

# FASTENOPFERPOLICYSTATEMENT



HIV/AIDS | Mainstreaming

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***'Friends, to keep it brief: AIDS has re-written the rules.'***

Peter Piot, UNAIDS executive director at the World AIDS Conference 2004

***'HIV has become a problem of the excluded.'***

Jonathan Mann, 1998, former Head of the WHO-AIDS-Programme



Source: iStockphoto

## 1 Introduction

### The relevance of HIV/AIDS for development

HIV/AIDS has a huge impact on development – more than any other disease. The pandemic threatens the stability and chances of development in the countries of the South, given that more than 8,000 people die every day worldwide from the effects of the viral disease, and day after day, approx. 18,000 people become newly infected.

In 2010, 33.4 million people worldwide were infected with the virus, of whom 90 per cent live in the countries of the South.<sup>1</sup> Roughly half of all HIV infections affect young people between the age of 15 and 24, and there are more than 14 million AIDS orphans living in Africa.<sup>2</sup> Taking a long view, experts assume that the pandemic is only at the early stage globally.

Poverty and disease reinforce each other. HIV/AIDS affects poor population groups most severely, and their socio-economic situation is made worse by the disease. Economic productivity – especially in agriculture – declines drastically and government structures and institutions, above all the education and health sectors, are severely weakened. The impact of the viral disease is one contributing factor in social conflicts, and explains why whole

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<sup>1</sup> In 2008, according to estimates by [unaids.org](http://unaids.org), 28.04.2010

<sup>2</sup> According to WHO: status at the end of 2008, and according to estimates by UNAIDS (AIDS epidemic update, 2009)

regions no longer have secure access to food.<sup>3</sup> HIV/AIDS leaves huge gaps in the workplace, well-educated people die, knowledge is lost, and progress is set back by many years. To make the situation worse, the group most affected is the (re)productive generation (age 15-49). Life expectancy is dramatically reduced due to the disease – in many regions of Africa and Asia by 20 years! This leads to massive changes in the population structures. A small number of young adults or grandparents are having to care for a growing number of children, sick people and older people.

While it has been possible to curb the spread of the disease in the Western industrialised countries through the use of antiretroviral drugs (ART), and to improve the quality of life of those affected, this therapy is only available to just 5% of patients in the countries of the South. Accordingly, the mortality rate in those countries is dramatically higher.

HIV/AIDS is thus simultaneously the cause and the consequence of poverty. That is why poverty reduction is a fundamental precondition for fighting the viral disease and vice versa.

HIV/AIDS poses a major challenge for international development cooperation, since the pandemic affects not only the health sector but touches on all areas of life. The subject also poses a challenge for Fastenopfer as a Catholic organisation, in that it is caught between the official position of the Catholic Church and the practical experience of the partner organisations. Nonetheless, against the background of the pandemic's relevance to development, Fastenopfer has decided to take on board the full implications of HIV/AIDS for the work in the programme countries and to define it as a strategic guideline. This policy statement serves as an operational guideline for implementation in the affected project areas.

The policy statement was approved by the Board on 1.3.2011 as the basis for implementing the strategic guideline on HIV/AIDS.

## 2 Context and key issues

### 2.1 Terms

AIDS was first recognised as a distinct disease that takes the form of a pandemic on 1 December 1981. This day has since been marked as World AIDS Day.

**AIDS** or **Acquired Immune Deficiency Syndrome** is the name for a specific combination of symptoms which, after infection with **HIV (Human Immunodeficiency Virus)** can weaken the immune system to a fatal degree. So HIV is the virus and AIDS is the disease. People suffering from HIV are susceptible to life-threatening opportunistic infections<sup>4</sup> and tumours. Antiretroviral drugs, which extend the life expectancy of people infected with HIV, can be administered as early as during the symptom-free latency phase, which may last several

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<sup>3</sup> See the Fastenopfer Policy Statement 'Securing basic needs – Promoting access to resources.' 2009

<sup>4</sup> Opportunistic pathogens are bacteria, fungi, viruses and parasites which exploit a primary illness and the resulting depleted condition of the body (above all the immune system) and cause an opportunistic infection. They also use the opportunity (Latin *opportunitas*) to multiply while the sick person is suffering immune deficiency. (Wikipedia, 10.10.2010).

years. However, a complete cure is not possible, because the HI viruses cannot be completely eliminated from the body.<sup>5</sup>

The HI virus is transmitted through contact with bodily fluids such as blood, semen, vaginal secretions and mother's milk. Consequently, the **risk** of becoming infected with **HIV** is determined by individual behaviour and by specific situations. This includes, for example, sexual intercourse with multiple partners, unprotected sex, or failure to treat sexually transmitted diseases. For intravenous drug users, the use of contaminated needles also presents a risk. Further risks of infection are inherent in blood transfusion, mother-child transmission before or during birth and during breastfeeding.

**HIV-Vulnerability** is defined as the individual and / or collective inability to control the risk of infection – which does not depend on individual behaviour. This refers to factors such as poverty, war, illiteracy, gender inequality, being a refugee, migration as well as living in rural areas with limited access to health systems or education.

**Impact** is defined as the long-term changes caused by HIV/AIDS at the individual level, the community level and the level of society as a whole.<sup>6</sup>

**Mainstreaming** aims to address and, as far as possible also integrate, the key issue of HIV/AIDS at all levels and in all processes of an organisation.

## 2.2 The importance of HIV/AIDS – mainstreaming for Fastenopfer's work

UN-AIDS defines HIV/AIDS mainstreaming as a 'process that enables development actors to address the causes and effects of HIV/AIDS in an effective and sustained manner, both in their day-to-day project and programme work and in their own workplace'.

In the international context, it becomes clear that HIV/AIDS mainstreaming is necessary because virtually all project work takes place in a context which is more or less severely affected by the disease. Mainstreaming therefore means that programmes and projects that are particularly gravely affected by the issue are analysed through 'HIV/AIDS glasses' and activities are adapted to the reality. There is no standard approach to HIV/AIDS mainstreaming. Different methodological approaches need to be adapted to the specific cultural background and the local status of the pandemic. A culturally sensitive approach is therefore the key factor of successful mainstreaming.

But it would be wrong to believe that mainstreaming HIV/AIDS also means that all coordinators and programme and project officers have to be trained as HIV/AIDS experts. The aim is not to forcibly integrate the issue into all programmes where this is not necessary, nor should all projects be compelled to demonstrate an HIV/AIDS component. However, for serious HIV mainstreaming it is not sufficient to engage in short-term awareness-raising of the partner organisations and thereafter get back to 'business as usual'.

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<sup>5</sup> based on Wikipedia, 27.04.2010.

<sup>6</sup> based on DEZA, 2004: "Mainstreaming HIV/AIDS in Practice".

### 3 Basic positions and approaches adopted by Fastenopfer

Although Fastenopfer does not work directly in the health sector and is not intending to support pure HIV/AIDS projects in the future, the central concerns of the organisation, such as poverty reduction, ensuring food sovereignty, gender equality, faith and justice, respect for human dignity and the protection of human rights are of fundamental importance for the HIV/AIDS work in the programme countries.

In adapting the existing programmes and projects to the challenges posed by HIV/AIDS, Fastenopfer supports the following basic positions:

#### 3.1 HIV/AIDS and the Millennium Development Goals

Less than five years remain in which to achieve the Millennium Development Goals. Goal 6 addresses combating HIV/AIDS, malaria, tuberculosis and other poverty-related diseases. By 2015, it aims to have halted and begun to reverse the spread of HIV/AIDS globally. In view of the actual facts, it is perhaps time to admit that these ambitious goals are rather unrealistic, and are unlikely to be achieved. It means that governments and NGOs must think beyond 2015 and develop a comprehensive approach to reducing poverty and achieving the right to health for all. Thus, the 18<sup>th</sup> International Aids Conference in Vienna (18.-23.7.2010) emphasized the importance of human rights in the fight against HIV/AIDS. More than 13,000 participants signed the *Vienna Declaration*, demanding that governments provide more funds for the fight against AIDS, in order to achieve the *Millennium Development Goals 6A/6B* (halting the spread of HIV/AIDS by 2015 and providing access to therapies for all people by 2010) as soon as possible.

The creation of the Global Fund is another clear sign of international efforts to get the pandemic under control. It is a financing institution to fight the three major infectious diseases, AIDS, tuberculosis and malaria. The Global Fund was established in 2001 after the G8 summit in Genoa, with the aim of ensuring medical supplies and campaigning to stop international patents from blocking the production of cheaper generic drugs. Today, the Fund is active in 144 countries. However, despite the funds contributed so far, amounting to around 19 billion US dollars, an ever widening gap is developing due to the growing need for funding and the discrepancy between promised and actually invested money. If patients hitherto supplied with drugs had to discontinue their AIDS treatment, this could lead to the development of drug resistance. The UNAIDS general secretary, Michel Sidibé, describes this prospect as an 'HIV nightmare'.

- Fastenopfer is involved in work to ensure that the MDGs can nevertheless still be achieved. It does this through committed lobbying on the one hand, and through its practical project work in the countries of the South on the other hand.

In the context of South Africa, where a particularly large proportion of the population is existentially threatened by HIV/AIDS, two Fastenopfer partner organisations are committed to work for the food sovereignty of HIV/AIDS sufferers. The UMTATHI organisation ensures the food supply for AIDS-sufferers by creating kitchen gardens. They are designed to ensure a healthy and balanced diet for the individuals who are already weakened. The partner organisation DELTA also backs community-building projects such as kitchen gardens, whose purpose is to secure the nutrition of AIDS patients and their relatives. Even more important than food security, however, is the preservation of human dignity. That is why DELTA has given priority to raising the self-esteem of those affected.

### 3.2 HIV/AIDS and human rights

Getting infected with HIV is not primarily a question of inappropriate individual behaviour, but is closely dependent on structural and social injustices. That is why questions related to HIV/AIDS always also concern human rights.<sup>7</sup> It is no coincidence that at the meeting of the United Nations on HIV/AIDS in 2006, the leading representatives of the world's governments reaffirmed that 'the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic'<sup>8</sup>. However, this is still rarely the case:

Those at greatest risk (drug consumers, homosexual men or transsexuals, sex workers, prisoners) are given the least attention in national HIV programmes, or are deliberately marginalised. Criminalisation, experience of violence and marginalisation of such fringe groups force them to hide, and thus make it difficult for them to access preventive measures, treatment and mitigation of the effects of HIV and AIDS. Being HIV positive, and the associated stigmatisation, affects the individual's human right to live **free from any form of discrimination**.

In the countries most seriously affected in Africa and Asia, the overwhelming number of those affected are denied the human right of unrestricted **access to a functioning health system**. Although appropriate therapy could practically prevent mother-to-child transmission, fewer than 1% of all HIV-positive pregnant women in the countries of the South are given the appropriate treatment. Every day, approx. 1,500 children are borne with the virus.

HIV/AIDS is an epidemic that affects above all young people. More than half of all people infected worldwide are aged between 15 and 24. Their **right to education** is often infringed, and many children and young people have no unrestricted access to life-saving information with regard to HIV prevention, sex education and HIV drugs suitable for children. Rather than providing clear information, many school and youth programmes exclusively exhort young people to abstain from sexual activity.

Time and again, orphans and children in families affected by AIDS are exploited, abused and stigmatized. Children affected by AIDS attend school more rarely than their peers. They are often being looked after by overburdened grandparents or older siblings, whose work is neither valued nor recompensed. Thus, children in countries without functioning social security systems are denied the **right to special protection and assistance** (Art. 20 of the Convention on the Rights of the Child).

Finally, the human right to live **free from gender-specific and sexual violence** is also breached in relation to HIV/AIDS. Thus, the UN Commission for Human Rights notes that a fatal spiral develops, linking the experience of violence with vulnerability to HIV/AIDS. Thus, women and girls who are exposed to violence show a markedly greater vulnerability to HIV/AIDS. Infection with HIV in turn increases the vulnerability of women and girls to being subjected to violence. And finally, the experiences of violence suffered by women and girls in turn help to promote the conditions for the spread of HIV/AIDS (UNHCR 2004). Forced abortions or sterilisation of women living with HIV in turn violate – according to the Report by the UN Human Rights Commission – not only the **human right to found a family**, but also the **right to liberty and physical integrity**.

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<sup>7</sup> See Fastenopfer Policy Document 'Human Rights - Human Rights Based Approach', 2007.

<sup>8</sup> 'Human Rights and HIV/AIDS: Now more than ever. 10 Reasons why Human Rights should occupy the Centre of the Global AIDS Struggle.' Open Society Institute, 2007.

- Fastenopfer works to ensure that all human rights can be protected and asserted, because this is the key to protecting people's psychological and physical health. The demands made with respect to the right to non-discrimination, the right to treatment, the right of people with HIV/AIDS to participate in health programmes and political processes, the right to protection against violence and the right to protection and assistance correspond to the key demands for human rights and are fully supported by Fastenopfer.

The church-based partner organisation IMCS Africa focuses in its HIV/AIDS work on educating young people – for example in the context of social studies taught at school. This pays regard to the human right to education and to appropriate HIV/AIDS education.

### 3.3 HIV/AIDS and gender

One can speak today of an increasing feminisation of the epidemic. Thus – depending on the context – women not only face the greatest risk of infection, they also frequently carry the main burden of the impact of HIV/AIDS, whether in terms of caring for relatives and losing their job or training place, or in the form of stigmatisation and discrimination.<sup>9</sup>

Women now represent half of the people living with HIV worldwide, and the majority of people living with HIV in sub-Saharan Africa are women. Worldwide, AIDS is the main cause of death in women of child-bearing age.<sup>10</sup> Anatomical reasons and psychological factors, low social status, the lack of political and social influence, economic dependency, certain cultural values and practices as well as gender-specific violence are all factors that heighten women's vulnerability. Because of legal and socio-economic injustices, women often have to accept living and working conditions in which they are at risk of abuse or violence. In crisis situations, violence against women and thus their vulnerability are further increased. Experience of violence and fear can in turn stop women from having an HIV test and insist on the use of condoms. Moreover, the widespread moral belief, prevalent in many contexts, that women must be virgins when getting married paradoxically increases their risk of infection. This is because their sexual inexperience prevents them from accessing information about HIV/AIDS and about appropriate protective measures. Furthermore, as unmarried virgins, young girls are at greater risk of being raped, and thus exposed to HIV infection. And since motherhood – just as being a virgin – is considered in many cultures as the ultimate female ideal, protective methods such as the condom present an insoluble dilemma for many women

For many women and girls living with HIV and AIDS, the health care system remains a system in which they are exposed to prejudice and discrimination. HIV-infected pregnant women in particular tend to be morally judged rather than being given appropriate treatment that could prevent the transmission of the virus from mother to child.

The main burden of caring for AIDS patients and for looking after AIDS orphans falls on older or very young women. As a result, they face a severe challenge in their economic, and frequently also their social position.

As for men, they also have a gender-specific vulnerability. Particularly young men, who are expected to play an active sexual role, have only inadequate knowledge about the risks. This

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<sup>9</sup> see the article by G. Gupta 'Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How'. Washington 2000.

<sup>10</sup> According to information of the International AIDS Conference 2010 in Vienna, organised by the International AIDS Society (IAS).

means that they often experiment with sex in unsafe ways and feel they have to prove their manhood (UNAIDS 1999).

The widespread belief that having the largest possible number of sexual partners is proof of masculinity, and that infidelity is 'part of men's nature', further increases their vulnerability to HIV infection.

Moreover, in many cultures men are socialised not to show their emotions, and not to seek assistance in times of need or stress (WHO 1999). These notions of invulnerability run counter to effective prevention and increase the risk that men are refuse to accept that they may be HIV positive. Overall, it can be said that widespread notions of masculinity are frequently associated with high-risk behaviour in relation to HIV infection.

- For this reason, Fastenopfer is reviewing all existing country programmes with regard to their gender mainstreaming and the possible effects this has for the spread of HIV/AIDS. In addition, Fastenopfer supports projects in its programme countries which place gender mainstreaming at the forefront, which focus on women's social, cultural and economic empowerment and give them the power to make their own decisions regarding their sexuality and their body. Men are to be encouraged to question their own behaviour and their ideas of masculinity, so that joint responsibility for safe sex can be aimed for.
- In programmes and projects with an HIV/AIDS prevention component, Fastenopfer will make sure that a gender-sensitive approach is chosen. This means that, in preventative work, a special focus is directed at gender-specific vulnerabilities, needs and strategies when dealing with the issue of HIV/AIDS.

In their fight against uterus prolapse<sup>11</sup>, the Nepalese Fastenopfer partner organisations SAHAVANGI and WRRP focus attention on the connection between reproductive health and HIV/AIDS. They place great emphasis on women's self-determination over their own bodies, and on lifting the taboos associated with the two subjects of uterus prolapse and HIV/AIDS.

The Columbian partner organisation SYNERGIA deploys two gender specialists who address HIV/AIDS as part of their gender training with all partner organisations. PACSA, a Fastenopfer partner organisation in South Africa, also takes a gender-specific approach on the subject, and has set up a specific gender-HIV desk.

The Brazilian partner organisation CEBI and the South African partner organisation DELTA approach their HIV/AIDS work by addressing the issue individually with men's and women's groups. They focus particularly on tackling the issue of masculinity in a critical way, and the associated issue of men's and women's roles.

### 3.4 HIV/AIDS in crisis situations

Although Fastenopfer does not work directly in war zones, most of the country programmes operate in contexts that are fraught with conflicts and / or are regularly afflicted by natural disasters. Conflict situations are marked by disintegrating social structures, a sharp increase

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<sup>11</sup> Uterus prolapse is the name for a prolapse of the womb, where the uterus slips down from its normal position through the birth channel, in some cases as far as the whole uterus being outside of the now upturned vagina. This is due to the weakening of the tissue and ligaments holding the uterus in place, which is usually due to hard physical work, to carrying heavy loads, and to many births occurring at short intervals. Uterus prolapse is the extreme form of Descensus uteri. (Based on Wikipedia, 22.12.2010).

in sexualised violence, and an adverse power shift in gender relations. In humanitarian crisis situations, people are forced to become refugees, children are left to fend for themselves, there is a lack of food, of clean drinking water, and of safe shelter. Armed troops and stationed UN troops further increase the HIV/AIDS rate due to sexual violence, prostitution or trafficking of children. At the same time, discrimination against people already infected increases further. All this leads to a significant increase in the risk of infection and in vulnerability factors. At the same time, the preventative, curative and psycho-social care often breaks down in conflict contexts. Mainstreaming HIV/AIDS and psycho-social support is therefore a particular priority in conflict areas.

### **HIV/AIDS as a traumatic experience**

A diagnosis of 'HIV positive' and the onset of AIDS is generally a traumatic process for the person concerned, because of the real threat to physical well-being and the fear of dying. In addition to the trauma induced by being diagnosed with the disease itself, the traumatic effect is further heightened by socio-political processes, stigmatisation and discrimination. Religious convictions propagated by certain aid organisations in connection with prevention, and associated moral judgements further increase the stress suffered by those affected.

Uncertainty about their own HIV status, fear of marginalisation, and finally the shock of being told about being infected, as well as the reason for the infection, all have a major impact on a person's psychological state.

- Fastenopfer is actively involved in opposing the social exclusion of those affected, and adopts a psycho-social approach to make subjects such as fear, grief, loss and death deliberately an integral part of the project work.

## 4 Challenges for the HIV/AIDS work

### 4.1 Socio-cultural factors

Specific cultural practices and local concepts can hinder the containment of HIV/AIDS or, in certain circumstances, even promote its spread. These include, amongst others, initiation rituals, tattooing and circumcision with contaminated instruments, socially encouraged promiscuity, the suppression of women's self-determination over their bodies, the enhancement of a man's social status by having a large number of sexual partners, or the mistaken belief, widespread in African contexts, that sexual intercourse with a virgin can cure a man infected with HIV. Accusations of witchcraft and other mechanisms of social exclusion of HIV/AIDS sufferers or their relatives further result in severe stigmatisation and isolation.

Furthermore, in cultural or economic contexts where men are highly mobile (e.g. mineworkers, lorry drivers, migrant workers, soldiers, sailors or port labourers), their own infection rate as well as that of their partners increases significantly.

But cultural or religious norms and social structures also contain a great potential for tackling HIV/AIDS, not least because they provide social networks that replace non-existing state structures and can catch individuals affected by HIV/AIDS. The integration of cultural concepts and emic<sup>12</sup> definitions of the body, sexuality, health and disease and the relations between the sexes is absolutely vital in a culture-sensitive HIV/AIDS mainstreaming process, and is often the key to a successful awareness-raising campaign. Forms of communication that are adapted to the local context – such as theatre, dance, painting, oral traditions etc., – are particularly well-suited for promising prevention work.

The involvement of local religious authorities and healers, midwives or TBA's (traditional birth attendants) ensures the integration of local concepts and norms, which usually has a positive effect on HIV/AIDS work. Local representatives must be actively involved in the specific projects as equal partners, from the planning to the implementation and evaluation

The Fastenopfer partner organisation GALS in the Democratic Republic of Congo trains volunteer promoters who raise awareness among the local population as part of generalized advice to village groups on the subject of HIV/AIDS.

### 4.2 HIV/AIDS and the church

*'As you have done it to the least of these my brethren, you have done it to me' (Mt 25,40)*

The Catholic church at the grassroots, and church-based aid organisations are actively engaged worldwide in supporting and caring for people living with HIV/AIDS.<sup>13</sup> They fight for comprehensive health provision, for access to affordable generics in antiretroviral therapies

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<sup>12</sup> The social-scientific term '*emic*' means to see a culture or a system 'with the eyes of an insider' and refers to a description which is first and foremost correct from the viewpoint of a participants in the examined culture. Emic is in contrast to an '*etic*' view, which reflects the 'view from the outside'.

<sup>13</sup> The 'Vatican's Pontifical Council for Health Pastoral Care', estimates that around 25% of all HIV- and AIDS care is provided by the Catholic church (Vitillo, 2009: 'Faith based Responses to the Global Pandemic').

for the countries of the South, they provide psychosocial care for people living with the disease, their relatives and orphans and actively oppose stigmatisation and discrimination.<sup>14</sup>

Thus, the World Council of Churches (WCC), which is today seen as the central organ of the ecumenical movement, launched an HIV/AIDS Initiative in Africa (EHAIA) in 2002 with the aim of helping African churches to gain access to information, training, resources and enabling them to make contact with other churches and bodies working in the field of HIV. This brings an ecumenical dimension to the churches' care, education and counselling programmes. In Brazil, there has even been an AIDS Pastoral in existence since 1999, which is affiliated to the Brazilian Bishops' Conference (CNBB). With the help of trained pastoral agents, it makes a vital contribution to fight HIV/AIDS across the whole country, by providing information about the disease to ordinary people and helping those affected by the disease.

The teaching of the Catholic church, however, rejects the use of condoms in prevention (in contrast to active grassroots groups). The Pope's utterances on strict abstinence until marriage and complete marital fidelity (so-called AB approach) teach very little about safe sexual practices or contraceptives. This approach ignores people's real situation (especially young people) and the exhortation to faithfulness and abstinence alone can have a counterproductive effect. The categorical rejection, until recently, of the use of condoms also creates problems for the Catholic church's own stance, as for example when 'faithful' marriage partners are infected by their HIV-infected partner having had unprotected sexual relations. Though people have taken notice of a recent statement by Pope Benedict XVI, in which he spoke in favour of a 'more human way of living sexuality' and considered the use of condoms legitimate in certain cases – surprisingly, particularly for male prostitutes.<sup>15</sup> Despite this, the teaching of the Catholic church rejects the use of condoms as part of a moral solution to halt the HIV pandemic. Thus, the Congregation for the Doctrine of the Faith declared, shortly after the publication of the Pope's statement, that the Pope's words 'changed neither the moral teaching nor the pastoral practice of the church.'<sup>16</sup>

Other churches, too, are still having problems with the use of condoms for prevention, and individual believers continue to see HIV/AIDS as the consequence of sinful, immoral behaviour and therefore as God's punishment. For the opening of the first summit of religious leaders in response to AIDS, in Utrecht (23./24.03.2010), the United Nations appealed to the representatives of World religions<sup>17</sup> to intensify the fight against AIDS and to permit their followers the use of condoms. However, in their closing statement, the approximately 40 leading representatives of all world religions only referred to condoms indirectly, by expressing themselves in favour of 'comprehensive prevention, including safe practices'. At the same time, the religious leaders also made a personal commitment to act more forcefully to ensure that the dignity of people living with or affected by HIV or AIDS in the respective faith communities and cultures would be respected. Stigmatisation and discrimination towards people living with HIV must be overcome, they declared.

Church-based organisations are today seen as key actors in the fight against AIDS. This is, firstly, because they are present wherever the poorest people are fighting for their survival,

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<sup>14</sup> See, for example, the Catholic church of Lucerne's activity of raising awareness among young people with the slogan 'Forgetting is infecting – protect your neighbour as you would yourself', as part of its campaign from 23.-25.10.2010.

<sup>15</sup> see Interview book by P. Seewald: 'Licht der Welt' 2010: 117-119, Vatikan Publishers

<sup>16</sup> KIPA (Catholic International Press Agency), 22.12.2010, No. 356: p.11.

<sup>17</sup> Representatives of some 40 religions and faith groups, including Christianity, Islam, Judaism, Buddhism as well as the Bahai, Hindus and Sikhs participated in the two-day conference near Utrecht.

secondly, because they have a strong capacity for communication, a large network and leadership capacity, and thus can reach the people affected, thirdly, because they are important partners in health provision, but also in securing the survival of the rural population, fourthly, because many church-based organisations also accept and care for people living with HIV-/AIDS in their institutions, and fifthly, because they can be actively engaged, in cooperation with international and national partners, at the political level against the spread of HIV/AIDS. That is also the reason why Fastenopfer, as a Catholic, faith-based organisation (fbo) actively works to stop the spread of HIV.

- Since the Catholic church has certain positions around the subject of HIV/AIDS which do not always correspond to the actual realities of our partner organisations, Fastenopfer engages in dialogue with the partners on this subject and looks for context-related solutions. In principle, Fastenopfer focuses on supporting the important grassroots work which is done in numerous programme countries. In this, it is bound by the life-giving strength of the gospel and the findings of the human sciences. It is thus guided by the basic values of Christian social teaching<sup>18</sup> and supports gender equality, the enforcement of the human rights of all people living with HIV/AIDS, and the improvement of their living situation. Only by critically examining the development-relevant subject of HIV/AIDS without prejudice, and by breaking the silence, can awareness-raising and prevention work become successful and save lives.

Fastenopfer supports several bible study groups in Brazil (CEBI), in South Africa (UJAMAA) and in Haiti (REBA), which are either composed of people living with HIV or which carry out important awareness-raising work by addressing the frequently taboo subject in a contextual bible reading.

In Fastenopfer's Laos programme (Partner organisation LBFD) Buddhist nuns and monks are also helped to implement small projects aimed at supporting people living with HIV.

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<sup>18</sup> See Fastenopfer policy statement 'Building communities – Living one's faith, 2008.

## 5 Synergies in the field of HIV/AIDS

AIDS is a global problem and can therefore only be contained through global networking. That is why Fastenopfer works in networks with other organisations that are actively involved in curbing the spread of HIV/AIDS.

### National networks

In Switzerland, the **SDC** is the leading agency for international cooperation in the field of HIV/AIDS.

At the same time Fastenopfer, together with some 30 other Swiss organisations, is a member of the specialist platform **aidsfocus.ch**, a project organised by **Medicus Mundi Switzerland**. By exploiting synergies among Swiss organisations, **aidsfocus.ch** aims to strengthen the competences and capacities of Swiss players involved in HIV/Aids to enable them to act more effectively to counter the pandemic and its drastic impact, and strengthen international solidarity.

**Caritas** has taken up the subject of HIV/AIDS in its 2010 International Cooperation strategy as one of four transversal themes. Experts of the **Bethlehem Mission Immensee (BMI)** are involved in several projects in Africa that focus on AIDS prevention, providing support to the sick and dying, and looking after AIDS orphans. **Heks / Eper** also developed a corresponding guideline in 2009. Finally, **Missio Schweiz** has made the subject of AIDS & children a priority, and is raising awareness among school students in Switzerland with its AIDS-Truck.

**AIDS-Hilfe Schweiz** (the Swiss Aids Federation) is also active in raising awareness in Switzerland, and thus helping to improve the quality of life for people living with HIV/AIDS.

### International networks

Through the work of the **Global Ecumenical Advocacy Alliance (EAA)**, Fastenopfer supports the linking up of churches, people living with HIV/Aids, non-governmental organisations and government actors. This enables an exchange of experiences, the joint development of new methods and strategies, as well as the shared use of existing resources. **Misereor**, too, has placed AIDS on its list of subjects and approved the first AIDS project as early as in 1985.

The same approach is also taken by CHAN, the **Catholic HIV/AIDS Network** (formerly AFNG), which was founded in 1992 by Caritas Internationals. The organisation aims to promote the networking and knowledge transfer of church-related organisations that are involved in the field of HIV/AIDS. CHAN is an international alliance of 15 Catholic agencies involved in emergency aid, development and social work, that have jointly developed HIV/AIDS guidelines that are informed by the Catholic Church' moral and social teaching, and have made the promotion of comprehensive HIV/AIDS programmes in 201 countries part of their agenda.

- Working in a network of organisations not only enables Fastenopfer to engage in a lively information exchange, but also to exploit synergies in the field of lobbying and advocacy, to push for greater attention being given to HIV/AIDS at the political level.
- In the field of **Lobbying and Advocacy**, Fastenopfer works with other organisations in supporting national and international lobbying projects that promote the rights and

needs of people who are directly or indirectly affected by HIV/AIDS. At the same time, it campaigns at the political level to ensure that the necessary resources and infrastructure are made available to fight the epidemic effectively and that all people – regardless of their background – can get access to antiretroviral drugs.

## 6 Strategies and operational guidelines for implementation

### 6.1 Methodological approach: ABC, SAVE and CCC

The methodological approach by church organisations, non-governmental or government institutions in the fight against AIDS varies according to the country and the context. The choice of a specific tool for prevention is, however, an indication of the respective actor's moral and ethical position. In principle, one can differentiate between two approaches that are most widespread in the prevention, treatment and lobbying work: ABC and SAVE. Fastenopfer aims to use a combination of both methods.



Educational panel in Botswana in the late 1990s

(<http://www.avert.org/aids-picture>, 08.11.2010)

**ABC** is short for 'Abstinence, Being faithful, Condom use' and was developed as a reaction to the growing HIV/AIDS epidemic in Africa in the late 1980s. The ABC strategy is really to be seen as an individual approach, since it relies on the individual taking responsibility. It does not take much account of structural causes such as poverty, mobility or war. Exclusive reliance on the ABC focus is advocated mainly by certain American actors (US Global AIDS Strategy, 2003) and implemented in the African context. In principle, an appeal to the individual's sense of responsibility is to be approved, and the combination of abstinence, being faithful and using condoms appears to make sense. Unfortunately, however, this often breaks down in light of the reality of the target groups' lives. Thus, what has been found in practice in the past few years is that the exclusive promotion of the ABC strategy provides insufficient protection for women in particular – as an especially exposed group. The demand of abstinence, for example, becomes a farce in many African contexts in which girls marry at an early age. Also, in situations in which girls and women (but also men) are forced into prostitution due to their precarious economic situation, the call for abstinence has a rather cynical overtone. 'Being faithful' also often has a negative impact on women. The UNAIDS report of 2004, for example, showed that in Zambia and Kenya, there was a markedly higher prevalence among young married women (age 15-19) than among sexually active, unmarried older women. The reason for this is that young women are often married to significantly older men who themselves are often HIV positive. The commandment of being

faithful only proves to be an effective means against HIV infection where both marriage partners have tested negative for HIV.



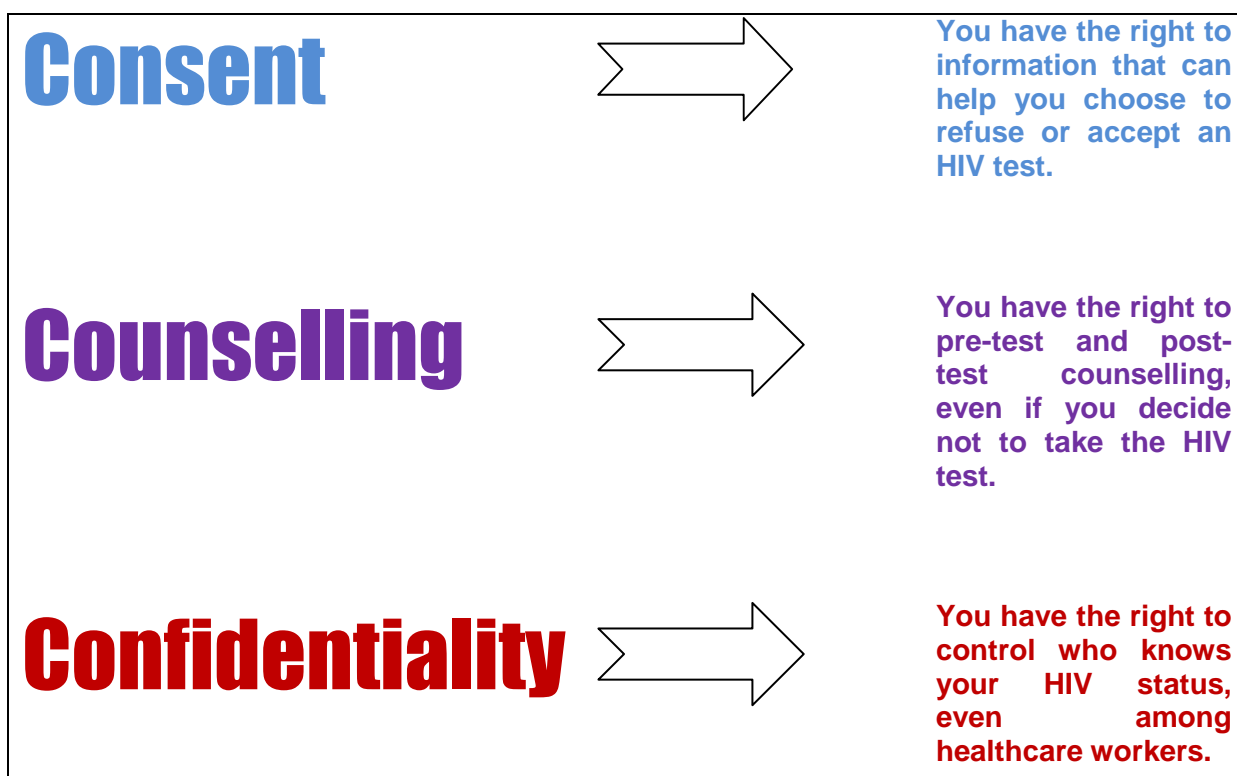
Australian educational poster aimed at the target group of young Aborigines, 1989

Although condoms have been proven to be the safest method of protection against infection, it has been shown in many countries of the South that, because of its low level of acceptance, using it as the sole approach is inadequate. Thus, in many African countries, it runs counter the concept that the purpose of the sexual act is first and foremost to create new life and thus continue the family line. An added factor is that the use of condoms tends to be associated more with HIV prevention than with family planning. This in turn increases the fear of stigmatisation. For women, the use of condoms only becomes a realistic option if the sexual partner also agrees to it. In reality, this is unfortunately still too rarely the case, because the insistence on a condom is often seen as a lack of trust. In view of the obvious limitations of the ABC approach, it has to be supplemented with more structural approaches, as for example in the form of the SAVE strategy:

**SAVE** stands for 'Safer Practices, Accessibility and availability of services, Voluntary counselling and testing, Empowerment through education.' 'Safer Practices' refers to, on the one hand, safe sexual practice, but also safe methods of blood transfusion, sterile needles and syringes for injection, and the correct training and practice to prevent mother-child transmission. 'Accessibility and availability of services' underlines the demand that everyone must at all times have access to medical services, whether in the form of information, support or treatment (ART). 'Voluntary counselling and testing' refers to the fact that each individual must take responsibility for knowing their HIV status. This is a key factor for successful prevention and treatment. Finally, 'Empowerment through education' points out that for long-term preventative work to be effective, it must be based on thorough and morally neutral awareness-raising activity.

This methodological approach was developed by a group of leading religious individuals<sup>19</sup> who were themselves affected by the disease and, because of this, wanted to develop a pragmatic option.

In addition to SAVE and ABC, Fastenopfer takes account of the three **C-factors** in its awareness-raising and prevention work: Consent, Counselling and Confidentiality. This method was developed to enable HIV tests and counselling to be given in an ethical and at the same time successful manner. Special importance was attached to the issue of consent.



Based on BONELA (The Botswana Network on Ethics, Law and HIV/AIDS), [www.bonela.org](http://www.bonela.org). 22.12.2010.

- As an organisation which is committed to combating structural injustices, Fastenopfer advocates a combination of the three strategies referred to. In principle, it is in favour of the ABC strategy, which makes sense in itself, and which appeals to the individual's moral behaviour, but at the same time, it also backs the more comprehensive and more gender-sensitive SAVE strategy and, in its awareness-raising work, also takes the three C-factors into account.

## 6.2 Do no harm and psycho-social approach<sup>20</sup>

Paying attention to the principle of 'do no harm' is one of the key tenets of Fastenopfer's project and programme work. Thus, when mainstreaming HIV/AIDS, it is essential to always analyse which of our activities may have negative implications for the spread of HIV. Special

<sup>19</sup> A leading role was played by the organisation ANERELA+, members of the Anglican church in Uganda.

<sup>20</sup> see 'Gender, conflict transformation & the psycho-social approach'– an SDC working paper, 2006. Paper 14.

attention therefore has to be paid to possible short or long-term harmful consequences which result from the planned or ongoing project activities and which lead to an increase in the vulnerability of project workers or target groups.<sup>21</sup>

Here, the following questions must be asked, proceeding methodically in such a way that, if the response to a question is positive, then this automatically leads to a follow-up question:

1. Does our programme/project take account of the increasing mobility of specific groups (women, men, road construction workers, traders, tourists)? Does this mean an increase in mobility between regions with high and those with low HIV prevalence<sup>22</sup>?
2. Will our programme/project create new sources of income that are likely to aggravate gender inequalities and are these new funds likely to be invested in sexual activities amongst other things (e.g. prostitution)?
3. Will our programme/project activities generally lead to inequalities (e.g. inequitable access to information, skills and resources for certain groups)? And will these inequities further marginalise and stigmatise people infected with HIV?
4. Does our programme / project exclude people living with HIV/AIDS (e.g. from activities, membership in savings groups etc.)?

Measures such as voluntary tests that create clarity and are integrated in a context of care and treatment, emotional and cognitive processing, and the development of different perspectives of life contribute to the empowerment of the affected individuals. Encouraging psychosocial discussion and counselling groups on the subjects of sexuality, shame, helplessness, fear, grief, anger, loneliness and feelings of guilt can break through the social silence. A conscious examination of the issues of dying, death and loss together with those directly affected, but also with relatives and children left behind, must be emotionally supported in every project context. Moreover, empowerment can be consciously boosted in the project work by supporting self-help groups and by helping a parent who is having to prepare his or her children for a near future when they will be orphans. One useful tool, for example, is *Memory Work* – a process of thinking about one's own history, desires, traditions, which parents living with AIDS may want to hand on to the children they have to leave behind.<sup>23</sup>

- Fastenopfer makes every effort not to increase the vulnerability of the staff, partner organisations and target groups with its programmes and projects and tries, via the 'do no harm approach', to recognise possible negative consequences of its activities at the planning stage and avoid them.<sup>24</sup>
- Fastenopfer actively works to prevent the exclusion and stigmatisation of people living with HIV/AIDS and focuses attention on the subject by using the psychosocial approach.

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<sup>21</sup> Based on the SDC Toolkit: 'Mainstreaming HIV/AIDS in Practice' 2004.

<sup>22</sup> Prevalence: Number of cases of an infection or disease in a population at a specific point in time (proportional).

<sup>23</sup> For more details see [www.aidsfocus.ch](http://www.aidsfocus.ch)

<sup>24</sup> See also the 'Do-no-harm approach combined with the PSA-tool' by OPSI, 2010, developed for Fastenopfer.

### 6.3 External and internal mainstreaming

In terms of external HIV/AIDS mainstreaming, all sectors and areas of a country programme or project should be examined to see whether contributions can be made to awareness-raising, prevention and risk reduction. In doing so, account must be taken of the close link between HIV/AIDS and poverty reduction, food sovereignty, human rights and gender equality. Depending on the prevalence in the respective country context, HIV/AIDS activities will be integrated in the planning, implementation and evaluation of the country programmes and projects with differing intensity. New applications, projects with a new focus and important tools used by Fastenopfer will be examined with regard to their possible negative impacts on the AIDS situation ('do no harm'), as well as their potential for combating the pandemic. At the same time, local initiatives and information and education campaigns by partner organisations are actively supported. In those programmes where HIV/AIDS is clearly identified as a problem, the programme portfolio must have the appropriate specialist knowledge at its disposal or acquire it.

Six key questions arise in the **practical programme and project work**:

1. What is HIV? How is it transmitted and how can people protect themselves? How does the disease develop? What specific local factors have to be taken into account?
2. In what way can HIV/AIDS adversely affect the aims, activities and results of the programme or project?
3. Does our programme or project reduce or promote the spread of HIV in the regions concerned?
4. What impacts of HIV/AIDS are mitigated or aggravated due to the programme or project?
5. Can the programme or project be planned, supported and monitored in such a way that it can stem a further spread of HIV/AIDS and diminish the impact of the disease?
6. Is the subject mentioned in reports and addressed during the project visits?

These issues can be discussed in partner workshops or project workshops. The workshops should preferably be led by external persons who have specific HIV/AIDS knowledge.

In addition to workshops that focus specifically on the theme of HIV/AIDS, awareness and knowledge about the epidemic must also be increased internally. This is accompanied by raising the level of awareness of the partners about the subject, for example when approving applications, when responding to reports, or during project visits.

Fastenopfer should also carry out an internal **HIV/AIDS mainstreaming** in relation to its own organisation and as an employer. This involves addressing, in particular, the following questions:

1. In what way does HIV/AIDS influence our organisation and our work?
2. How can we prevent the stigmatisation of employees affected by HIV/AIDS?

Fastenopfer wants to contribute, through its activities, to the reduction of HIV/AIDS and at the same time support people affected by HIV/AIDS in their difficult situation and help them (re)integrate into society. Fastenopfer is conscious that to achieve this, efforts must be made in all areas of activity: Together with the partner organisations, it supports awareness-raising work so that they find an effective way of dealing with the disease, using locally appropriate methods. It is committed to protecting the human dignity and human rights of the people living with HIV/AIDS, contributes to reducing poverty and thus reducing vulnerability and tries, in all its country programmes, to integrate awareness-raising and preventative measures with regard to HIV/AIDS.

## 7 Facts about the Fastenopfer programme countries

Figures and statistics should always be treated with caution. This applies to an even greater degree when dealing with a subject such as HIV/AIDS, which in many cases still has a powerful taboo attached to it. Although the figures below can give an impression of the extent of the epidemic, their reliability has to be qualified because of the lack of population figures, of fictive or manipulated figures, and sources of error when recording new HIV diagnoses.

Experts differentiate between countries with a low prevalence rate – as for example Madagascar or the Philippines – and countries with concentrated epidemics<sup>25</sup> – such as India. A country with a generalised epidemic<sup>26</sup> is, for example, South Africa.

	People infected with HIV	Prevalence rate of adults (15-49)	Adults infected with HIV (> 15)	Women infected with HIV (> 15)	Children infected with HIV (0-14)	Deaths from AIDS	Orphans (0-17) due to AIDS
<b>Senegal</b>	67'000	1 %	64'000	38'000	3'100	1'800	8'400
<b>Kenya</b>	1'750'000	7.1-8.3 %	1'550'000	1'000'000	155'000	100'000	1'200'000
<b>D.R. Congo</b>	450'000	1.2-1.5 %	400'000	240'000	43'000	29'000	325'000
<b>Burkina Faso</b>	130'000	1.6 %	120'000	61'000	10'000	9'200	100'000
<b>South Africa</b>	5'700'000	18.1 %	5'400'000	3'200'000	280'000	350'000	1'400'000
<b>Madagascar</b>	14'000	0.1 %	13'000	3'400	>500	770	3'400
<b>India</b>	2'400'000	0.3 %	2'300'000	880'000	no data	no data	no data
<b>Laos</b>	5'500	0.2 %	5'400	1'300	no data	<100	no data
<b>Nepal</b>	70'000	0.5 %	68'000	17'000	no data	4'900	no data
<b>Philippines</b>	8'300	0 %	8'200	2'200	no data	<200	no data
<b>Brazil</b>	730'000	0.6 %	710'000	240'000	no data	15'000	no data
<b>Guatemala</b>	59'000	0.8 %	53'000	52'000	no data	3'900	no data
<b>Columbia</b>	170'000	0.6 %	160'000	47'000	no data	9'800	no data
<b>Haiti</b>	120'000	2.2 %	110'000	58'000	6'800	7'500	no data
<b>Switzerland</b>	25'000	0.6 %	25'000	9'200	no data	<500	no data

Source: unaids.org, 26.04.2010, Epidemiological Fact Sheet on HIV/AIDS 2008

<sup>25</sup> These are considered to be countries that, although they have a low prevalence rate in the general population, have certain vulnerable groups with high-risk behaviour (e.g. sex workers) and a prevalence of above 5%.

<sup>26</sup> In these countries, the prevalence rate both in vulnerable groups and in the general population is above 5%.

## 8 Glossary and abbreviations

ABC	Abstinence, <b>B</b> eing faithful, <b>C</b> ondom use
AIDS	<b>A</b> cquired <b>I</b> mmune <b>D</b> eficiency <b>S</b> yndrome
ART	<b>A</b> nti- <b>R</b> etroviral <b>T</b> herapies
CCC	<b>C</b> onsent, <b>C</b> ounseling and <b>C</b> onfidentiality
CNBB	<b>C</b> onferência <b>N</b> acional dos <b>B</b> ispos do <b>B</b> rasil
FBO	<b>F</b> aith <b>B</b> ased <b>O</b> rganisation
HIV	<b>H</b> uman <b>I</b> mmunodeficiency <b>V</b> irus
IAS	<b>I</b> nternational <b>A</b> IDS <b>S</b> ociety
MDG	<b>M</b> illennium <b>D</b> evelopment <b>G</b> oals
MSM	<b>M</b> en having <b>S</b> ex with <b>M</b> en
WCC	<b>W</b> orld <b>C</b> ouncil of <b>C</b> hurches
SAVE	<b>S</b> afer <b>P</b> ractices, <b>A</b> ccessibility and availability of services, <b>V</b> oluntary counselling and testing, <b>E</b> mpowerment trough education
TBA	<b>T</b> raditional <b>B</b> irth <b>A</b> ttendants
UNAIDS	<b>U</b> nited <b>N</b> ations Programme on HIV/ <b>A</b> IDS
UNHCR	<b>U</b> nited <b>N</b> ations <b>H</b> igh <b>C</b> ommissioner for <b>R</b> efugees
WHO	<b>W</b> orld <b>H</b> ealth <b>O</b> rganisation