HIV/AIDS Policy Initiatives

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Too often, we take modern health care and legal protections for granted, failing to realize that two thousand years of Christian engagement with people who were sick and vulnerable made these things possible. Driven by compassion and a devotion to their faith, Christians throughout history have cared for populations at risk using their available resources, skills and knowledge. Some also engaged in advocacy for policy reform, enabling humanitarian principles underlying faith initiatives to become incorporated into global and national policies Christian initiatives have laid the foundation for child welfare reform and state involvement in ensuring universal access to health care in the twenty-first century. That governments have obligations to ensure the rights of every citizen and that every child has the right to access health, education and social protection are recent notions (United Nations, 1948; United Nations, 1989). Throughout history, most political leaders considered the provision of health care and children's rights to be private matters. The main providers of health services were religious organizations, a situation that continues today in some countries with severe HIV/AIDS epidemics. Religious health networks are the second largest entity of health care providers in the developing world after government programs (Institute for Development Training, 1998).

Churches have made significant contributions to health provision and child welfare, most remarkably displayed in their response to HIV/AIDS in sub-Saharan Africa. Christian responses to HIV/AIDS vary wildly in scope and scale. Some are projects coordi-

nated by large organizations while most are grassroots projects implemented by congregations serving a small number of beneficiaries.

Currently, most contributions by Christian organizations to HIV/AIDS and vulnerable children involve local service provision. Despite their scale and undoubted impact, thousands of small, un-networked and under-documented initiatives remain unnoticed by governments, international organizations and religious networks. Due to their vast influence and service provision, it is essential that Christians recognize the vital role of advocacy and policy initiatives as essential to promoting the care and protection of children being affected by HIV/AIDS. The church must embrace its history of influence in health care to impact the significant challenges presented by this epidemic.

CHRISTIAN INFLUENCE ON CHILDCARE REFORM AND HEALTH SERVICE PROVISION

Christians of the Roman Empire helped change society's attitudes toward the vulnerable and sick through their radically different outlook, which involved advocating for the sanctity of marriage, compassionate care, natural as well as spiritual healing and provision of services regardless of social position or religion. The early church emphasized the importance of care for the sick, widows, and orphans. This service was not limited to church members but was directed toward the larger community, particularly in times of pestilence and plague (Schmidt, 2004).

Basil, Bishop of Caesarea, is celebrated as the pioneer of hospital establishment that led to the development centuries later of national health systems. In AD 369, Basil set up the first large-scale hospital with 300 beds for the sick, disabled, poor and aged and organized isolation wards for people with contagious diseases like leprosy and plague. This was the first of many hospitals later established by monasteries under the influence of Benedictines dedicated to serving the sick (Schmidt, 2004).

In the Roman world, children were routinely abandoned in rural places and the marketplace. But early Christians also provided alternatives by rescuing and adopting abandoned children. Deacons in Rome functioned as regional child welfare administrators, facilitating the care of children who had lost both parents (Faherty, 2006). Callistus placed abandoned children in Christian foster families. In later times, children abandoned on the steps of monasteries and foundling hospitals were raised in church institutions (Peet, 2009).

Basil also advocated for the rights of vulnerable children and mobilized Christians to provide women facing unwanted pregnancies with prenatal and postnatal support. His efforts led in 374 A.D. to the Emperor Valentinian outlawing abortion, infanticide and child abandonment. Tertullian and other second century Christian writers also denounced abortion and infanticide. Benignus of Dijon offered nourishment and protection to abandoned children, including those with disabilities caused by unsuccessful abortions (Peet, 2009). Many states established after the fall of the Roman empire followed Valentinian's example and enacted laws to outlaw infanticide that remain in place today, one of Christianity's great legacies.

In the eighth century, Charlemagne decreed that every cathedral should have a school and hospital attached. Monastic infirmaries throughout the middle ages incorporated physical treatments, such as herbal remedies and blood-letting, as well as prayers for healing (Silverman, 2002). They stressed the importance of cleanliness, relaxation and nutrition, and created an environment where the sick and disabled could play a positive role (Crislip, 2005). Cathedral hospitals reflected a more sophisticated design with increased privacy being provided to patients through partitioning wards into small rooms The oldest surviving hospitals are the 7th-century Hôtel Dieu in Paris, St Bartholomew's (1123) and

St Thomas's (1200) in London, and the Hospital of Jesus of Nazareth in Mexico (1524). At one stage, church hospitals were ubiquitous in populated centres in Europe and were visited by people of means because they were considered to provide quality services (Knowles & Hadcock, 1953).

After the reformation, free churches led in the care of the sick in Protestant countries. John Wesley founded the Methodist church in Britain and promoted the prevention of disease through healthy living and treatment especially for the poor through time-honored, inexpensive methods. The practices of Wesley and other Christians influenced Florence Nightingale who campaigned against the neglect and exploitation of children and in favour of the provision of decent housing, clean water, good nutrition and safe childbirth (McDonald, 2005). Nightingale promoted the hygienic design of hospitals, training of nurses and the role of women and contributed to the expansion in hospital building that took place in the late nineteenth century. By 1873, there were only 178 hospitals in the USA; less than forty years later, there were more than 400,000 beds and 4,300 hospitals (Brieger, 1987). Though many new hospitals were set up by churches – for instance, 400 were Catholic – the majority were non-religious institutions (Dolan, 2002). Meanwhile, Josephine Butler, another Christian feminist, campaigned against child prostitution that involved girls as young as five years old. She mobilized churches in a successful campaign that raised the age of sexual consent in Britain from 13 to 16 years old; other countries followed suit. Health care provision and child welfare reform by secular authorities in Europe and North America were thus challenged and stimulated by Christian initiatives.

Churches have also been at the forefront of advancing health care and child welfare in developing countries. The first hospital in India was established in Goa in 1514 AD by Christian missionaries. During the nineteenth and twentieth centuries, missionaries in India established hospitals and training schools for doctors and nurses. By 1940, most tuberculosis sanatoria and leprosy institutions were Christian. At that time, there were 2,000 Christian hospitals that provided nearly two-fifths of all beds in Indian institutions (Shah, 2005). By 1947, 95% of all nurses, mostly from Christian communities, were graduates of mission nursing schools and women's medical colleges. And in China by the 1930's, Christians had established 254 mission hospitals and six of China's 12 medical schools were financed by missionary societies (Campbell, 2000). One-fifth of hospital beds throughout Asia are currently administered by church and mission institutions (Martin, 1999).

The same is true of sub-Saharan Africa. Christian missionary endeavors contributed to modern health, education, and social welfare services. Most early hospitals and health programs were established by Christian churches. More than one-third of health care provision in sub-Saharan Africa is provided by church hospitals (See Figure 1); 40% of health service delivery is provided by 780 church health facilities in Kenya and by 84 Christian hospitals and health centers in Lesotho (Foster, 2009). Although mission hospitals and clinics are visible and their contribution to the health sector is apparent, they nevertheless represent a minority of faith-based organizations involved in health-related activities. Every administrative district in Africa and beyond is home to hundreds of health-focused initiatives, many being implemented by churches and other Christian groups (World Health Organization, 1994; Richter & Foster, 2006). These may have greater impact on people's health and well-being than hospitals and clinics. For example, in Lesotho, some 5,000 support groups were established, mostly by religiously motivated people concerned about the economic inability of community members to access health and social services. Most groups focus on home-based care, support

people living with HIV materially and spiritually, and assist orphans and vulnerable children. They rely on the resources of community members to feed, clothe, hospitalize, and medicate beneficiaries. Support groups were rated as being one of the most effective responses in addressing the health and well-being of community members (AR-HAP, 2006).

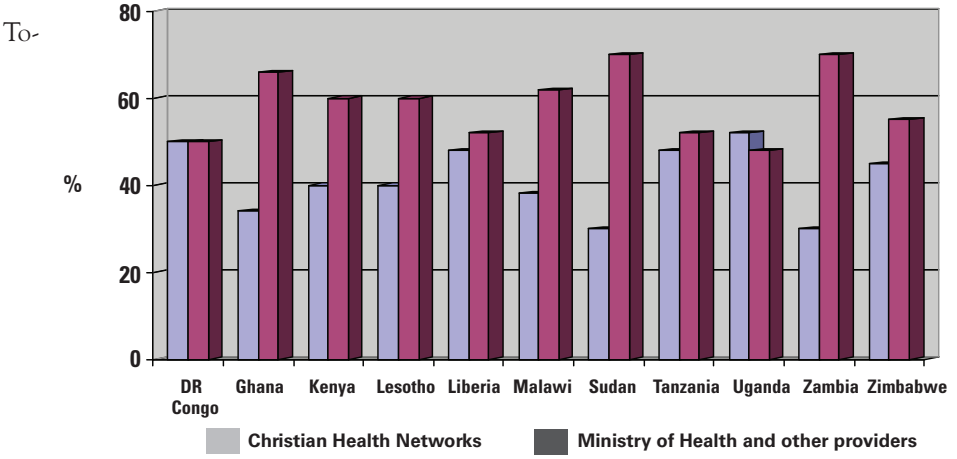

Figure 1: Contributions of Christian Health Networks to Health Services (Chand & Paterson, 2007)

ward the end of the twentieth century, systems for health care provision were reformulated after the principle of primary health care (PHC) was adopted. Surveys in Africa and Asia evaluated the effectiveness of mission hospitals in meeting people's needs. They concluded that churches had concentrated their efforts on building and operating hospital-based curative services that acted as health repair facilities but did little to address the underlying causes of sickness or promote preventive health practices. Moreover, church-related institutions, together with other available facilities of Western medicine, reached only one-fifth of the population. The remaining 80%, usually the poorest and neediest, were deprived of modern medical services. The PHC movement was spearheaded by the German Institute for Medical Mission and the Christian Medical Commission of the World Council of Churches who together influenced the World Health Organization. The process led in 1978 to the landmark Alma Ata conference at which a universal access "health for all" policy was adopted. This led to the promotion of community-based PHC in developing countries by organizations such as the United Nations Children's Fund and dramatic improvements in child health through community engagement, promotion of oral rehydration, breastfeeding, immunization and female literacy (Bryant, 2008).

THE CHURCH'S RESPONSE TO THE PEDIATRIC AFRICAN HIV/AIDS EPIDEMIC

Children are affected by HIV and AIDS through the loss of teachers and health care providers, and most critically, when their parents become ill and die. When parents suffer AIDS-related illnesses, relatives provide economic and social support to affected children. Children cope with new burdens, including new caregiving chores and increased work responsibilities, often without adequate support. The economic and caregiving burdens imposed on extended families during parental illness, death and beyond deplete them of two resources essential for children's healthy development: time and money (Heymann & Kidman, 2008).

Faith-based responses for orphans and vulnerable children are widespread throughout sub-Saharan Africa and have expanded

rapidly in the last decade, especially in the "AIDS belt" of East and Southern Africa. When Ugandans were asked what most concerned them about the impact of AIDS, the most common response was that the epidemic was affecting children (Bolton & Wilk, 2004). It is therefore not surprising to find that community initiatives for vulnerable children are mushrooming throughout Africa, expanding their reach and broadening their activities (Foster et al., 2008). A six-country survey of 690 faith-based organizations found that 47% of initiatives supporting children affected by HIV/AIDS were established in the preceding four years (Foster, 2004). In Uganda, a study identified 108 community initiatives for vulnerable children, one initiative per 1,300 people (Foster et al., 2008). Most initiatives were independent groups or linked to local churches, schools or clinics.

In Namibia, a national survey of 109 faith-based organizations found only 13% —mostly small independent churches— with no HIV/AIDS response (Figure 2). Around one-quarter had a "minimal" response—a few volunteers providing counseling, spiritual support and prevention. "Developing" responses were from larger, mainline churches, such as Anglican, Methodist and larger Evangelical and Pentecostal denominations. Churches usually had several volunteers involved in home-based care, youth HIV prevention, or temporary shelters for orphans, with support provided by a coordinator at denominational level. Around one-quarter had "established" HIV/AIDS responses with 10 or more trained volunteers involved in different activities as part of a large national program. More than half of the church responses provided support to orphans (Yates, 2003).

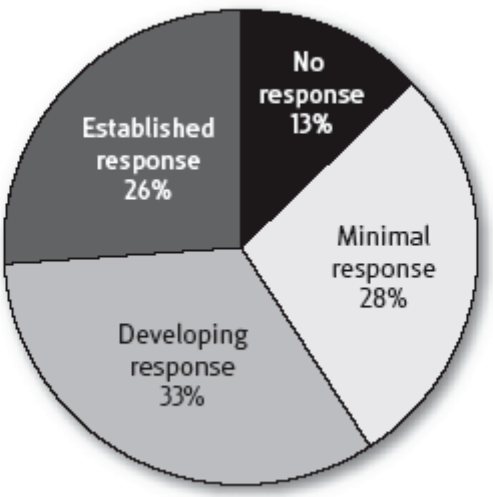

Figure 2. Level of development of HIV/AIDS responses among 109 FBOs in Namibia (Yates, 2003)

Catholic AIDS Action, which represents the largest faith-based response to HIV/AIDS in Namibia, was established in 1998 and has more than 44 full-time staff working in nine regions. In 2003, Catholic AIDS Action had 110 volunteer groups with 1,686 active volunteers offering home-based care and counseling to approximately 3,000 households. The Evangelical Lutheran Church in Namibia established an HIV/AIDS program that supported 48 home-based care groups operating with more than 400 volunteers. Another evangelical Lutheran denomination had two coordinators supporting HIV/AIDS committees in 55 congregations with home-based care and orphan support programs involving some 1,800 volunteers in 35 congregations (Yates, 2003).

A Zambian study attests to the scale of faith-based responses. The study mapped 265 health, education, and development entities. Three-quarters provided HIV/AIDS-related services and two-thirds were faith-based. About a quarter of the 96 congregations and religious support groups provided support to orphans and vulnerable children and more than 90% of FBOs offered an HIV/AIDS service (ARHAP, 2006). In another large multi-country study, faith-based initiatives provided

children affected by HIV/AIDS with a wide range of services, such as the provision of food and clothing, assistance with the costs of health care or education, psychosocial and spiritual support and HIV prevention activities (Figure 3) (Foster, 2004).

Few faith-based HIV/AIDS responses are as comprehensive as the Integrated AIDS Program, a non-governmental organization (NGO) established in 1993 administered by the Catholic Diocese of Ndola. The program operates in 32 shanty compounds of five towns in northern Zambia with a total population of 400,000. Eleven different agencies, most of which are church related, coordinated the provision of home care to around 9,000 people, representing around three-quarters of chronically ill patients. In 2005, more than 15,000 orphans were identified through 750 community volunteers. More than three-quarters of identified households were eligible for food and other welfare support through the program (Fikansa, 2005).

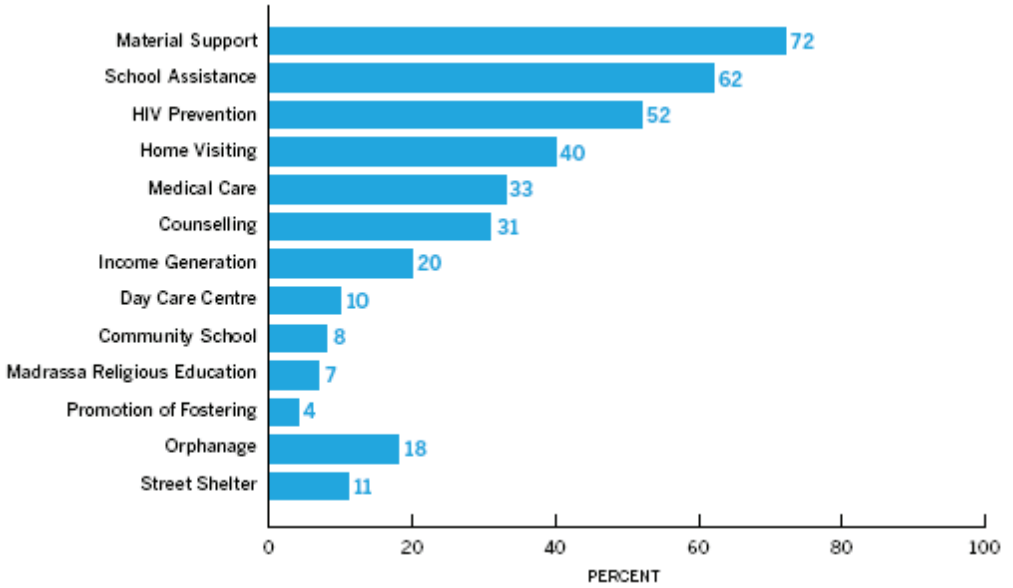

Figure 3: Services for Orphans and Vulnerable Children Provided by Faith-Based Organizations (Foster, 2004)

CHARACTERISTICS OF FAITH-BASED HIV/AIDS RESPONSES

Intangible Contributions. Faith-based organizations possess significant advantages in delivering HIV/AIDS interventions. When asked, "What does religion contribute to health?" African respondents considered that intangible factors were most important, ranking higher than more visible, tangible factors such as comprehensive care, material support, and curative interventions (ARHAP, 2006).

The principal intangible factor was spiritual encouragement, that included contributions such as "hope," "faith," "trust," "prayer," and "spiritual counseling." Spiritual encouragement encompassed the way in which religion gave people the inner strength to proceed with resilience, courage, and determination in the midst of ill health, poverty, and misfortune. Another intangible factor was knowledge giving—the contribution of religion in the areas of education, training, and prevention. Moral formation summed up contributions such as "morality," "behavior change," "self-control," "positive living," "patience," and

"temperance" and described the way in which religion was perceived to shape the behavior and lifestyles of people. It was the combination of both tangible and intangible contributions to health and well-being that gave faith-based activities, in the eyes of those receiving services, an advantage over non-faith-based programs. Recipients of faith-based organization's health services place great value on intangible factors. The quality of the services were said to result from the compassion and love that stemmed from the religious motivation of health care providers, especially volunteers, and from the delivery of medical, physical, and material support supplemented with spiritual and psychosocial care by faith-based providers.

In a Kenyan study, 53% of respondents from the general public had confidence in church-related services, while government health services only received a 3% confidence rating (Green, 2008). A World Bank study of 155 health care facilities in Uganda found that missions provided services of better quality than government facilities (Reinikka & Svensson, 2003).

Volunteers. Volunteers play a central role in HIV/AIDS responses. One of the most important strengths of religious groups is their ability to mobilize large numbers of volunteers to implement HIV/AIDS activities. For Christians, volunteerism stems from religious teachings that encourage followers to care for the sick, visit widows and orphans, and feed the hungry. In a six-country study of 690 FBOs in Africa, more than 9,000 volunteers were reported to be involved in the care and support of some 156,000 orphans and vulnerable children (Foster, 2004). In another study, the vast majority of home-based caregivers were noted to be women of faith between the ages of 25 and 50. When volunteers were asked why they had chosen to become involved in home care work, they ranked the different motivating factors as follows:

1. I see my neighbors are sick and many children have been orphaned, and I want to help them.
2. It is my Christian duty to follow the teachings of the church, including the example of Jesus.
3. I am willing to help out because I see that my community and my nation need me.
4. As a volunteer, I want to become educated and learn new skills that can help others.
5. I realize that today it is you and tomorrow it may be me; becoming a volunteer will prepare me in case my own family needs help (Steinitz, 2003).

Retention rates of faith-based volunteers are high, especially when sufficient training, regular supervision, and necessary supplies are provided, even where financial incentives are lacking. The fiscal contribution of this army of faith-based volunteers throughout Africa is enormous—their labor was conservatively estimated to be worth US $5 billion per annum in 2006, an amount similar in magnitude to the total funding provided for HIV/AIDS by all bilateral and multilateral agencies (Tearfund, 2006).

Sustainability. For centuries, churches have proven their resilience and sustainability. They have continued their work despite conflicts, natural disasters, political oppression, and disease. Christians have demonstrated their commitment to respond to human need based on their teachings, and they do so voluntarily and over long periods. Churches, addressing the universal need for community and spiritual life endure for the long term when others tire, drop out, or shift energies to other crises. Within the context of HIV/AIDS, churches typically work with smaller budgets and over longer time frames than secular agencies based on a realistic assessment of what is sustainable in the long term.

The substantial amounts of resources that churches contribute to support their activities is evidence of their sustainability and contrasts with programs implemented

by governments and NGOs funded mostly by taxpayer dollars. A study of the South African National AIDS Database examined 162 FBOs and found that donations were by far the major source of funding. Congregations stood out because they requested additional resources to meet the basic needs of their clients, an indication of their service mentality (Birdsall, 2005).

A Namibian study of 109 FBOs found that local donations constituted the majority of their resources for HIV/AIDS activities. Seventy-nine percent reported that they received no external funding whatsoever. Only seven respondents stated that they required funds for core support; the vast majority would like to see additional funds used to support orphans and vulnerable children, home-based care, and prevention activities (Yates, 2003). Many FBOs are unable to respond to increasing needs because they lack resources. There is urgent need for external agencies to develop mechanisms that "drip feed" FBO initiatives with appropriate levels of resources to enable them to increase their effectiveness and expand the scale of their responses (Foster, 2005).

Prevention. Religion is an important determinant of personal risk behavior. Churches have focused on promoting abstinence and marital faithfulness both for HIV prevention and for general well-being. Efforts by the faith sector are believed to have contributed to reductions in numbers of sexual partners, delayed onset of sexual debut, and stabilization of HIV prevalence in countries as diverse as Uganda, Senegal, Zimbabwe, Kenya and Jamaica (Green & Herling, 2007).

In Uganda, national HIV prevalence fell from around 15% in 1991 to 5% in 2001. The main behavior changes that occurred were a decrease in the number of sexual partners and an increase in monogamy and marital fidelity. In 1989, 41% of males and 23% of females had more than one sex partner; by 1995, these rates declined to 21% and 9% respectively. The proportion of young males (15-24) reporting premarital sex declined from 60% to 23% while for young females, premarital sex declined from 53% in 1989 to 16% in 1995. In 1995, about 6% of Ugandans used a condom with some regularity. Evidence suggests that the efforts of religious organizations and other opinion leaders in Uganda who advocated abstinence and fidelity contributed to the observed decline in HIV prevalence (Green, 2003).

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Religious leaders began working closely with the Ministry of Health in HIV prevention activities in the late 1980s. Religious groups stated that they wished to promote "fidelity" and "abstinence" while steering clear of condom promotion or distribution. At that time, many people working in AIDS prevention believed that it was unlikely that the promotion of abstinence and faithfulness would lead to reduction in HIV transmission. Nevertheless, grants were issued on the condition that faith-based organizations should agree not to criticize condom promotion being implemented by other groups. Two of the projects later became involved in some condom promotion activities. A project, implemented by the Anglican Church of Uganda in five of the 27 dioceses trained 863 leaders and 5,702 community health educators and distributed 1.2 million condoms in the first 18 months of activities. A United States Agency for International Development (USAID)-funded evaluation of sexual behavior change among those reached by the project found the proportion of adults reporting two or more sexual partners declined from 86% to 29% among men, and from 75% percent to 7%

among women while use of condoms rose from 9% to 12% (Green, 2003).

THE IMPORTANCE OF CHRISTIAN ADVOCACY EFFORTS FOR CHILDREN SUFFERING FROM THE HIV/AIDS EPIDEMIC

The enduring neglect of children in the context of HIV and AIDS has been perpetuated because children lack power and voice to defend their interests. Only 12% of households with orphans and vulnerable children received basic external support in an 18-country survey (UNICEF, 2008). Though it may appear contradictory, neglect of children affected by HIV and AIDS has resulted from the extent to which care and support is provided by family members, churches and surrounding communities. Governments, both rich and poor, have ignored obligations ratified in conventions to provide the necessary resources to ensure the social protection of children. It is shocking that vulnerable children must rely on the charity of the poor living in communities affected by HIV/AIDS who are required to go on subsidizing the destitute (Wilkinson-Maphosa et al., 2005; Foster, 2005).

This situation will continue until governments assume their coordinating, monitoring and backstopping responsibilities. There is evidence that African governments have started to assume some of these responsibilities (Foster, 2008). The establishment of national social protection schemes involving cash transfers to the most vulnerable households is gaining momentum and has the potential to alleviate suffering on a wide scale (JLICA, 2009). It is imperative that governments are brought into the center of responses to vulnerable children affected by HIV and AIDS.

The very large numbers of children in severely AIDS-affected countries whose poor living circumstances and limited access to services compromise their health and well-being justifies systems-based responses. The strategic approach is illustrated in the notional Figure 4 (Richter et al., 2006). This demonstrates that most children, the high arc of the curve, are doing reasonably well in health and development as relatively smaller numbers of children, on either side, are doing either very well or very badly. As a result of the HIV/AIDS epidemic, the health and well-being of increasing numbers of children are threatened – the shaded portion of the curve on the left hand side. This group includes other vulnerable children with disabilities, abused children, orphans without supportive family care, and abandoned and street children. In addition to efforts to help individual children, a strategic approach is to shift the whole curve to the right, through improved access to health, educa-

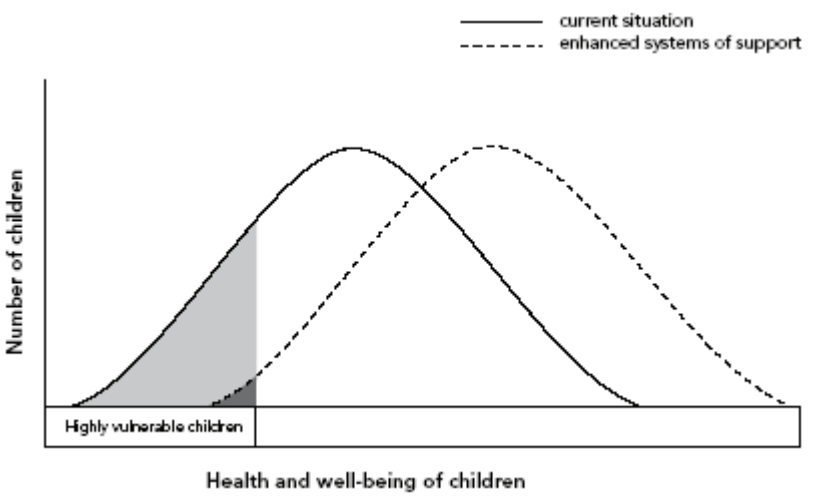

Figure 4: Universal curve shift to improve children's health and wellbeing (Richter et al., 2006)

tion and social services for all children in AIDS-affected countries. When the mean level of health and well-being of all children in the society is improved, the curve shifts to the right – and this, simultaneously, reduces the number of extremely vulnerable children who may need individual assistance.

Christian influence, leadership, and action in policy initiatives and advocacy concerning children affected by HIV/ AIDS are every bit as important as service initiatives. The modern church, currently entrenched in service provisions, must advocate for the rights of children in institutional care. The church must look critically at how international non-governmental organization funds, designated to aid affected children, are being used to benefit impoverished families. Given the church's significant provision of health care, services, and ministry in response to the sub-Saharan HIV/AIDS epidemic, those active in these ministries must look at holistic, systemic policies and programs that will improve the overall effectiveness of their work.

Christian engagement in health and child welfare in the West led some two millennia later to the establishment of national health and welfare systems that enabled the poor and vulnerable to be legally protected and obtain access to essential services.

Christian groups and individuals involved in providing services for children affected by HIV and AIDS in Africa need to expand into advocacy and policy initiatives, which have the potential to improve the living conditions for vastly larger numbers of children than are being reached by existing projects.

The current response throughout Africa by churches to the needs of children affected by HIV and AIDS is a vital stop-gap measure. But whether an individual child happens to receive charitable support and whether that support is adequate is serendipitous. Church involvement in HIV/AIDS policy reform can lead to benefits for many more children than are being reached by current initiatives.

Throughout history, when the church was involved in the charitable provision of child welfare and health services, Christians also realized the importance of advocacy for policy reform and systematized care. From Valentinian's call to end infanticide through to the Christian Medical Commission's drive for primary health, Christian advocacy initiatives eventually enabled many more people to benefit from health and social welfare provision than those reached by individual initiatives. Church engagement in health provision and child welfare reform over the centuries challenge the modern church to further alleviate the suffering of children affected by the HIV/AIDS epidemic by engaging in policy initiatives.

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African Proverbs

A deaf ear is followed by death and an ear that listens is followed by blessings. (Kenya)

The eyes of the wise person see through you. (Tanzania)

When God cooks, you don't see smoke. (Zambia)

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