involvement of civil society organizations and over half the reports included PLWHA involvement.

The data submitted in 2003, had significant drawbacks, for example, only 40% of the countries providing complete information on all the national indicators and the level of reporting among regions was uneven.

A high-level meeting on HIV AIDS in June 2005, followed the session in 2003 for an interim technical review of the 2005 goals set out in the Declaration of Commitment (UNAIDS, 2005)

THE CRUCIAL ROLE OF FBO's IN THE FIGHT AGAINST HIV/AIDS

FBOs play a vital role in the fight against HIV/AIDS. Their far-reaching networks to even the most isolated areas of resource-poor regions, in addition to their strong infrastructures and their understanding of the cultural and social environment of the people make them the strongest and most influential group in the fight against HIV. It also puts them in a unique position to stem the spread of HIV and to provide care and succour to those already affected by the epidemic. They are a part of the same social reality as those directly/indirectly affected by HIV/AIDS, they walk (or can walk) alongside the community before, during and after HIV/AIDS.ⁱ

FBOs' success, or potential for success, in developing interventions stems from several sources. Besides extensive far-reaching infrastructure, in many cases, members of FBOs demonstrate more commitment to their FBOs compared to other political, social and economic institutions. FBOs often have a direct impact on social institutions, such as schools, which socialize people and change values over time. In addition, their jurisdiction often includes a number of areas closely connected to HIV/AIDS, such as morality, beliefs about the spiritual bases of disease, and rules of family life and sexual activity. Other institutions

such as public health organizations, political leadership, and international NGOs have frequently excluded such areas from their activities. For all these reasons, therefore, FBOs are in a unique position to contribute to the campaign against the AIDS epidemic in Africa.ⁱⁱ

CHURCHES DECLARATION OF COMMITMENT ²

Churches from all over the world have signed declarations: the DAKAR Declaration, Statement from the Bishops' Conference etc. recognising the HIV/AIDS problem, the consequences of HIV/AIDS, the ways the church can help PLWHA and the limitations of the church. There are different and conflicting views among the churches in helping PLWHA and in preventing HIV/AIDS. However it is heart-warming to note in these declarations that the church declares its support to PLWHA and states that it will not abandon them just as Christ will not abandon them. As Christ said in the scriptures that he came to earth for sinners: "It is not the healthy who need a doctor, but the sick. ... 'I desire mercy, not sacrifice.' For I have not come to call the righteous, but sinners." Matthew 9:12,13. Therefore the church in keeping with Christ, needs to show mercy and compassion and help out all in need of help without discrimination. These declarations essentially embrace the same principles Christ taught us in helping the poor, sinners, sick and helpless and not abandoning them. The churches have therefore made a very positive move with the declarations.

WCC WORK PLACE POLICY

A work place policy was formulated by the WCC , in conjunction with African Network of Religious Leaders Living with or personally affected by HIV & AIDS (1ANERELA+) and the Global Network of People living with HIV/AIDS (GNP+) to help churches take the lead, and embrace and accept people living with HIV and AIDS both within and outside churches. This was done to deal effectively with stigma and discrimination problems so that church leaders and congregants could live openly with their HIV status without fear and knowing that they are both accepted and supported by their church.³ Many churches signed this policy.

CALL FOR PARTNERSHIPS WITH PLWHA ORGANIZATIONS

WCC prepared a paper encouraging churches to form partnerships with PLWHA organizations and also developed guidelines on how to work with these organizations. This was backed up with examples of successful partnerships between churches and PLWHA organizations.⁴

² Kurian, M, **Text of Declarations and Policy Statements by Churches and Faith Based Organizations from 2001 to 2005, World Council of Churches**

³ WCC, **Towards a policy on HIV / AIDS, Working Document**

⁴ **WCC, Partnerships between Churches and People Living with HIV/AIDS Organizations, 2003**

This is the basic background to UNGASS 2001 and the commitments made by churches, the project seeks to ensure that the promises are being kept.

ABOUT THE STUDY

Much of the work of FBOs in the fight against HIV/AIDS has not been documented. This study therefore commissioned by the Health and Healing programme of WCC aims to identify, measure and analyze the level of commitment of Faith Based Organizations in combating HIV and AIDS and also to scrutinize the steps taken by Faith Based Organizations in keeping the promises they made.

RESEARCH OBJECTIVE

The main research objective of this project is to assess and analyse whether churches and FBO's have made progress in the implementation of the UNGASS Declaration of Commitment, the WCC Work place policy and the HIV/AIDS church declarations.

Elements of the Framework through which the performance of FBOs is analyzed through the views of global stakeholders include:

A) POLITICAL COMMITMENT:

An effective and sustained response to the HIV/AIDS crisis can only be achieved with the commitment of political leaders at all levels. What efforts are religious leaders undertaking at all levels to mitigate the impact of HIV/AIDS?

B) PUBLIC MOBILIZATION:

This second element focuses on the level of public knowledge and awareness of the HIV/AIDS epidemic and the FBO policies and commitments formulated to tackle the HIV/AIDS crisis. Of specific interest here is whether FBOs were involved in the development and implementation of the National HIV/AIDS Policy. Additionally, this element seeks to measure level of stigma and discrimination against PLWHA in FBOs. Finally this element looks for evidence on the translation of public awareness into behavioural changes (for example, increased testing and openness about status)

C) PREVENTION:

Fewer than one in five people globally have access to the basic HIV prevention programs. (Global HIV Prevention Working Group, 2003) This element looks at the HIV/AIDS prevention options provided by FBOs and the prevention messages being advocated.

D) TREATMENT:

This element looks at the various treatment options in place for FBO members.

E) CARE AND SUPPORT:

This element focuses on the provision of hospice palliative care, home based care and support by FBOs.

The findings will play a major role in shaping a systematic, efficient and effective strategy for Christian FBOs to more successfully handle the HIV/AIDS crisis. The study will encourage Christian FBOs by recognising their excellent work and, hopefully, also bring in a measure of accountability and galvanise, energise and mobilise inactive Christian FBOs to start taking active steps to keep their promises.

RESEARCH METHODOLOGY

A review of all the declarations made by Christian FBOs was undertaken to identify the promises made. This was followed by the preparation of a framework of goals and indicators to measure progress in implementation of the promises made. Stakeholders were identified in the churches, ranging from the senior clergy to the common lay church member. This was done to get comprehensive feedback from all levels of the FBOs. A questionnaire was designed and developed by the WCC in collaboration with UNAIDS, World Health Organization and the Ecumenical Advocacy Alliance. The questionnaire was based on the main indicators of leadership, public mobilization, prevention, treatment and care as outlined in the UNGASS DoC. Stakeholders for the study were then identified ranging from church leaders, lay people and people living with or affected by HIV or AIDS.

The first phase of the study was conducted at the WCC's Ninth Assembly in Porto Alegre, 14-23 February, where questionnaires were distributed to church leaders to evaluate and review their efforts, attitudes and roles in leading the fight against HIV and AIDS. This was followed by an online survey of a sample of other stakeholders for feedback on the role played by their FBOs and leaders in the fight against HIV and AIDS, the attitudes of members towards people living with HIV, and the services available for people living with or affected by HIV or AIDS.

Secondary research was also carried out to examine the social, political, economic and HIV/AIDS situation in the region where the church is. This is to analyse the possible reasons for the success or failure of the churches in implementing the declarations they have made and to make suitable recommendations based on scientific studies carried out in the regions the church is situated in.

STAKEHOLDERS

Two hundred and ninety four (294) respondents from FBOs representing eighty-eight (88) countries responded to the survey. Thirty-two percent (32%) of the respondents were from Africa. Sixty (60) respondents identified themselves as National religious leaders, 22 identified as regional religious leaders, 62 identified as ordained members and 67 identified themselves as lay members.

DATA ANALYSIS

The data was analysed using SPSS. Cross tables were generated to determine commonalities, variations, dominant emerging themes and disagreements between variables. In addition the respondents qualitative feedback was studied in terms of FBO contributions (or lack thereof). The analysis is limited to what the survey respondents perceive and does not aim to validate the objectivity of these perceptions.

STUDY FINDINGS

Two hundred and ninety four (294) respondents from FBOs representing eighty-eight (88) countries responded to the survey. It is recognised that the global AIDS epidemic has different faces in different regions of the world, varying according to differing social, cultural and political contexts. The study has also tried to look at regional efforts underway and to analyse these.

LEADERSHIP

- 53% of the respondents were aware of the UNGASS Declaration of Commitment, 32% of the respondents were completely unaware of UNGASS Declaration of Commitment and 15% were not sure.
- 60% of the respondents reported that their church/organization has developed a policy on HIV and AIDS, 30% responded that their church /organization has not developed a policy on HIV/AIDS while 10% were not sure.
- 33% of the respondents reported that their church/organization has developed a comprehensive workplace policy on HIV and AIDS, 52% responded that their church /organization has not developed a comprehensive workplace policy on HIV/AIDS while 15% were not sure.
- 38% of the respondents reported that the policies developed by the church were being implemented, 37% of the respondents responded that the policies developed by the church were not being implemented, 3% of the respondents reported that the policies were being partly implemented and 22% were not sure.

- 72% of the leaders in the respondent's church or organization speak publicly and acknowledge in forthright, constructive and non stigmatizing terms the enormity of the AIDS problem, 19% of the respondents reported that their leaders do not speak publicly while 22% were not sure.
- 29.3% of the respondents were aware of leaders in the church/organization who were living with HIV, 50.7% of the respondents were not aware of any of their leaders who were living with HIV/AIDS while 20.1 % were not sure
- 50.7% of the respondents reported that their leaders were not open about their status, 29.3% felt that their leaders were open about their status while 20.1% were not sure
- 42.5% of the respondents were aware if any leaders /their family members in the church /organization had died of AIDS related illnesses, 39.8% were not aware of any such deaths and 17.3% were not sure
- 17.7% of the respondents had never attended/heard any sermons, speeches, prayers, workshops and discussions on HIV and AIDS prevention, treatment or related problems have in the past year, 87.8% of the respondents had heard /attended less than 20 sermons, speeches, prayers, workshops and discussions on HIV and AIDS prevention, treatment or related problems in the past year while 12.2% had heard over 20 sermons, speeches, prayers, workshops and discussions on HIV and AIDS prevention, treatment or related problems in the past year

RESPONSES FROM LEADERSHIP ON THEIR ROLES

- 57.8% of the respondents had been tested for HIV/AIDS, 41.5 % had not been tested while 0.7% were not sure
- 53.7% had discussed their test results with other, 48.3% had not discussed their test results with anyone.
- 90.8% of the respondents reported that they spoke publicly about issues surrounding HIV and AIDS while 8.5% of the respondents did not speak publicly about HIV/Aids issues
- 28.6% of the respondents had lead no sermons, prayers, speeches, workshops and discussions on HIV and AIDS prevention, treatment and related problems in the past year, 34.2 had lead less than 20 sermons, prayers, speeches, workshops and discussions on HIV and AIDS prevention, treatment and related problems while 37.2 % had lead over 20 sermons, prayers, speeches, workshops and discussions on HIV and AIDS prevention, treatment and related problems
- 60.9% of the respondents personally visited with people living with HIV or AIDS and offered them support,34% did not do visits or offer support while 4.8% were not sure

From the findings it is apparent that there have been considerable efforts being made by a major proportion of the leadership in the fight against HIV /AIDS. However some areas of concern remain such as 49.18 % of the ordained members of the respondents were unaware of the UNGASS Declaration as compared to 37.7% of the ordained members who were

aware of UNGASS. This points to a need for the incorporation of HIV/AIDS awareness training in all theological curricula. Additionally though the development of a comprehensive workplace policy have been promoted only 33% of the respondents reported to the development of the policy while the majority did not have a workplace policy. This reflects the need to either strongly encourage church or faith based organizations further to develop workplace policies or to make it mandatory as the workplace policy is extremely important to protect and support PLWHIV. Further the majority of the leadership did not incorporate HIV/AIDS issues in their services, were still not open about their status or about any personal HIV/AIDS problems. Initiatives taken by the leadership could go a long way in decreasing the level of stigma and discrimination surrounding HIV/AIDS.

PUBLIC MOBILIZATION

- 17% respondents estimated that (0-10%) of members of their church/organization could name at least two effective ways of HIV transmission, 28.9% respondents estimated that (10-50%) of members of their church/organization could name at least two effective ways of HIV transmission while 53.4% respondents estimated that (greater than 50%) of members of their church/organization could name at least two effective ways of HIV transmission
- 87.4% respondents estimated that (0-10%) of members of their church/organization were living with HIV/AIDS , 10.9% respondents estimated that (10-50%) of members of their church/organization were living with HIV/AIDS while 1% respondents estimated that (greater than 50%) of members of their church/organization were living with HIV/AIDS
- 82% respondents estimated that (0-10%) of members of their church/organization were open about their status, 11.9% respondents estimated that (10-50%) of members of their church/organization were open about their status while 5.1% respondents estimated that (greater than 50%) of members of their church/organization were open about their status
- 56.8% of the respondents reported that their church or organization newsletter discusses issues surrounding HIV and AIDS, 32% responded that their newsletter didn't cover HIV/AIDS issues while 10.9% were not sure.
- 52.6% of the respondents reported that, less than 20 articles appeared per year in their newsletter on HIV and AIDS topics, while 47.4% of the respondents reported that over 20 articles appeared in their newsletter per year.
- 8.8 % of the respondents reported that the frequency of this publication was weekly, 3.1% of the respondents reported that the frequency of this publication was fortnightly, 26.5 % of the respondents reported that the frequency of this publication was monthly, 24.5% of the respondents reported that the frequency of this publication was quarterly and 17.4 % of the respondents reported that the frequency of this publication was of other kinds

STIGMA AND DISCRIMINATION

"I don't know anybody living with HIV or AIDS. Nobody says nothing about it. It's a "shame" to talk about it."

Keeping the Promise Survey Respondent

"People don't talk about these issues at my church."

Keeping the Promise Survey Respondent

"The church "pretends" to care but doesn't in reality. HIV and AIDS is an "african issue" and that's how we like to think of it. Don't dare mention gay men living with it in Scotland, for instance."

Keeping the Promise Survey Respondent

"There have been instances when PLWHIV/AIDS are left alone on the pew, while others squeeze themselves on a single pew that does not have much space for them. Others don't allow their children to play with other children whose parents are considered to be HIV+"

Keeping the Promise Survey Respondent

"People living with HIV & AIDS are not encouraged to participate in sermons or discussions around HIV & AIDS. They are regarded as sick people who need sympathy and assistance whilst locked away and receiving prayers and help under Home Based Care."

Keeping the Promise Survey Respondent

These are some of the responses received to the survey query about the forms of stigma and discrimination observed by respondents against people living with HIV/AIDS, or their family members in the church/ organization.

Sadly stigma and discrimination ranges from isolation and rejection to excommunication from the church or organization.

Some of the forms of stigma and discrimination against PLWHA in the church /organization as observed by respondents are detailed below:

- The PLWHIV/AIDS are looked down upon as sinners and sent out of their places of work (even the Church)

- AIDS is associated with homosexuality / primarily in Africa
- Fear through ignorance; lack of touch / do not shake hands etc.
- Stopping the sharing of the cup of blessings for fear of HIV transmission
- Once their condition is revealed they are no longer asked to participate in leadership roles or allowed to work with children
- Although Aids is not seen as a punishment from God, the infections is often linked to immoral behaviour, promiscuity or unfaithfulness. Thus being open about a positive status is made more difficult.

PREVENTION

- 47.6 %of the respondents reported that HIV and AIDS was a part of the educational curriculum at the educational institution run by the church or organization, 30.2% responded that this was not the case while 21.4% were not sure
- 63.3% of the respondents reported that HIV and AIDS prevention programs or activities were available for members in their church or organization, 23.1% responded that this was not the case while 12.2 % were not sure.
- 28.2% responded that their church/organization ran HIV and AIDS prevention programs for all five groups, 10.9% responded that their church/organization ran HIV and AIDS prevention programs exclusively for the youth, 2.7% responded that their church/organization ran HIV and AIDS prevention programs exclusively for women,0.7% responded that their church/organization ran HIV and AIDS prevention programs exclusively for men,1% responded that their church/organization ran HIV and AIDS prevention programs for women and men.
- 40.5% responded that their church/organization used prevention messages which advocated abstinence faithfulness to one partner and use of condoms, 22.1 % responded that their church/organization used prevention messages which advocated Abstinence and faithfulness to one partner only, 3.1% responded that their church/organization used prevention messages which advocated Abstinence only, 4.1% responded that their church/organization used prevention messages which advocated faithfulness to one partner only,5.8% responded that their church/organization used prevention messages which advocated use of condoms only,7.5% responded that their church/organization used prevention messages which advocated faithfulness to one partner and use of condoms only, 0.7% responded that their church/organization used prevention messages which advocated abstinence and use of condoms only while 0.7% responded that their church or organization promoted the SAVE model.

Under this element the majority of the respondents report progress in the promotion of HIV/AIDS awareness. The prevention messages are streamlined for each setting, we will analyse this further when we look at the regions.

TREATMENT AND CARE

- 53 % respondents reported that treatment options for PLWHIV were not provided by their church/organization, 34% respondents that treatment options were provided while 12.6% were not sure
- 50.7% respondents reported that information leaflets were available in their church or organization on the prevention and treatment of AIDS, 38.8 % responded that this was not the case while 9.9% were not sure
- 13.6% respondents reported that their church or organization offered Home- based care, programs for Orphans and vulnerable children , Voluntary counselling and testing, Counselling and home visits and Anti-retroviral therapy while 8.5% of the respondents reported that their church or organization offered antiretroviral therapy, counselling and home visits.

There are not many treatment facilities available or provided by the church / organization this can be attributed to the situational and country context to the access of treatment.

HINDRANCES FOR BETTER HIV / AIDS WORK

- The number one important hindrance ranked by respondents which prevents their church or organization from doing more and better HIV and AIDS work was lack of funding followed closely by the difficulty to talk about human sexuality. The least important hindrance as ranked by respondents was poorly functioning health institutions and facilities.

RECOMMENDATIONS FOR IMPROVEMENT OF HIV AND AIDS WORK

“Preach an inclusive attitude from the pulpit; strengthen the value, role and rights of women; Show that God blesses our sexual relations; If you preach abstinence you have to condone masturbation!!!; publicly touch and embrace PLWHAs; seek to employ or promote/put into public church positions known and open PLWHA.I think a general awareness of the problems needs to be implemented in our society, also according to other deceases related to sexual behaviour. Church must always be relevant in adressing these things, and we ned better insight in the life of our members.”

World Vision Germany- Keeping the Promise Survey Respondent

“In my parish, AIDS is considered something that happens to other people. It is a very conservative, upper middle class environment. People who attend have very fixed ideas about how life should be lived and any deviation from the norm is just not discussed. Since AIDS is a disease that is spread mainly through lifestyles, sexual activity that is forbidden by the church and drug abuse, it is just not discussed, since

such people do not attend our church. When we do speak of AIDS as a pandemic, it is only with reference to all those poor folks in Africa. A cheque is written to deal with the epidemic THERE, but that's about as far as it goes."

Keeping the Promise Survey Respondent

The respondents have outlined a number of recommendations to improve the work being done in the fight against HIV/AIDS.

- Early education in HIV, perhaps from Sunday school.
- Supporting holistic approaches accordingly to the Social Teaching of the Church, using community empowerment as a tool.
- Financial Support
- Build upon and capitalise the potential synergy for all religious groups to jointly fight HIV/AIDS at country levels.
- Programs that enhance the horizon of understanding in the clergy and a change in the mindset with regard to working on HIV/AIDS.
- Provide more easy to understand and accessible information in all languages
- Need for trained people
- Awareness training to the congregation people.
- Need to break the silence on human sexuality generally, so that HIV/AIDS prevention, especially among youth, can be included in all discussion
- More support programs for vulnerable groups
- Need to develop liturgies, manuals on sexuality and HIV/AIDS with the assistance of WCC.
- Involve youth in outreach work to rural areas and vulnerable groups
- Need for more involvement of PLWHA in planning, implementation and monitoring and evaluation
- Define SAVE as a better strategy than ABC
- Clear statements by church leaders in support of churches involvement into anti-AIDS work, statements against stigmatization of PLWHA, institutional proactive measures to promote churches involvement into primary prevention among children and youth.

REGIONAL ANALYSIS

SUB-SAHARAN AFRICA:

Sub-Saharan Africa has just over 10% of the world's population, but is home to more than 60% of all people living with HIV—25.8 million. In 2005, an estimated 3.2 million people in the region became newly infected, while 2.4 million adults and children died of AIDS. Among young people aged 15–24 years, an estimated 4.6% [4.2–5.5%] of women and 1.7% [1.3–2.2%] of men were living with HIV in 2005. Declines in adult national HIV prevalence appear

to be underway in three sub-Saharan African countries: Kenya, Uganda and Zimbabwe. With the exception of Zimbabwe, countries of southern Africa show little evidence of declining epidemics. Progress in expanding treatment and care provision in sub-Saharan Africa in the past year has been uneven. At least one third of people in need of antiretroviral therapy are receiving it in such countries as Botswana and Uganda, while in Cameroon, Côte d'Ivoire, Kenya, Malawi and Zambia between 10% and 20% of people requiring antiretroviral drugs were receiving them in mid-2005. However, there is extensive unmet need in most of the region. At least 85% (almost 900 000) of South Africans who needed antiretroviral drugs were not yet receiving them by mid-2005; the same applied to 90% or more of those in need in countries such as Ethiopia, Ghana, Lesotho, Mozambique, Nigeria, the United Republic of Tanzania and Zimbabweⁱⁱⁱ.

Findings: 28% of the survey respondents were from Sub-Saharan Africa.

- 66% of the respondents from Sub Saharan Africa were aware of the UNGASS Declaration of Commitment on HIV/AIDS, while the rest were unaware or not sure.
- 57.31% of the respondents from Sub Saharan Africa reported that their church or organization had developed a policy on HIV/AIDS while 17.7% of the respondents reported that their church or organization had not.
- 40.24% of the respondents from Sub Saharan Africa reported that their church or organization had developed a comprehensive work place policy on HIV/AIDS while 45.12% of the respondents reported that their church or organization had not.
- 56.09% of the respondents from Sub Saharan Africa reported that their church or organization had implemented one or both policies while 28.04% of the respondents reported that their church or organization had not.
- 81.7% of the respondents from Sub Saharan Africa reported that they spoke publicly about issues surrounding HIV/AIDS while 13.4% responded that this was not the case.
- The ABC approach (48.1%) is predominantly the message advocated in South Africa, followed by Abstinence and Faithfulness (11.25%) and Abstinence (7.6%).

In Sub Saharan Africa the majority of the respondents reported that the church/organization had not developed a comprehensive work place policy, this must be strongly encouraged. The prevention messages being promoted also center around abstinence and faithfulness as opposed to protection, this may have repercussions.

ASIA:

National HIV infection levels in Asia are low compared with some other continents, notably Africa. However, the populations of many Asian nations are so large that even low national HIV prevalence means large numbers of people are living with HIV. Latest estimates show some 8.3 million [5.4 million–12 million] people (2 million [1.3 million–3 million] adult women) were living with HIV in 2005, including the 1.1 million [600 000–2.5 million] people who

became newly infected in the past year. AIDS claimed some 520 000 [330 000–780 000] lives in 2005. Risky behaviour—often more than one form—continues to sustain serious AIDS epidemics in Asia. At the heart of many of Asia's epidemics lies the interplay between injecting drug use and unprotected sex, much of it commercial. Yet prevention strategies still rarely reflect the fact that such combinations of risk-taking exist in virtually every country in the region. As a result, many of the epidemics in Asia are in transition—including in those countries where the spread of HIV to date. The long-standing epidemics in several other countries involve a further challenge: providing treatment and care to the thousands of people who are infected. In 2005, an estimated 1.1 million people in Asia needed antiretroviral treatment, the second-highest number in the world. Treatment provision has grown substantially since early 2004—nearly tripling from 55 000 to 155 000 by mid-2005. Much of that momentum has been due to strong efforts in Thailand (where more than half the people in need of the drugs were getting them) and China. A huge challenge still remains: some 85% of people needing treatment were not yet receiving it in mid-2005.^{iv}

Findings: 11.2% of the survey respondents were from Asia.

- 57.5% of the respondents from Asia were aware of the UNGASS Declaration of Commitment on HIV/AIDS, while the rest were unaware or not sure.
- 15.15% of the respondents from Asia reported that their church or organization had developed a policy on HIV/AIDS while 12.12% of the respondents reported that their church or organization had not.
- 36.36% of the respondents from Asia reported that their church or organization had developed a comprehensive work place policy on HIV/AIDS while 45.45% of the respondents reported that their church or organization had not.
- 42.42% of the respondents from Asia reported that their church or organization had implemented one or both policies while 36.36% of the respondents reported that their church or organization had not.
- 48.48% of the respondents from Asia reported that they spoke publicly about issues surrounding HIV/AIDS while 33.33% responded that this was not the case.
- The ABC approach (40.6%) is predominantly the message advocated in Asia, followed by Abstinence and Faithfulness (9.3%).

Again in Asia as in Africa the majority of the respondents reported that their church/organization had not developed a comprehensive work place policy which is a cause for concern.

EASTERN EUROPE AND CENTRAL ASIA:

The epidemics in Eastern Europe and Central Asia continue to grow and are affecting ever-larger parts of societies in this region. The number of people living with HIV in this region reached an estimated 1.6 million in 2005—an increase of almost twenty-fold in less than ten

years. AIDS claimed almost twice as many lives in 2005, compared with 2003, and killed an estimated 62 000 adults and children. Some 270 000 people were newly infected with HIV in the past year. The overwhelming majority of people living with HIV in this region are young; 75% of the reported infections between 2000 and 2004 were in people younger than 30 years (in Western Europe, the corresponding figure was 33%). The patterns of the epidemics are changing in several countries, with sexually transmitted HIV cases comprising a growing share of new diagnoses. In 2004, 30% or more of all new reported HIV infections in Kazakhstan and Ukraine, and 45% or more in Belarus and the Republic of Moldova, were due to unprotected sex. Increasing numbers of women are being affected, many of them acquiring HIV from male partners who became infected when injecting drugs. The bulk of the people living with HIV in this region are in two countries: the Russian Federation and Ukraine. Ukraine's epidemic continues to grow, with more new HIV diagnoses occurring each year, while the Russian Federation has the biggest AIDS epidemic in all of Europe. Both epidemics have matured to the point where they constitute massive prevention, treatment and care challenges.⁹.

Findings: 4.08% of the survey respondents were from Eastern Europe and Central Asia.

- 30% of the respondents from Eastern Europe and Central Asia were aware of the UNGASS Declaration of Commitment on HIV/AIDS, while the rest were unaware or not sure.
- 45.45% of the respondents from Eastern Europe and Central Asia reported that their church or organization had developed a policy on HIV/AIDS while 54.54% of the respondents reported that their church or organization had not.
- 9.09% of the respondents from Eastern Europe and Central Asia reported that their church or organization had developed a comprehensive work place policy on HIV/AIDS while 81.8% of the respondents reported that their church or organization had not.
- 9.09% of the respondents from Eastern Europe and Central Asia reported that their church or organization had implemented one or both policies while 81.8% of the respondents reported that their church or organization had not.
- 36.36% of the respondents from Eastern Europe and Central Asia reported that they spoke publicly about issues surrounding HIV/AIDS while 36.36% responded that this was not the case.
- The Abstinence and Faithfulness to one partner approach (41.6%) is predominantly the message advocated in Eastern Europe and Central Asia, followed by Faithfulness to one partner and use of condoms (8.3%) and only abstinence (8.3%).

A low number of respondents in Eastern Europe and Central Asia were aware of the UNGASS declaration calling for increased advocacy. In addition the lack of development of workplace policies was significantly higher than other regions. There is also a lack of

openness of leadership to speak openly about HIV/AIDS issues as compared to other regions. A lot of these issues could be explained by political/ social factors. However there is seen to be a need for extensive support in this region.

LATIN AMERICA AND THE CARRIBEAN:

The number of people living with HIV in Latin America has risen to an estimated 1.8 million. In 2005, approximately 66 000 people died of AIDS, and 200 000 were newly-infected. Among young people 15–24 years of age, an estimated 0.4% of women and 0.6% of men were living with HIV in 2005. Primarily due to their large populations, the South American countries of Argentina, Brazil and Colombia are home to the biggest epidemics in this region. Brazil alone accounts for more than one third of the estimated 1.8 million people living with HIV in Latin America. The highest HIV prevalence, however, is found in the smaller countries of Belize, Guatemala and Honduras — where approximately 1% of adults or more were infected with HIV at the end of 2003. The region's epidemics are being fuelled by varying combinations of unsafe sex (both between men, and men and women) and injecting drug use, with the role of sex between men in HIV transmission a more prominent factor than is commonly acknowledged.

The AIDS epidemic claimed an estimated 24 000 [16 000–40 000] lives in the Caribbean in 2005, making it the leading cause of death among adults aged 15–44 years. A total of 300 000 [200 000–510 000] people are living with HIV in the Caribbean, including the 30 000 [17 000–71 000] people who became infected in 2005. In the Caribbean Community (CARICOM) region 240 000 [150 000–450 000] people are living with HIV, including the 25 000 [12 000–65 000] people who acquired the virus in 2005. More than 20 000 [13 000–36 000] people died of AIDS in the past year in this region. The Caribbean's status as the second-most affected region in the world masks substantial differences in the extent and intensity of its epidemics. Estimated national adult HIV prevalence surpasses 1% in Barbados, Dominican Republic, Jamaica and Suriname, 2% in the Bahamas, Guyana and Trinidad and Tobago, and exceeds 3% in Haiti. In Cuba, on the other hand, prevalence is yet to reach 0.2%. The region's epidemics are driven primarily by heterosexual intercourse (the documented mode of transmission in three quarters or more of all AIDS cases reported to date), with commercial sex a prominent factor, against a backdrop of severe poverty, high unemployment and gender inequalities. In-depth research on the interplay between the sex industry and HIV transmission, however, remains comparatively limited in the Caribbean.^{vi}

Findings: 9.5% of the survey respondents were from the Latin America and Caribbean region.

- 40.74% of the respondents from Latin America and the Caribbean were aware of the UNGASS Declaration of Commitment on HIV/AIDS, while the rest were unaware or not sure.

- 37.03% of the respondents from Latin America and the Caribbean reported that their church or organization had developed a policy on HIV/AIDS while 48.14% of the respondents reported that their church or organization had not.
- 29.6% of the respondents from Latin America and the Caribbean reported that their church or organization had developed a comprehensive work place policy on HIV/AIDS while 29.6% of the respondents reported that their church or organization had not.
- 33.33% of the respondents from Latin America and the Caribbean reported that their church or organization had implemented one or both policies while 44.44% of the respondents reported that their church or organization had not.
- 59.25% of the respondents from Latin America and the Caribbean reported that they spoke publicly about issues surrounding HIV/AIDS while 11.11% responded that this was not the case.
- The ABC approach (42.9%) is predominantly the message advocated in Latin America and the Caribbean, followed by Abstinence and Faithfulness (25%) and abstinence (10.7%).

The level of development of policies and their implementation is low in the region.

NORTH AMERICA, WESTERN AND CENTRAL EUROPE:

The number of people living with HIV in North America, Western and Central Europe rose to 1.9 million in 2005, with approximately 65 000 people having acquired HIV in the past year. Wide availability of antiretroviral therapy has helped keep AIDS deaths comparatively low, at about 30000. Overall, prevention efforts are lagging behind changing epidemics in several countries where the main patterns of HIV transmission have been shifting. Although sex between men and, in a minority of countries, injecting drug use remain important routes for HIV transmission, increasing numbers of people are being infected through unprotected heterosexual intercourse. The estimated number of people living with HIV in the United States of America (USA) at the end of 2003 exceeded one million for the first time. In Canada, just under 58 000 HIV diagnoses had been reported by the end of 2004. More than half a million people are living with HIV in Western Europe, and that number continues to grow with signs in several countries of a resurgence of risky sexual behaviour. The biggest change in Western Europe has been the emergence of heterosexual contact as the dominant cause of new HIV infections in several countries. Western Europe and North America remain the only regions in the world where most people in need of antiretroviral treatment are able to receive it. As a result, the number of AIDS deaths plummeted in the late 1990s.^{vii}

Findings: 35.37% of the survey respondents were from North America, Western and Central Europe

- 50.47% of the respondents from North America, Western and Central Europe were aware of the UNGASS Declaration of Commitment on HIV/AIDS, while the rest were unaware or not sure.

- 61.5% of the respondents from North America, Western and Central Europe reported that their church or organization had developed a policy on HIV/AIDS while 25% of the respondents reported that their church or organization had not.
- 26.92% of the respondents from North America, Western and Central Europe reported that their church or organization had developed a comprehensive work place policy on HIV/AIDS while 51.92% of the respondents reported that their church or organization had not.
- 29.8% of the respondents from North America, Western and Central Europe reported that their church or organization had implemented one or both policies while 34.6% of the respondents reported that their church or organization had not.
- 65.38% of the respondents from North America, Western and Central Europe reported that they spoke publicly about issues surrounding HIV/AIDS while 17.3% responded that this was not the case.
- The ABC approach (41.23%) is predominantly the message advocated in North America, Western and Central Europe, followed by Abstinence and Faithfulness (15.46%).

MIDDLE EAST AND NORTH AFRICA:

The advance of AIDS in the Middle East and North Africa has continued with latest estimates showing that 67 000 people became infected with HIV in 2005. Approximately 510 000 people are living with HIV in this region. An estimated 58 000 adults and children in 2005 died of AIDS-related conditions. Although HIV surveillance remains weak in this region, more comprehensive information is available in some countries (including Algeria, Libya, Morocco, Somalia, and Sudan). Available evidence reveals trends of increasing HIV infections (especially in younger age groups) in such countries as Algeria, Libya, Morocco and Somalia. The main mode of HIV transmission in this region is unprotected sexual contact, although injecting drug use is becoming an increasingly important factor (and is the predominant mode of infection in at least two countries, Iran and Libya).^{viii}

Findings: 2.04% of the survey respondents were from Middle East and North Africa

- 33.33% of the respondents from Middle East and North Africa were aware of the UNGASS Declaration of Commitment on HIV/AIDS, while the rest were unaware or not sure.
- 50% of the respondents from Middle East and North Africa reported that their church or organization had developed a policy on HIV/AIDS while 33.33% of the respondents reported that their church or organization had not.
- 33.33% of the respondents from Middle East and North Africa reported that their church or organization had developed a comprehensive work place policy on

HIV/AIDS while 66.6% of the respondents reported that their church or organization had not.

- 33.33% of the respondents from Middle East and North Africa reported that their church or organization had implemented one or both policies while 50% of the respondents reported that their church or organization had not.
- 33.33% of the respondents from Middle East and North Africa reported that they spoke publicly about issues surrounding HIV/AIDS while 50% responded that this was not the case.
- The ABC approach (33.33%) is the message advocated in Middle East and North Africa, along with Faithfulness to one partner and use of condoms (33.33%) and faithfulness to one partner only (33.33%).

OCEANIA:

An estimated 74 000 people in Oceania are living with HIV. Although less than 4000 people are believed to have died of AIDS in 2005, about 8200 are thought to have become newly infected with HIV. Among young people 15–24 years of age, an estimated 1.2% of women and 0.4% of men were living with HIV in 2005. More than 90% of the 11 200 HIV infections reported across the 21 Pacific Islands countries and territories by end-2004 were recorded in Papua New Guinea where an AIDS epidemic is now in full swing. Australia, by contrast, has the oldest epidemic in the region. Having declined by about 25% from 1995–2000, the annual number of new HIV diagnoses in Australia has been edging upward again and reached 820 in 2004. This brought to an estimated 14 800 the number of people living with HIV in the country in 2004. HIV-infection levels are very low in the rest of Oceania, with the total number of reported HIV cases exceeding 150 only in New Caledonia (246), Guam (173), French Polynesia (220) and Fiji (171). The data are based on limited HIV surveillance. Given the high levels of other sexually transmitted infections that have been recorded in some Pacific islands, none of these countries and territories can afford to be complacent. ^{ix}

Findings: 3.06% of the survey respondents were from Oceania

- 33.33% of the respondents from Oceania were aware of the UNGASS Declaration of Commitment on HIV/AIDS, while the rest were unaware or not sure.
- 55.5% of the respondents from Oceania reported that their church or organization had developed a policy on HIV/AIDS while 33.33% of the respondents reported that their church or organization had not.
- 11.1% of the respondents from Oceania reported that their church or organization had developed a comprehensive work place policy on HIV/AIDS while 55.5% of the respondents reported that their church or organization had not.

- 11.1% of the respondents from Oceania reported that their church or organization had implemented one or both policies while 44.4% of the respondents reported that their church or organization had not.
- 66.66% of the respondents from Oceania reported that they spoke publicly about issues surrounding HIV/AIDS while 22.2% responded that this was not the case.
- The ABC approach (55.5%) is predominantly the message advocated in Oceania, followed by Abstinence and Faithfulness (22.2%).

The development of the work place policy and implementation of policies was found to be low in the region along with levels of awareness about UNGASS.

THE WAY FORWARD

TACKLE STIGMA AND DISCRIMINATION HEAD ON

As was seen in the responses by the stakeholders on stigma and discrimination, often approaches by churches/organizations have accentuated the stigmatised situation of PLWHIV/AIDS. Efforts need to be made to bring about a ministry of compassion, inclusion and healing. Religious leaders should lead the way in this effort.

INVOLVEMENT OF PLWAHIV/AIDS

“The meaningful involvement and leadership of persons living with HIV/AIDS is a key strategy in the expanded response to the pandemic.”^x

The involvement of PLWHIV/AIDS in formulating programs, policies and undertaking leadership roles can deliver superior benefits in the way of reduction of stigma and discrimination, acceptance and relevant and effective programs/policies.

HIV/AIDS POLICY DEVELOPMENT AND IMPLEMENTATION:

A significant number of respondents reported from all the regions that the comprehensive workplace policy was not developed. An in-depth study is needed to understand the reasons for the church or organization to not develop the work place policy and develop it. Reasons for not implementing the policies developed also need to be studied. In addition a new approach needs to be designed to encourage churches/organizations to develop and implement HIV/AIDS policies.

EDUCATION

HIV/AIDS Education at all levels is well recognised by all the respondents. Therefore including HIV/AIDS awareness topics in the curriculum of school children, Sunday school children to clergy is an important positive step in addressing the HIV/AIDS problem.

EXPLORE PARTNERSHIPS

Many of the churches/organizations do not have facilities to provide VCT or ART options. Linking up with medical institutions and clinics in the vicinity to expand access to these services for their members is important for a comprehensive response.

CONCLUSION- SOME REFLECTIONS

Advocacy in HIV and AIDS is a double-edged sword. As we challenge our governments to measure up to what they have committed themselves to do to overcome the AIDS epidemic, it is vital that we look at ourselves too:

- **Are we doing enough to mobilise the huge human and material resources within and related to the churches?**

- **Are we reliable stewards of the resources to which we have access?**

- **Do we look beyond our denominations, organisations and religions to work in collaboration with the wider society?**

- **Are we faithful to the promises that we have made and to the principles that we hold?**

Let us reflect, and respond appropriately!

APPENDIX

List of Abbreviations and Acronyms

AIDS Acquired Immune Deficiency Syndrome

ART Antiretroviral Therapy
ARV Antiretroviral
CBO Community-based Organisation
CHBC Community Home-based Care
FBO Faith-based Organisation
HAART Highly Active Antiretroviral Therapy
HBC Home-based Care
HIV Human Immunodeficiency Virus
IDU(s) injecting drug user(s)
IEC Information, Education, and Communication
M&E Monitoring and Evaluation
MCH Maternal and Child Health
MOHP Ministry of Health and Population
NAC National AIDS Commission
NSO National Statistics Office
NGO Non-governmental Organisation
OI Opportunistic Infection
PEP Post-exposure Prophylaxis
PLWA People Living with HIV/AIDS
PMAPB Pharmacy, Medicines and Poisons Board
PMTCT Prevention of Mother-to-child Transmission
PRSP Poverty Reduction Strategy Paper
STI Sexually Transmitted Infection
TB Tuberculosis
TBA Traditional Birth Attendant
UNDP United Nations Development Programme
UNAIDS Joint United Nations Programme on HIV/AIDS
VCT Voluntary Counselling and Testing
WHO World Health Organization

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ENDNOTE

ⁱ Samuel,R, The contribution of Christian congregations to the battle with HIV/AIDs at the community level,2005

ⁱⁱ **The impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa** ,Prepared by jeremy liebowitz, ph.d. ,October 2002
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ⁱⁱⁱ UNAIDS website

^{iv} UNAIDS website

^v UNAIDS website

^{vi} UNAIDS website

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^{viii} UNAIDS website

^{ix} UNAIDS website

^x **Faith in Action: Examining the Role of Faith-Based Organizations in Addressing HIV/AIDS** by Sara Woldehanna et al