

# Women and AIDS: A Global Crisis

Approved by the 213th General Assembly (2001)  
Presbyterian Church (U.S.A.)



**Developed by**  
**The Advocacy Committee for Women's Concerns**

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**A Ministry of the General Assembly Council**



# REPORT ON WOMEN AND AIDS: A GLOBAL CRISIS

APPROVED BY THE 213TH GENERAL ASSEMBLY (2001)  
PRESBYTERIAN CHURCH (U.S.A.)

The 213th General Assembly (2001):

1. Designate the year 2002 to 2003 to be a year of Global AIDS Pandemic Awareness in the church.
2. Urge all entities of the church to
  - a. pray for families, communities, and nations suffering from the epidemic;
  - b. consider generating funds for Extra Commitment Opportunities established to address the global AIDS epidemic and all funding entities to consider making AIDS a priority concern;
  - c. remember World AIDS Day on December 1.
3. Commend the Worldwide Ministries Division for
  - a. establishing two new mission personnel positions to address AIDS in Africa;
  - b. providing leadership to the cross-divisional PC(USA) strategy team in order to address the AIDS pandemic as it relates to our international partner churches;
  - c. its support of presbytery and ecumenical partnerships, in particular partnerships that strengthen AIDS ministries around the world;
  - d. participating in the World Health Organization's Massive Effort (a collaborative initiative with international agencies, private corporations, and nongovernmental organizations to address the diseases of poverty: Malaria, Tuberculosis, and HIV/AIDS).
4. Direct the Worldwide Ministries Division (WMD) to
  - a. support the administrative and programmatic needs of the two new WMD mission personnel positions that will address AIDS in Africa;
  - b. consider establishing a mission personnel position to assist churches working to address the AIDS epidemic in Southeast Asia, which may soon be at the epicenter of the epidemic;
  - c. support indigenous efforts, such as literacy, income generation, and other basic development projects that address underlying gender inequalities that intensify the epidemic and to do so in a culturally sensitive manner and to allocate resources in a just manner to men and women and addressing the unique needs of men and women and children;
  - d. establish funding for the provision of financial and technical support to indigenous efforts in all regions of the world that seek to develop programs and educational materials concerning gender inequalities that exacerbate the pandemic;

- e. facilitate local or regional gatherings of church women overseas who are working to address the AIDS pandemic and seek the opportunity to exchange information, receive additional training, and support one another's work, recognizing that women are valuable partners in addressing community concerns yet often lack political power and access to financial resources;
  - f. facilitate partnerships between Presbyterian women's groups in the United States and women's groups in partner churches and ecumenical organizations;
  - g. maintain a database of women's groups and partnerships between women's groups that are working to address gender inequalities and HIV/AIDS;
  - h. develop materials on the global pandemic and its gender dimensions to be sent out in the already established resource packet mailing for World AIDS Day;
  - i. consider establishing a two- to three-year staff position with International Health Ministries focusing on community- and congregation-based initiatives that target support for people infected and affected by HIV/AIDS and, in particular, orphans.
5. Request that the Worldwide Ministries Division AIDS Task Team and the Presbyterian United Nations Office host a consultation or educational event on the gender dimensions of the AIDS pandemic, and invite partner churches, ecumenical leaders, and faith-based women's organizations in different regions of the world to participate and help plan the event.
6. Encourage congregations and national and local AIDS networks to
  - a. educate their constituencies about the global pandemic by holding educational events or writing articles about the issue;
  - b. engage in advocacy efforts, such as the World Health Organization's (WHO) Massive Effort Against the Diseases of Poverty (Malaria, HIV/AIDS, and Tuberculosis) and to increase funding for prevention strategies and to make affordable medications available to countries in the developing world.
7. Direct the Stated Clerk to write a letter to the president of the United States, calling upon the United States government to allocate greater resources towards addressing the epidemic and poverty that fans it, as well as prevention and affordable treatment initiatives recommended according to the WHO Massive Effort, and to show flexibility regarding trade agreements and intellectual property rights so that life-saving drugs can be available to all affected populations.
8. Direct the Stated Clerk to write a letter to members of Congress, alerting them of the 213th General Assembly (2001)'s approval of "Women and AIDS: A Global Crisis" and how to obtain a copy.

9. Request the Presbyterian Washington Office and the Presbyterian UN Office to support advocacy efforts to address the massive effort against the diseases of poverty, and the need to make affordable medication available to countries in the developing world.
10. Commend the work of the Jubilee 2000 campaign in advocating for debt-relief programs and encourage Presbyterians to continue their work with this campaign.
11. Commend the United Nations, in particular UN AIDS, for its global leadership in addressing the epidemic.
12. Direct the Stated Clerk to write a letter to UN AIDS, commending their efforts and encouraging them to support faith-based initiatives that seek to curb the HIV/AIDS epidemic by teaching abstinence, being faithful in marriage, as well as the use of condoms as viable measures of HIV/AIDS support by churches in the developing world.

## **Rationale**

[Each year, the ACWC has the privilege of presenting an issue report to the General Assembly. This year (2001) the report, "Women and AIDS: A Global Crisis," prepared in close consultation with the Presbyterian United Nations Office and the AIDS Task Team of the Worldwide Ministries Division, provides a rationale for the recommendations found in the section of the Annual Report on Recommendations.]

### **I. Introduction**

A Presbyterian missionary in the Congo tells of a tragic story that illuminates the devastating impact of the AIDS pandemic. A Congolese doctor in a small town contracted the virus. He soon transmitted the virus to his wife. Both parents quickly died of the disease, leaving their seven children orphaned and the village without a doctor. The village, already lacking in resources, had little with which to support the orphaned children or the medical needs of villagers.

In South Africa, Mercy found out she was HIV-positive when she was pregnant with her second child. She had been married for five years and was faithful to her husband. She cried all the way home from the prenatal clinic, but was too afraid to tell anyone for nearly a year. When she finally did tell her husband, he beat her and threw her out of the house, refusing to believe it was he who gave her the virus. Her employers dismissed her that afternoon. "My story," she told a women's group, "is not just my story. If you talk to other women, you will hear 90 percent the same."

In India, Mala's husband, a minister who traveled often, infected her with the disease. She took care of him until he died, holding him in her arms as he breathed his last breath. Her mother-in-law then took her children from her, fearing they might become infected. Mala fell into depression, neglecting her health and appearance. One day, she

met a pastor of a church that had started a HIV/AIDS support group. Mala, who volunteers with an HIV/AIDS support group says, "I now feel valued." She is making a difference with her life by helping others.

These two real-life case studies illustrate how women are now at the center of the global AIDS pandemic and face unique challenges when coping with the disease, very often because they lack equal access to economic, political, and social power. Mala's situation demonstrates how churches can play a major role in saving communities from the disease.

This report seeks both to bring before the church the urgency of addressing the global HIV/AIDS epidemic, to draw attention to the unique needs of women and men at risk or infected by HIV/AIDS, and to address underlying gender inequalities in all societies that exacerbate the spread of HIV.

The PC(USA) General Assembly adopted a comprehensive report on the AIDS crisis in 1988. This policy, "To Meet AIDS with Grace and Truth," called the church "to maturity of proclamation, education, service, and advocacy in response to the human needs of persons who would otherwise be alone and alienated in their suffering" (*Minutes*, 1988, Part I, p. 362, paragraph 31.064). A 1986 "Resolution on Acquired Immune Deficiency Syndrome," adopted by the 198th General Assembly (1986) responded to the stigma attached to HIV/AIDS in the United States, declaring that AIDS was an illness, not punishment for behavior deemed immoral (*Minutes*, 1986, Part I, p. 496, paragraph 27.254).

Since this time, much has changed and new concerns have emerged. In 1988, the number of cases worldwide was 300,000, a small number when compared to today. At that time, small percentages of women had the disease, and gender aspects of its transmission were not examined.

The church, with its extensive outreach capabilities, ability to nurture human beings physically as well as spiritually, and as the voice of moral conscience in many societies, is in a unique position to promote health, to lift up hope, and to advocate for justice on behalf of those who are vulnerable.

## II. The Pandemic

In the United States, AIDS continues to present challenges—the numbers of new cases of HIV/AIDS are just as numerous as they were ten years ago. New cases in the United States are especially prevalent in communities disadvantaged by racial and gender inequalities. In the developing world, where poverty and disease are inextricably linked, the epidemic has had even more disastrous consequences.

Consider the following statistics:

## 1. Geographic

- Worldwide—Since AIDS emerged as a global concern two decades ago, 18.8 million people around the world have died of AIDS. The numbers of women dying continue to increase, accounting for an estimated 52 percent of adult deaths this year.<sup>1</sup> Worldwide, an estimated 34.3 million adults and children are living with AIDS or the virus, split almost equally between men and women. Of those living with HIV, 95 percent are in developing countries.
- Africa—24.5 million of those living with HIV/AIDS are in sub-Saharan Africa. In Africa, there are now sixteen countries in which more than one-tenth of the population aged 15 to 49 is infected with HIV. In seven countries, all in the southern cone of the continent, at least one adult in five is living with the virus. In Botswana, a shocking 35.8 percent of adults are now infected with HIV. In South Africa, 20 percent are infected.
- Asia —Trends in infection rates in Africa indicate that AIDS deaths in Asia will mirror those of Africa unless drastic actions are taken soon. In East Asia and Pacific, 530,000 are infected; in South and Southeast Asia, 5.6 million are infected.
- Caribbean—Some islands in the Caribbean have worse epidemics than any other country in the world outside of sub-Saharan Africa. Official estimates put the number of HIV and AIDS cases at 360,000, but many health experts believe the number exceeds 500,000.<sup>2</sup> In Haiti, where the spread of HIV may have been fueled by decades of instability and conflict, more than 5 percent of adults are living with HIV.<sup>3</sup> In the Bahamas, the adult prevalence rate is more than 4 percent. In the Dominican Republic, one adult in forty is HIV-infected.
- Latin America—In Latin America, 1.4 million adults and children are living with HIV/AIDS.
- Eastern Europe—HIV is spreading rapidly in Eastern Europe, mainly due to the growing number of intravenous drug users, a problem fueled by socioeconomic instability. Some predict that one million Russians will be infected with HIV within two years.<sup>4</sup>
- North America—The world's wealthiest countries are becoming too complacent about HIV/AIDS. There are as many new infections in North America and Western Europe today as there were ten years ago. Researchers predict 45,000 new cases this year in North America and 30,000 in Western Europe.

Poverty prevents governments and individuals from being able to curtail the spread of the epidemic. The epidemic, in turn, ravages societies and economies, leading to greater poverty and increasing levels of human suffering. The impact of AIDS in the

world's hardest hit regions, particularly sub-Saharan Africa, is reversing years of development. The epidemic poses acute danger to development in sub-Saharan Africa, but is a rapidly growing threat in Asia and the Caribbean, and a probable threat in many Eastern European countries as well. According to the World Health Organization, HIV/AIDS is the "fastest growing threat to development today."<sup>5</sup> The following statistics paint a picture of how the epidemic threatens to unravel communities, nations, even entire regions.

## 2. Education

- Since the AIDS epidemic began, 13.2 million children, 95 percent of them in Africa, have lost their mother or both parents to AIDS while they were under the age of fifteen. In Zimbabwe, 48 percent of orphans or primary-school age had dropped out of school. Not one orphan of secondary school age was still in school. In urban areas of Cote d'Ivoire, spending on school education fell by half.
- AIDS is eroding the supply of teachers. During the first ten months of 1998, Zambia lost 1,300 teachers, equivalent to two-thirds of the new teachers the country trains each year.

## 3. Economy

- The gross domestic product in Jamaica could be reduced by 6.4 percent and in Trinidad and Tobago by 4.2 percent by 2005.
- Kenya's Gross Domestic product (GDP) will be 14.5 percent smaller than it would have been had AIDS never occurred.
- Agricultural production in Zimbabwe, where 2,000 people die each week of AIDS, is falling. Businesses are going bankrupt because of the deaths of educated and skilled staff members.

## 4. Life Expectancy

- More than twenty-nine years in life expectancy in Africa had been gained in recent years. In many countries, this will be lost by the year 2010.
- In Zambia the life expectancy has fallen from 54 years of age to 43 in the last ten years.

So devastating is the epidemic in Africa, the United Nations Security Council in January 2000 declared the epidemic to be an international security issue, because the problem could decimate the economic, political, and military establishment of many countries. Said World Bank Director James D. Wolfensohn, the epidemic "is being more effective than war in destabilizing countries."<sup>6</sup>



### III. HIV as a Gender Issue

People in the United States first became aware of HIV/AIDS as a disease found largely in the White male population, in homosexuals and drug users. This picture of the epidemic is no longer accurate in the United States or, clearly, worldwide.

In the United States during the past decade, the proportion of all AIDS cases reported among adult and adolescent women more than tripled, from 7 percent in 1985 to 22 percent in 1997 according to the Center for Disease Control. Today, about one out of every three persons found to have HIV infection in the United States is a woman. The epidemic has increased most dramatically among women of color. African American and Hispanic women together represent less than one-fourth of all United States women, yet they account for more than three-fourths (77 percent) of AIDS cases reported to date among women in the United States.<sup>7</sup> The third leading cause of death in African American women aged 25–44 in 1998 was HIV/AIDS. So severe is the situation in some areas, Pandora Singleton, executive director of Project Azuka and treasurer for the National Minority AIDS Council, claims, “This is what I remember Africa looking like before the epidemic took hold there. I see people dying in the prime of their lives, so we’re losing valuable and needed skills. Children are being orphaned. . . . I would like to see us be more proactive, especially with young women.”<sup>8</sup>

Poverty fuels the epidemic in the United States as in other parts of the world, and the majority of the world’s poor are women. Many poor women cannot afford to give much attention to preventative care and do not have access to important health information. Women frequently place the needs of their families first and their own needs second, which may delay early diagnosis. Systemic racism helps create and perpetuate cycles of poverty and is a factor in why many communities are neglected by government agencies. Health-care programs are often slow to offer assistance or even identify problems that emerge in disadvantaged communities. In addition, the focus of AIDS research and surveillance has only recently shifted to include women and minorities. In fact, no research was conducted until the early 1990s to determine indicators of the virus in women, its progression, and methods of prevention and treatment. In addition to these challenges, the stigma associated with AIDS leads most communities to remain in denial for a period of time before they begin to organize and address needs.

Today, the World Health Organization estimates that worldwide almost half of all newly infected adults are women, many of them living in Africa, and increasing numbers in Asia. In sub-Saharan Africa, more women than men are infected.<sup>9</sup> More than 70 percent of HIV infections worldwide occur through sex between men and women (10 percent of HIV infections occur through sex between men and 5 percent among people who inject drugs). The overwhelming majority of women at high risk of infection in many countries are wives who are contracting the disease from their husbands.

How is it that women worldwide have been placed at the center of the epidemic? According to United Nations studies, differences in the way men and women are socialized, and the inequalities built on these gender roles have made it easier for the disease to spread further and faster.<sup>10</sup> In most countries, women are taught that they

must obey their husbands at all costs, even if that means putting themselves at risk for a fatal disease. Women, especially young women, generally lack the social power to set the terms of sexual relationships. Societies often teach men that they are more masculine or virile if they have multiple sex partners. Men are socialized to believe that using condoms is not masculine or encourages infidelity in their wives. A high percentage of sexual violence in many countries places women at further risk. One study in India reports that 60 percent of the 13- to 15-year-olds studied had been victims of sexual abuse. During war, women are especially vulnerable to sexual violence.

Cultural myths in most countries, such as the belief that promiscuity is a sign of masculinity, fuel the demand for prostitutes. The myth that having sex with virgins cures HIV/AIDS or gives a man strength drives the demand for younger girls, many of whom are sold into sexual slavery. Poverty, lack of job possibilities, violence in the home, and war are several factors that force many women to sell sex to survive. In impoverished countries, the search for work often separates families. For example, thousands of men leave villages to labor in mines that have no place for families. Each mining camp has a nearby supply of women sex workers who are also there out of economic desperation. Armed conflict also separates men and boys from families for long periods. During armed conflict, the rate of sexual violence increases, increasing the chance women will become infected with the virus.

Taboos about discussing sex exist in most cultures and prevent many, especially women and girls, from learning how to protect themselves. The high social value placed on virginity in unmarried girls may pressure parents and the community to keep young women ignorant about sexual matters. Female ignorance of sexual matters is often viewed as a sign of purity and innocence, while young women who know "too much" may be seen as "loose." In the vast majority of countries, educating girls is often a lower priority than educating boys. Therefore, female literacy is still low in many countries, and young women therefore have less access to health information. When women are socialized to be timid about discussing issues around sexuality, they are often fearful of discussing with health workers illnesses related to sex. This leads many women to avoid diagnosis and treatment.

As the numbers of women contracting HIV began to rapidly increase, distinct symptoms of the infection and women were initially missed because health-care workers in all parts of the world have been taught to identify the disease in White male patients. For example, the case definition of AIDS originally issued by the United States Center of Disease Control and used worldwide focused on marker diseases that were characteristic of HIV-related illnesses in men and omitted conditions found in women.

In addition to the inequalities between women and men, women are also biologically more vulnerable. Women have a larger mucosal surface exposed during sexual intercourse. Women may also face the agony of passing their disease along to their children during pregnancy. Up to one third of infants born to infected mothers may be HIV positive.

Women, because of their roles as caregivers in most societies, usually are the ones to provide care to family and community members with the disease. Because of this very same reason, say experts, women are also less likely to receive the kind of care and support made available to male household members. When a male head of household dies from AIDS, women may be ostracized by extended families and their communities, which leads them to become destitute. Gender discrimination in many societies prevents single women from taking care of themselves, as they are denied the right to legal protection, to inherit land and property, to work outside the home, or to receive education and job training. The widow of a victim of AIDS cannot easily remarry.

Women are not just victims of the pandemic, however. They are at the front lines of giving care to victims, educating communities, and advocating for stronger action on the part of community leaders. For instance, a recent study in South Africa revealed that 99 percent of the initiative and work done in all the churches to respond to the AIDS pandemic is being done by women.<sup>11</sup> Women often lead such efforts without access to funding networks and decision-making bodies. To address this issue, AFRUS-AIDS—a unique coalition of church organizations, United Nations experts, and other outreach organizations—has formed to help channel resources to women of faith at the grassroots level.

#### IV. Global Inequalities and the Epidemic

Global inequalities have also contributed to the devastation of the epidemic. Countries in the northern hemisphere have access to antiretroviral treatments (ARVs) and other drugs that lengthen the lives of those infected and lessen the ability of the disease to spread. Countries in other parts of the world lack access to these drugs and other cheap, essential drugs for treatment and prevention of common HIV-related illnesses. This situation prompted Dr. Gro Brundtland, director of the World Health Organization to point out “the drugs are in the North and the disease is in the South.”<sup>12</sup>

The AIDS crisis has illuminated the tensions that arise between the corporate quest for profits and immense human need. Consider the following ironies. In July 2000, Nevirapine, which prevents mother-to-child transmission of HIV (the virus that causes AIDS) costs \$430 per 100 units in Norway, where there is little market for it. In Kenya, where the need is desperate, it costs \$874. The drug fluconazole, patented by the drug company Pfizer, Inc., treats cryptococcal meningitis, an AIDS complication that rapidly kills those infected. In Kenya, the drug costs \$18 per pill. A cheaper, generic version of the drug is made in Thailand. It costs only 60 cents per pill. Still in some countries, only a small percentage of people, typically those in urban areas and who are in the upper class, will be able to afford medicine at that cost. Reducing the price of medications may not benefit the poorest of the poor, which always includes women and children, unless government agencies and humanitarian organizations are willing and able to purchase medications and provide them free of charge.

Why the difference in price? Governments, in particular the United States government, often have a vested interest in protecting the profits of the pharmaceutical industry. Drug companies work closely with the United States Trade Representative (USTR) to make sure their interests are protected. The United States government has pressed other countries to pass patent and copyright laws more restrictive than its own to protect American corporations against piracy. Such laws sometimes prevent countries from importing or producing generic versions of the drug, which are cheaper.

Corporate interests were further strengthened in a 1995 World Trade Organization (WTO) agreement called the Trade Related Aspects of Intellectual Property (TRIPS). The TRIPS agreement goes much further than earlier intellectual property agreements. It requires all prospective or current WTO members to set up twenty-year patents in all industrial fields (including pharmaceutical) for both products and manufacturing processes. The United States pharmaceutical industry lobbied heavily for a strict TRIPS agreement to protect their profits. While the agreement protects intellectual property rights, it restricts the ability of countries to produce essential drugs at a price people can afford.

Countries that do not comply potentially face heavy sanctions. For example, in 1997 when South Africa tried to pass a law allowing the health minister to ignore the South African Patents Act in the case of a health crisis such as AIDS, the United States Commerce Department put South Africa on a watch list that is the first step toward sanctions. A bill went through Congress making all American aid to South Africa contingent on dropping the law.

Due to the efforts of religious groups and community activists, the United States government has gradually started to balance drug company interests and the lives of those suffering from the worst epidemic since the bubonic plague. In December 1999, the United States softened its stance towards South Africa, saying that it would not object if South Africa violated American law in seeking AIDS medications. In May 2000, President Clinton signed an executive order affording sub-Saharan governments flexibility to bring life-saving drugs to affected populations. The order said that the United States will not invoke U.S. trade laws concerning patents, but will instead hold sub-Saharan countries "to the less stringent standard of a World Trade Organization agreement on intellectual property protection."

These measures, while helpful, do not fully address the crisis and are subject to change under new administrations or in the face of new pressures. Other countries are in need of the privileges granted to South Africa and sub-Saharan countries. In an effort to circumvent the production of generic versions of drugs, pharmaceutical companies have offered to donate drugs and money. Experts state that donations are only temporary solutions, are not large enough to address the problem, and keep countries dependent on Western drug companies.

Countries have also pointed out that debt service payments of the nations most affected by the epidemic far exceed government health-care budgets. For instance, according to the United Nations Human Development Report and World Bank data:

Uganda spends 1.6 percent of its GDP on health and 2.4 percent on foreign debt service; Zimbabwe spends 3.2 percent of GDP on health and 10.3 on foreign debt service. Malawi has appealed to its creditors to provide debt relief, saying that it will use the freed-up monies to combat the epidemic. The Jubilee 2000 campaign for debt relief has increased awareness of the importance of canceling the debts of the world's poorest nations and channeling those funds into health care and education.

Funds available for HIV/AIDS are pitifully small. National governments must allocate enough money to deal with the size of the epidemic. However, international resources must also be made available to combat HIV/AIDS. Rather than increasing the amount dedicated to the epidemic, government contributions to development agency funds for AIDS programs were more than halved between 1988 and 1997.

## V. Addressing Gender Injustices

Much can be done to address gender inequalities that help drive the AIDS epidemic. Those working to address the epidemic can seek to empower women with accurate information on the epidemic and make sure that women have equal access to resources given to fight the epidemic. Laws regarding sexual and domestic violence need to be enforced. Community education programs can address social norms that enforce male dominance and female submission. Laws guaranteeing economic and education rights for women can be drafted and enforced. More research needs to be conducted to determine indicators of the virus in women, its progression, and methods of prevention and treatment.

On October 5, 2000, Dr. Gro Harlem Brundtland, director-general of the World Health Organization, made the following observations:

Poverty is the underlying obstacle to human well-being. Despite the unprecedented prosperity and quality of life enjoyed in large parts of the world, 1.2 billion people survive on less than one dollar a day and another 1.3 billion scrape out a living on less than two dollars a day. . . . For poor people, becoming ill frequently means becoming poorer. . . . During the early 1990s, the world began to accept that there is a complex, but close-knit relationship between health and poverty. Being poor is bad for your health.

This is particularly true for women who are often forced by poverty to engage in sexual activities that put them at risk for HIV infection. Recent data clearly demonstrates the extent to which ill health is impacting on the economy of some communities and nations, particularly in Africa. The data shows that a few diseases, such as malaria, HIV/AIDS, and tuberculosis significantly obstruct the economic growth of poor countries. Health prevention and affordable treatment interventions can dramatically reduce mortality from these three main killers. The World Health Organization has subsequently launched the project entitled "Massive Effort," which aims to decrease malaria deaths by 50 percent, TB deaths by 50 percent, and AIDS deaths by 25 percent

over the next ten years. Campaigns as these should significantly decrease the mortality of AIDS in women directly as they implement HIV-prevention strategies targeted at women and indirectly as they improve the overall economic status of these nations.

Applying a gender lens to the epidemic ensures that the unique needs of both men and women are met. The UNAIDS World AIDS Campaign 2000 focused on the theme "Men Make a Difference." The program noted that men and women alike are harmed by social and cultural factors that lead men to participate in risky behavior. The UNAIDS established programs that could help men be better able to protect themselves and their families. Researchers found that men need places they can talk about sex and sexually transmitted diseases without fear of scorn or censure. Having made this observation, an AIDS project in Botswana, for example, was able to reach 2,000 men in shebeens (bars) to talk about issues such as ambivalence to condom use and improved communication between couples. Many communities have begun to ask what they can do to prevent boys and men from being violent to women.

Partnerships between churches in the United States and in countries where the pandemic is strong have proven successful. The Presbytery of New York has developed a strong relationship with a presbytery in South Africa, in particular with the local women's group. The South African women's group is struggling to educate its community about the pandemic and to support those living with HIV/AIDS. The Presbytery of New York brought the women's group to the United States to meet with church entities and other organizations to form stronger partnerships that would further strengthen their work.

## VI. The Role of the Church

Taboos about sex and death prevent many societies from educating people about the epidemic. Education is one of the strongest deterrents available. The epidemic cannot be curbed unless community leaders, including religious leaders, work to remove the stigma and resultant discrimination associated with the disease. Churches, as the voice of moral conscience in many cultures, can be especially helpful in removing the stigma attached to AIDS in every country. Jesus set the example by associating with those in society that others considered to be sinful, unclean, and unworthy. He dined with tax collectors, the poor, lepers, and prostitutes. Church leaders follow in Jesus' footsteps when they reach out to those with AIDS and seek to prevent the spread of HIV.

The church can be, and in many cases has been, a leader in addressing the epidemic. Churches can communicate with large numbers of people about sensitive issues of life, death, and sexuality. In communities with little infrastructure, churches are especially adept at mobilizing resources and people. The Church of Uganda is involved in nearly all of Uganda's national programs on HIV/AIDS prevention, counseling, and care. The church supports orphans and widows, and educates youth about the epidemic. The Ethiopian Evangelical Church, Mekane Yesus, is targeting "bar ladies" and doing counseling, income generation, and job training with them. The Churches Medical Association (CMA) of Zambia is providing a counseling course for AIDS activists and church leaders. The program is funded with help from UNAIDS. The CMA has been

successful in changing sexual behavior and traditional practices that exacerbate the epidemic, such as wife inheritance, the practice in which a widow is given to her deceased husband's brother. If the husband died of AIDS, his wife may have the disease and pass it on to her new husband.

In December 2000 religious leaders met with the White House and the United States Agency for International Development to talk about the role of faith communities in combating HIV/AIDS. The conference was inspired in part by the work of the United Methodist Church in Zimbabwe, where as many as one in four people are infected.

Sometimes religious leaders prevent education about the epidemic from occurring due to religious beliefs about sex and morality. Despite numerous studies that indicate that sexual activity outside marriage declines when sex education is available, religious leaders mistakenly assert that education will lead to immoral behavior. Many religious leaders have prevented the distribution of condoms for the same reasons. Religious leaders sometimes stigmatize victims of the epidemic as being immoral, which often leads to their being ostracized and neglected by their communities, families, and churches. Attaching a stigma to the disease also prevents people from seeking help, getting tested, and informing themselves and their loved ones about the virus.

Many religious leaders who initially were uncomfortable advocating the use of condoms as the main method of preventing HIV felt isolated from international efforts at HIV/AIDS prevention. As the international community has increasingly understood the value of focusing on abstinence and marital fidelity as effective methods of prevention, many churches have become more willing to participate in the global effort to prevent HIV/AIDS. Churches once timid about discussing issues related to sex have now found an entry point through which to discuss the issue.

Churches everywhere can play a critical role in addressing the epidemic by teaching abstinence, fidelity in marriage, and the use of condoms. The church has a powerful role to play in bringing an end to this disastrous epidemic.

## VII. Working in Partnership

The struggle to deal with the AIDS epidemic raises complex issues about how those who live in wealthy, powerful countries such as the United States can support the efforts of people in less powerful countries while avoiding paternalism and arrogance. Forming genuine, non-colonialistic relationships with partner churches in other regions of the world has been challenging due to a long history of Western cultural, economic, and political imperialism. When a subject as sensitive as AIDS or gender inequality arises, it can exacerbate old suspicions and frustrations. Also, racist myths and stereotypes about AIDS persist, especially in the United States and understandably make some reluctant to draw attention to the issue. For instance, the media most often portrays Africa in a negative light, seldom highlighting successes on the continent.

The Reverend Dr. Leon Spencer, executive director of the Washington Office on Africa, highlighted guidelines for partnership in a recent article addressing the epidemic.

Spencer highlights Jesus' example when he questioned the blind Bartimaeus—"What is it that you want me to do for you?" Spencer observes that Jesus permitted the blind man to define his own needs and agenda. Spencer cautions, however, that just as relationships between partners should not be defined by power, as has too often been the case, then neither should partnership be defined by a seemingly well-intentioned silence. True partnership involves being able to engage in dialogue and constructive debate when necessary. In a healthy relationship, partners do not hide or withhold life-saving information and constructive criticism must be a two-way street. Says Spencer, "For the Western churches to yield their convictions to an alternative African agenda is as mistaken, from the standpoint of ethics of authentic relationship, as it would be to insist on a specific course of action by their African partners."<sup>13</sup> Still, efforts to help churches in need in other countries must be done in a culturally sensitive manner. Ultimately, efforts to address problems in any culture will be more successful when led by people within that culture.

Leaders in the global women's movement have to wrestle with the tension of how to respect culture, while at the same time advocating for human rights for women. Indian women's rights scholar and advocate Arati Rao has stated, "no social group has suffered greater violation of human rights in the name of culture than women." Women leaders in all parts of the world assert that violations of women's rights are not cultural, they are criminal. These leaders have also taught Western women's rights activists that they must confront racism and cultural imperialism, still present within the women's movement itself. Women in dominant cultures are being challenged to bring to the fore the perspectives of women from the developing world. This process has helped to strengthen the movement for women's rights.

#### VIII. The United Nations' Response

From 1986, the World Health Organization (WHO), a UN-affiliated agency, had the lead responsibility on AIDS in the United Nations. By the mid-1990s, it became clear that the relentless spread of HIV and its impact on all aspects of human lives and on development were creating an emergency that would require an expanded effort. To address these challenges, the UN in 1996 drew six organizations together in a joint and cosponsored program. Besides the World Health Organization, the other original cosponsors are the UN Fund for Children (UNICEF); the UN Development Program (UNDP); the UN Educational, Scientific, and Cultural Organization (UNESCO); the World Health Organization; and the World Bank. The Joint United Nations Program on HIV/AIDS (UNAIDS) is the leading advocate for worldwide action against HIV/AIDS. The UNAIDS has a budget of 60 million dollars and a staff of 129 professionals. It operates as a catalyst and coordinator of action on AIDS, rather than as a direct funding or implementing agency. The UNAIDS materials and programs apply a gender lens to the epidemic. In addition, the World Health Organization is starting the Massive Effort against the "diseases of poverty": malaria, tuberculosis, and HIV/AIDS. The Massive Effort is a collaborative effort with international agencies, private corporations, and nongovernmental organizations, including those that are faith-based..



When the United Nations General Assembly met in June 2000 to review progress made towards advancing the status of women, the United Nations highlighted the AIDS epidemic as one of the major emerging issues threatening women's progress. In March 2001, the UN Commission on the Status of Women will meet to monitor the progress of implementation of the Platform for Action agreed to by 189 nations at the UN Fourth World Conference on Women held in 1995. The commission has identified AIDS as one of two major issues to be the focus of the meeting. The UN Fund for Women (UNIFEM) established an AIDS program to help conduct gender analysis of the epidemic and establish programs to ensure that the needs of women were being met.

## IX. Conclusion

Jesus demonstrated the love of God by embracing those who had been ostracized because of illness or social status. While others in society blamed them as having brought illness on themselves because of sinful behavior and ostracized them from community and aid, Jesus embraced them and healed them. He dined with lepers. He healed the woman with an issue of blood. He made the blind see again. The church shows forth Jesus Christ when it ministers to and with some of the most rejected people in the world: people living with HIV/AIDS. Jesus also revealed the spirit of God working to free us from the bonds of sin embraced by our culture. Jesus shows how his disciples are called to struggle with that which prevents us from reaching out to those in need—whether it be racism, sexism, fear, or judgement.

As Disciples of Christ who make up the church, we receive the exciting invitation to follow in Jesus' footsteps. Now is the time for the church to follow those footsteps and set a powerful example for the rest of the world. God is continually at work with people in all cultures, transforming us so that we reflect God's good will and purpose. May God fill us with compassion that moves us to action, and wisdom to know how best to offer our loving support to those in need.

## X. Endnotes

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2. David Gonzalez. "Caribbean, Badly Hurt, Is Promised Help on AIDS." *The New York Times*. September 13, 2000. [www.nytimes.com/2000/09/13/world/13Cari.html](http://www.nytimes.com/2000/09/13/world/13Cari.html).
3. UN AIDS. p. 8.
4. UN Wire. "HIV/AIDS: New UN Report Shows Rapid Spread in Eastern Europe" [www.unfoundation.org](http://www.unfoundation.org). November 28, 2000.
5. *WHO's Initiative on HIV/AIDS and Sexually Transmitted Infections*, World Health Organization, May 2000 (WHO/HSI/00.3). p. 1.
6. Barbara Crossett. "Gore Presides Over Rare Security Council Debate on AIDS," *New York Times*. Tuesday, January 11, 2000.
7. According to the Center for Disease Control, in 1997, African American women represented 60 percent of the 13,105 United States women reported with AIDS in 1997; 20 percent of the total number of cases reported were Hispanic; 19 percent were Caucasian; and less than 1 percent of the cases were diagnosed in Asia/Pacific and American Indian/Alaska Native women.
8. Cox News Service. "Conference will address AID's Grip on Black Women." September 29, 2000. Taken from [www.intelihealth.com/IH/ihIH/WSSNP001/333/8013/299105.html](http://www.intelihealth.com/IH/ihIH/WSSNP001/333/8013/299105.html). January 5, 2000.
9. *WHO's Initiative on HIV/AIDS and Sexually Transmitted Infections*, World Health Organization, May 2000 (WHO/HSI/00.3). p. 1.
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11. Joe Mdhlela and Albert Nolan. "Women Take the Initiative in AIDS Ministries," *Challenge*. South Africa. August/September 2000 (number 61).
12. January 2000.
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