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THE CHURCHES CONFRONTED WITH THE PROBLEM OF HIV/AIDS
ANALYSIS OF THE SITUATION IN FIVE COUNTRIES OF
CENTRAL AFRICA
CAMEROON – CHAD – CONGO/BRAZZAVILLE DEMOCRATIC REPUBLIC OF CONGO – GABON

Presented by
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CAMEROON

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"Nobody deserves AIDS. Churches must envision a world where people experience and extend compassion and live together in hope as God's community with or without HIV/AIDS"

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FOREWORD

After two decades, HIV/AIDS has become a global emergency with far-reaching effects. Today, there is no country that has been left unscathed by the Epidemic. It affects all countries including Cameroon socially, economically, spiritually and culturally. HIV/AIDS threatens development and human security. In 1986, the HIV prevalence in Cameroon was estimated at 0.5% and reached 12% in 2002. In the absence of a greatly response that has a significant impact, the HIV prevalence is projected to exceed 15% in 2010 where nearly one in five adults will be infected. As a result a decrease of 10 years in life expectancy at birth will be achieved in 2010.

Time is come to recognise that there have been barriers among faith-based organisations based on religion, class, age, nationality, physical ability, gender, sexual orientation which have generated fear, stigmatisation, discrimination, persecution and even violence. These obstacles within religious communities did much harm than good especially when it comes to prevention measures. Today Christians and clergy are dying of AIDS. This means that AIDS does not only appear to "other people".

I call upon faith-based organisations to adopt as highest priority the confrontation of stigmatisation and social exclusion of people infected and affected by HIV/AIDS. Despite the devastating impact of HIV/AIDS, members of faith communities must acknowledge that they are called by God to affirm a life of hope and healing in the midst of HIV/AIDS. The enormity of the pandemic itself should compel faith-based organisations to join forces despite differences of belief. Christian traditional calls the faith-based organisations to embody and proclaim hope, and to celebrate life and healing in the midst of suffering.

Faith-based organisations must assure that all of who are infected and affected by the epidemic regardless of religion, class, age, and gender and sex orientation will have access to compassionate, non-judgemental care, respect and assistance. God does not punish with sickness but is present together with us (including faith-based organisations and people of good will) as the source of strength, courage and hope. The God of my understanding is in fact, greater than AIDS.

1. GENERAL AND EPIDEMIOLOGICAL DATA

1.1. General data on the Republic of Cameroon

1.1.1. The Republic of Cameroon country profile

The Republic of Cameroon is located in western Central Africa. It lies between longitudes 8 and 16 degrees, east of Greenwich Meridian and between latitudes 2 and 13 degrees, north Equator. It is bounded to the northwest by Nigeria, to the Northeast by Chad, to the east by Central African Republic, to the South by the Republic of Gabon, the Republic of Congo and Equatorial Guinea. The Republic of Cameroon covers a total of 475,442 square kilometres and has two main climates: Equatorial and tropical. The north has a hot dry Sahelian climate. The south is covered by dense equatorial rainforest. The north-south vegetation pattern is substantially modified by the relief and human activities. The Benue river basin and the tributaries of Lake Chad lie further north. The west of the country is dominated by a rang of volcanic mountains, stretching northeast from Mount Cameroon which is high. The Sanaga River runs through the centre of the country, entering the Atlantic near Douala. The main seaport and largest city is Douala; the Capital Yaoundé, is second largest.

1.1.2. Population

At the end of 1996, based on the projections of 1987 population census, the population was estimated at 16,184,748 million people of whom 51% female and 49% male. According to the Ministry of Health, life expectancy has been rising over the past decades, and is now 59 years for women and 55 years for men. Taking into account the high birth rate (5.9 children/women) and “increased life expectancy”, these have led to rapid expansion. There are 24 African languages, with French and English as official languages. Tradition African religious beliefs influence both Muslims who constitute 20% (concentrated in the north) and Christians 40% (concentrated in the South) and indigenous beliefs 40%. Cameroon has over 200 different ethnic groups presented in the table below:

Table 1: Ethnic groups

Ethnic groups	*Percentage*
Cameroonian highlanders	31%
Equatorial Bantu	19%
Other Africans	13%
Kirdi	11%
Fulani	10%
North western Bantu	08%
Eastern Negritic	07%
Non African	01%

Source: The World Fact 2002

The 200 tribes and clans speak at least one of the many African languages and major dialectes.

Table 2: Demographic indicators

Demographic indicators	*Year*	*Estimate*	*Source*
Total population (thousands)	1999	14 693	UNPOP
Population aged 15-49 (thousands)	1999	6713	UNPOP
Annual population growth	1990-1998	2.8%	UNPOP
% of population urbanised	1998	46%	UNPOP
Average annual growth rate of urban population	1990-1998	4.4%	UNPOP

1.1.3. Economy

The Republic of Cameroon's economy is predominantly based on agriculture and oil resources. Cameroon has one of the best-endowed primary commodity economies in central Africa. Over 79% agricultural products account for the country's export earning. Despite the fact that agriculture is a relatively productive sector, 48% of Cameroonians live beneath the poverty level. Additionally, the Cameroonian's economy has been in decline in food production since the main cities are experiencing an unprecedented rate of rural exodus. According to the World Bank, the Cameroonian's external debt was USD 10.9 billion in 2000 and that is why it was subject to structural adjustment programmes instituted by the World Bank. In January 2001, the Paris Club agreed to reduce the Cameroon's debt of 1.3 billion by USD 900 million, total debt relief now amounts to 1.26 billion (the World Fact, 2002). However, the International Monetary Fund is pressing the authorities for more reforms, increasing budget transparency and privatisation. The Cameroonian's currency is the *"Communauté Financière Africaine Franc",* note-responsible authority of the Bank of the Central Africa States.

Table 3: Economic indicators

Economic indicators	Year	Estimate	Source
GNP per Capita	1997	620 USD	World Bank
Human Development Index rank	2000	134	UNDP
% population economically active	-	-	-
Unemployment rate	2002	30%	World Fact

Source: AIDS in Africa, page 39

1.1.4. Education

Cameroon is one of the few countries in Central Africa to offer mass education. In consequence, the literacy rate is quite high. School facilities are available both in rural and urban areas. Due to the cultural harmful practices on education, some ethnic groups are less educated than others particularly in rural areas. For instance, the Fulani tribes are nomadic cattle rearers that move constantly from place to place in quest for pasture for their cattle. As a result, many of the school-aged children do not attend school. In addition, in the Muslim circles especially those in the Northern provinces send a few of their children to school but discriminate between the sexes.

Therefore, girls are sometimes expected to go into early marriages before they have opportunity to go to school. For instance in 1997, the Banso Hospital of the Cameroon Baptist Convention conducted a survey of the sexual histories of 1701 post-primary schools at 14 schools in Northwest Province. The survey revealed that 8% of students had had sex by age 10, while 58% of students in secondary school were sexually active. This shows partly why the level of education is so low among the northerners especially the female children. Therefore, the need to start HIV education during primary school is felt. The same survey was repeated in 2001 in all the 14 schools. The survey indicated that 63% of the students were virgins and that 7% of students had had sex by age of 10. This helps to understand that HIV education works and such programme needs to be replicated elsewhere.

There is a higher number of Cameroonians who are literate in terms of primary school. The remaining large group is made up of those who have completed secondary education and may hold university degree. Many of those who have university level education lack employment. This constitutes a big back for Cameroonians.

Table 4: Education indicators

Economic Indicators	Year	Estimate	Source
Total adult literacy rate	1995	63.0	UNESCO
Adult male literacy rate	1995	75.0	UNESCO
Adult female rate	1995	52.0	UNESCO
Male secondary school enrolment ratio	1996	30.3	UNESCO
Female secondary school enrolment	1996	20.6	UNESCO

1.1.5. Health

According to the Ministry of Public Health, as of November, 1998, Cameroon had 284 hospitals, 1042 health centres and 215 pharmacies. Faith-based organisations are also key players in the provision of health care. For instance, Catholic health service is managing 179 health clinics of which 8 hospitals and 1315 health personnel. Protestant churches are under the umbrella of FEMEC (*Fédération des Eglises et Missions Evangéliques du Cameroun*) have 163 health institutions of which 28 hospitals and 2683 health personnel. The ten leading causes of death are malaria, HIV/AIDS, meningitis, tuberculosis, pneumonia, diarrhoea/worms, cardiovascular disease, post-operation complications, hepatoma and diabetes mellitus (Tih, 2003). Taking into account the fact meningitis and tuberculosis are "twin sisters" of HIV/AIDS, it could be said that over the past decade HIV/AIDS has become the leading cause of death in Cameroon. This will result in the decrease of life expectancy, high morbidity and mortality rates, population reduction and changes in the distribution of population by age and sex than would otherwise be expected.

Table 5: Health indicators

Health Indicators	Year	Estimate	Source
Crude birth rate (births per 1000 pop)	1999	42	UNPOP
Crude death rate (deaths per 1000 pop)	1999	20	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1300	WHO
Life expectancy at birth	1998	43	UNPOP
Total fertility rates	1998	6.2	UNPOP
Infant mortality rates (per 1000 live births)	1998	116	UNICEF
Contraceptive prevalence rate (%)	1990-1999	9	UNICEF
% of births attended by trained personnel	1990-1999	24	UNICEF
% of one-year-old children fully immunised	1995-1998	50	UNICEF

1.1.6. Poverty and vulnerability

Problems related to income distribution and poverty have regained importance and have become a topical issue in Cameroon, especially since the country adopted economic reforms and liberalisation policies after the onset of the economic crisis in 1986-1987, a crisis which lasted a decade until 1994/1995. The first of the economic reforms were designed by the Cameroonian government and supported by the International Monetary Funds and the World Bank not only to correct the structural imbalances in the economy that triggered the economy crisis but also to liberalise the economy, disengage the government from productive sector of the economy, and to prepare the private sector as the possible engine of economic growth.

Although the Cameroonian's economy regained the path of growth since 1995, the effect of the crisis have been such that inequality in the distribution of income and poverty have increased the addition of social dimension to these adjustment programmes as well as the debt alleviation measures which are just beginning to be implemented. However, these programmes put more emphasis on economy efficiency to the detriment of equity considerations. These criticisms have been raised by several organisations and authors namely UNDP (1990, 1997) and Killick (1984).

With regard to vulnerability, 48% of Cameroonians are falling below the poverty line while 30% of Cameroonians are facing unemployment. This makes them vulnerable to HIV/AIDS since most of them have to sell themselves in order to have some money for survival reasons. This could partly explain why 600 Cameroonians are getting infected with HIV daily.

1.2. Epidemiological data

1.2.1. The HIV/AIDS epidemic in Cameroon

Cameroon's first case was reported in 1986 and ever since, there has been a significant increase in the number of people living with HIV/AIDS. As of December, 1994, the total number of AIDS reported was 5,375. Cameroon's HIV/AIDS epidemic is defined as one of the significant risk. Subtype O, a rare variant of HIV, has been detected in Cameroon, and 3% of the sexually active population is estimated to be HIV+; in some regions the prevalence has passed 10% (Bamenda). Ninety percent of HIV transmission is by heterosexual sex. Seventy-five percent of reported cases are found between 20-39 years of age. HIV seroprevalence in women age 15-24 years, range from 0.7% (Yaoundé) to 8.5% (Bamenda). By the year 2005, the government estimates 10,000-14000 new AIDS cases since the seroprevalence increased from 0.5% in 1987 to 12% at the end of 2002.

Table 6: Estimated number of people living with HIV/AIDS

Designation	Number
Adult and children	920,000
Adults (15-49)	860,000
Women (15-49)	500,000
Children (0-15)	69,000

53,000 are the estimated number of adults and children who died of AIDS during 2001.

At the end of 2001, the estimated number of children who lost their mother or father or both parents to AIDS and who were alive and under age of 15 were 210,000.

Source: Cameroon Epidemiological Fact sheets 2002 Updated

1.2.2. Sentinel surveillance

HIV prevalence information among antenatal clinic attendees has been available since 1989. In Cameroon, Yaoundé and Douala are the major urban areas. In Yaounde, HIV prevalence was 11.2% and the median HIV prevalence in Douala was 11.6%. In 2000, the overall HIV prevalence among antenatal attendees in 28 sites was 10.8%. In areas outside Yaounde and Douala, HIV prevalence among antenatal clinic increased from less than 1% in 1989 to 8% in 1996 and this has continued to rise especially among 15-19 years-old and among the 20-24 years-old antenatal attendees across all the sites.

HIV prevalence among sex workers in Yaounde increased from 5.6% in 1990 to 45.3% in 1993. In 1994, 21% sex workers who tested both in Yaounde and Douala were found to be HIV+. However, this prevalence noticed a little decline (17%) in 1995. A couple studies conducted among truck drivers in 1993 and 1994 showed a medium prevalence of 13%. In 1996, 15% of military personnel tested were HIV positive. HIV prevalence increased among male sexually transmitted infections clinic patients tested from 5% in 1992 to 16% in 1996. In the countryside, HIV prevalence among STI clinic patients had reached 8% in 1992. Limited information was available on sexual behaviours although the age at first sex among the 20-24 years old surveyed in the 1991 Demographic Health Survey was 16.1%. The 2000 HIV/AIDS epidemiological data available shows that the HIV/AIDS vary from one province to another. These data are presented in the table below:

Table 7. HIV Prevalence by Provinces in 2000

Province	Number of tested persons	Number of tested positive	% Prevalence rate
Centre	403	45	11,2
South	322	36	11,2
Littoral	276	17	6,2
South-West	399	49	12,3
West	434	26	6,0
North-West	400	46	11,5
East	339	34	10,0
Adamoua	330	56	17,0
North	417	40	9,6
Extreme-North	335	44	13,1
Total	3655	393	11,0

Comments

Although, these statistics are bio-medical oriented, Amadoua, the North and the South-West of Cameroon seem to hold the highest HIV prevalence. This could be due to the following contributing factors.

1.2.3. Contributing factors to the spread of HIV/AIDS

There are many contributing factors to the spread of HIV/AIDS. They include:

- The persistence culture of silence and denial to the spread of HIV/AIDS within the churches and the government
- Poverty that hinds control efforts
- Political instability of 1990s with its consequences: insecurity, rape and sexual violence
- Socio-cultural issues:
  - Taboos surrounding discussion about sex and sexuality
  - Stigma, discrimination and fear of rejection that force people not to be tested
  - Gender inequity
  - Lack of education that makes little girls to get married very earlier
- Global economic and injustice
- Heavy external debt
- Structural adjustments with its cut in social services
- Little opportunity to access to antiretroviral

1.2.4. Impact of HIV/AIDS in Cameroon

1.2.4.1. Socio-economic impact

In Cameroon, HIV prevalence among the sexually active is presently at 12%, 22 times higher than in 1987, when it stood at 0,5%. The number of people living with HIV is estimated at 937,000 and 1 Cameroonian out of 9 among the sexually active today is infected. This situation calls on all the stakeholders involved in the fight against AIDS in Cameroon and especially the government for increased resources to help stem the epidemic. Cameroon has been granted a debt reduction about 36 billion FCFA for the year 2001 out of which 7 billion have been paid into a special account and expendable. The government considers HIV/AIDS as a factor aggravating poverty, social and economic development.

1.2.4.2. Health sector impact

The increasing mortality and the growth of the number of orphans pose unprecedented social welfare demand for countries such as Cameroon already burdened by huge development and health challenges. As mentioned elsewhere, HIV/AIDS is becoming a great threat in rural areas than in cities. Ironically, more people living with HIV/AIDS reside in rural areas. For instance, in Bamenda, HIV is the main the main leading cause of death among the clinic patients (Tih, 2003). Health care systems in Cameroon are overstretched as they deal with a growing number of AIDS patients and loss of health care personnel.

1.2.4.3. Agricultural impact

The epidemic is undermining the progress of agricultural and rural development made during the previous decades. In contrast to other diseases, AIDS kills mostly people members of the productive age group (people aged 15-49 years). With regard to 600 Cameroonians who are getting infected daily, AIDS will cut productivity as more people will became ill and as more time will be devoted to caring for the sick and for funeral rituals. Researchers have calculated that HIV/AIDS is causing the loss up to 50% of agricultural extension staff in sub-Saharan Africa.

1.2.4.4. Education impact

Teachers and students are dying or leaving school, reducing both the quality and efficiency of educational system. The qualified personnel who are now employed cannot be all replaced. This poses a humane resource problem for the entire community.

1.2.5. Politics

Cameroon is one of the few stable countries in Central Africa region. However, a multiparty declaration was made by the current President in 1990. In 1991, the country experimented a political upheaval. Between 1999-2000, Cameroon became a state of emergency. Soldiers were sent out. It is well known that soldiers are among HIV high risk target (15% soldiers tested HIV positive in Cameroon), sexual promiscuity, rape, sexual violence took place. Additionally, HIV/AIDS high prevalence was found by the close settings in the plantation camps whereby most workers may venture into sexual intercourse to meet their financial needs.

Formerly a strong pro-natalist country, in 1992 Cameroon adopted both a National Population policy and a comprehensive family planning service delivery policy. Since, HIV/AIDS should be dealt in the light of sexuality; one can understand why the national response to combat HIV/AIDS was not so prompt.

2. THE HIV/AIDS CONTROL COMMITTEE

2.1. Background information of the AIDS Control Programme

Cameroon across the Central Africa region is expanding and upgrading its response to HIV/AIDS. A Committee to fight HIV/AIDS was created in 1996 following the National AIDS Control Programme that took place within the Ministry of Public Health.

Table 8. Dates and major events of the National Response

Designation	Year
1 year Short Term Plan	1997
First Medium Term Plan	1988-1992
Second Medium Term Plan	1993-1995
Comprehensive Policy developed on HIV/AIDS	1999-2000

Comment

These dates and major events of the National Response are self explanatory that Cameroon lacked the political commitment from the onset of HIV/AIDS to combat the epidemic. Taking into the culture of silence and denial of the disease associated with HIV/AIDS; this could justify why Cameroon has become one of the worst countries hit by HIV/AIDS in Central Africa.

Despite these above plans that aimed at consolidating and expanding interventions on HIV/AIDS, monitoring behaviour change and epidemic through epidemiological prevalence, the National AIDS Control Programme faced many shortcomings namely:

- Insufficient coordination mechanisms between stakeholders and programme partners
- Little resources allocated to the programme
- No or little implication of the government sectors other than health sector to combat HIV/AIDS

- Increased HIV/AIDS prevalence especially among the 20-39 years old

2.2. The National response of Cameroon

However, today, Cameroon is one of the countries that have used to good report the present opportunities for mobilising resources for HIV/AIDS control in terms of how these resources have been utilised. The strategic document prepared by the government under the auspices of the World Bank in consultation with other partners, considers HIV/AIDS as a factor aggravating poverty and social and economic development. The elaboration of the national strategic plan has brought to the fore the AIDS problematic and has shown how and with what budgetary resources, HIV/AIDS control actions would cost in terms of financing in the forthcoming days in Cameroon. This programmatic framework has facilitated negotiations on the priority to be given to HIV/AIDS not only with the global poverty reduction strategy, but equally with respect to the allocation of additional resources obtained from debt reduction gains to face this epidemic.

The launch by the Prime Minister of the Strategic Plan with the technical support of co-sponsors and other partners in the amount of 200 million USD for 2001-2003 has helped to re-affirm the government's and the political will to consider HIV/AIDS not only as a priority but also integrating it in the Cameroonian's development instruments. Cameroon is has elaborated an ambitious emergency plan to make possible a 100% condom distribution to vulnerable groups such as drivers, truckers, soldiers, the police, gendarmes, custom agents, prisoners, prison wards and sex workers etc.

Testing and counselling, the prevention of mother-to-child transmission of HIV, the behavioural change programme among young people is underway. The government organised three days of discussions on reaching multisectoral programme whose goal is to halt the spread of the HIV epidemic in Cameroon. This will minimise the effects on those infected and affected by HIV/AIDS, by strengthening the means to fight to AIDS that are available to communities, for the design and implementation of strategies and sectoral plans 50 million USD that have granted by the World Bank towards this end.

2.3. Partnership

The government has shown its openness to work with several stakeholders namely local and foreign Non Governmental Organisations, national secular and religious associations, churches, civil society, the private sector and external partners that have associated their efforts with those already engaged by the National AIDS Control Programme to combat the HIV/AIDS.

Faith-based organisations

Over the few past years, the government has been increasingly concerned about the epidemic of HIV/AIDS since the partnership is based on the premise that, in isolation, none of its constituencies be they government, civil society and or the various national and international organisations working against AIDS can turn the epidemic around. In addition, the government considered the faith-based organisations as appropriate channels to implement effective preventive measures as well as care, counselling and advocacy. The interventions of faith-based organisations are part of the sectoral response within the National AIDS Control Committee. In 2001, 17 conventions were signed between the faith-based organisations and the National AIDS Control Committee. 15 Faith-based organisations received an amount of FCFA: 253 981 333.- The religious communities which received the amount are presented in the table below:

Table 9. Faith-based organisations that received funding from the government in 2002

Faith-based organisations	Amount in FCFA
Eséka Diocese	9 400 000
Bafia Diocese	27 950 000
Mbalmayo Diocese	29 970 000
Sangmélima Diocese	24 480 000
Ebolowa Diocese	23 950 000
Obala Diocese	14 070 000
Eglise Presbytérienne du Cameroon	9 860 000
Eglise Evangélique du Cameroon	25 970 000
Eglise Evangélique Luthérienne du Cameroon	19 710 000
Oeuvre Médicale des Eglises Evangéliques du Cameroon	4 738 000
Presbyterian Church in Cameroon	12 040 000
Cameroon Baptist Convention	11 610 000
Union des Eglises Adventistes en Afrique Centrale	11 003 333
Christ de la Nouvelle Alliance	15 500 000
Conseil Supérieur Islamique du Cameroon	23 100 000
Mission des Eglises Evangéliques du Cameroon	10 340 000

Source: Annual report of the National AIDS Control Committee 2002 page 30

Comments

The partnership between the Cameroonian Government and the faith-based organisations is nation-wide. I would like to suggest that its utmost important role would be at grass root level, where it would support national plans to fight AIDS and boost existing initiatives. With the various faith-based organisations sharing their experiences and successful stories, the partnership can help transform isolated actions into coherent plans of actions. The venture should build on the strengths of each religious community to provide national leadership.

External Partners

The National AIDS Control Programme works in collaboration with the following partners: World Health Organisation, UNAIDS, UNDP, World Bank, GTZ, French Cooperation, UNICEF, Oxfam, Red Cross, FNUAP, European Union, USAID, etc.

3. FAITH-BASED ORGANISATIONS: PERCEPTIONS AND INVOLMENT IN ADDRESSING HIV/AIDS

Faith-based organisations in Cameroon

With regard to the mapping exercise, I met religious leaders and heads of health services of the following religious communities: Eglise Evangélique du Cameroon, Eglise Evangélique Luthérienne du Cameroon, Eglise Anglicane, Eglise Presbyterienne du Cameroon, Eglise Catholique, Cameroon Baptist Convention, Presbyterian Church of Cameroon, Muslim Community, Methodist church of Cameroon and Fédération des Eglises et des Missions Evangéliques du Cameroon.

Perceptions of HIV/AIDS by the above Faith-based organisations

AIDS remains a major concern for the many church leaders and heads of health services that I met in Cameroon. Many of them are still acknowledging that HIV/AIDS cases have been increasing at an alarming rates during the past decades. In addition, they know that as far as the HIV/AIDS is concerned, there is neither cure and nor vaccines. They also know the name of the virus that causes AIDS, its mode of action and the principal modes of transmission. This could be partly the result of the many theological seminars and workshops that are taking place in Cameroon. However, the perceptions of HIV/AIDS from church to church.

Eglise Evangélique du Cameroon

From the National President of the Eglise Evangélique du Cameroun viewpoint, HIV/AIDS is not a single epidemic. It should be understood to involve contributing factors such as poverty and immoral behaviours inconsistent with God's commandments, etc.

"HIV/AIDS is not merely a health issue but a life crisis of spirit, mind, and social environment due to socio-economic and political pressure in which we are living on. In Cameroon, people are dying daily as a result of HIV/AIDS and this tendency is rising dramatically. Many Ecumenical organisations in the North are still holding great planning to fight HIV/AIDS. Time is come now to undertake great action."

Rev. FOCHIVE, The National President of the Eglise Evangélique du Cameroon.

Eglise Evangélique Luthérienne du Cameroun

The Eglise Evangélique Luthérienne du Cameroon is aware that HIV/AIDS is threatening the churches. Many of the church members are infected. The church itself is living with HIV/AIDS.

"From the onset of the disease, the Eglise Evangélique Luthérienne du Cameroon understood that HIV/AIDS is also an issue of churches. In order to help the church to break the silence around HIV/AIDS within its congregations, we called upon the Kenyan Journalist John who came to Cameroon in the 1990s to share his testimony of leaving positively with HIV/AIDS. This will help the church very much on the fact HIV/AIDS is no longer a private concern but could be spoken about openly and honestly by everybody including the church leaders"

"I used to pay my brother's tuition fees from the primary school up to the University. After completing his bachelor degree, my brother only taught 5 months before he died of AIDS leaving behind him his infected wife and many children that I have to look after. Much has been invested on my brother's training but he did not stay longer to contribute to the family economic growth. Apart from my brother, I have lost up to 9 members of my family".

Rev.Robert PINDZIE ADAMOU, Deputy President of EELC

Anglican Church of Cameroon

The perception of HIV/AIDS in the Anglican Church of Cameroon is similar to that of the Evangelical Church of Cameroon. HIV/AIDS is acknowledged as a reality with unprecedented consequences on medical, social, economic, religious and ethical aspects.

"The disease does not make any discrimination and everybody is concerned in one way or another as being infected or affected by its consequences. The Anglican church does not consider HIV/AIDS as a divine punishment since our God is a God of love and mercy who gives life and not death"

The RT.Rev.Jonathan RUHUMULIZA, Anglican Bishop.

Eglise Presbytérienne du Cameroon

The willingness and the commitment to combat HIV/AIDS of the Eglise Presbytérienne were visible. The general secretary of the EPC that I met showed that he has been sensitised on the serious of the problem.

"HIV/AIDS is a reality that we are facing in Cameroon as 600 Cameroonians get infected daily. The youth is paying the highest cost to this dreadful disease. Human resources are the mainstream of the development within a country. What's next if the whole population is infected by HIV/AIDS? There will be no more churches in Cameroon. Time has come now to halt the spread of this awful pandemic A dollar now is worth more than 1000 USD in future in the sense that a life lost cannot be redeemed. A dollar will save a life now."

Rev.Dr MASSI GAMI Dieudonné, General Secretary of the E.P of Cameroon.

Eglise Catholique of Cameroon

Taking into account the immense and manifold suffering in many parts of Cameroon, the Catholic's perceptions of the disease is that HIV/AIDS is a threat to all of us and to our communion.

> *"Since we consider HIV/AIDS as any other disease, the Catholic had recognised the urgent need to break the silence surrounding HIV/AIDS in our churches and congregations to provide prevention measures, care, counselling, support and advocacy".*
>
> *Sister Dr Anne Daban, Director of Health services Archdiocese of Yaounde.*

Presbyterian Church of Cameroon

The Presbyterian Church of Cameroon is one of the pioneers in HIV/AIDS work in Cameroon. As mentioned earlier, the Presbyterian Church of Cameroon acknowledged that HIV infections have increased greatly both among people who are tested because they have symptoms of the Acquired Immune Deficiency Syndrome (AIDS), and among those who are tested as blood donors and on a voluntary testing basis.

> *"Time to combat HIV/AIDS is now. Tomorrow will be too late to save the population of Cameroon from dying of AIDS. That is why the PCC has been considering HIV/AIDS on the same level as malaria. People must be taught many times in order to prevent the past failure characterised by the fact that having attended a workshop on HIV/AIDS, they willingly accepted to avoid getting infected by HIV. However, as time goes on people forget their commitment to combat HIV/AIDS as they go back to their past lifestyles. People need to be preached about the HIV/AIDS from the pulpit just like John the Baptist preached in the wilderness"*

Muslim Community of Cameroon

The Muslim community has not remained in the margin of the struggle against HIV/AIDS. Imams are doing their best to inform, train and enlighten their audience about the HIV/AIDS phenomenon and its socio-economic impact on individual and collective well-being.

> *"HIV/AIDS is a reality in Cameroon which spares no religions, particular gender, age, social or ethnic groups and races, etc. HIV/AIDS could be a divine test that has been given to the humankind. The root causes could be the result of disobedience to God's laws and sexual wanders. According to the Koran, in the end of the days a certain number of sufferings will rise. This constitutes a warning message for the human kind to get back to their Lord, Allah."*
>
> *Oustaz Mouhammad Aminoudine, Lecturer at Yaounde-Mimboman*

Cameroon Baptist Convention

Over the past decade, HIV infections have become the leading cause of hospital deaths at Banso and Mbingo Baptist Hospitals. Additionally, many other patients with HIV infections go home just to die. The Cameroon Baptist Convention has been increasingly concerned at the pandemic of HIV infections and the resulting increase in other infections.

> *"HIV has generated an AIDS epidemic that has spread to every part of the world including Cameroon. The epidemic has proved devastating effect on the population. It is reversing important development gains, robbing millions of their lives, widening the gap between rich and poor, and undermining social and economic security. The Cameroon Baptist Convention has a community based and focuses on training of AIDS educators who deliver AIDS education in schools, local communities, and in churches, educating people on how to stay safe from the VIH. They also give general counselling to people living with HIV/AIDS"*
>
> *Rev. TANGWA Charles FONDZEFE, General Secretary of CBC*

Federation of Protestant churches and Mission of Cameroon

11 religious communities (Cameroon Baptist Convention, Native Baptist Church, Evangelical Church of Cameroon, Eglise Evangélique Luthérienne du Cameroon, Eglise Fraternelle Luthérienne au Cameroun, Eglise Presbytérienne du Cameroon, Eglise Presbytérienne Camerounaise, Eglise Protestante Africaine, Presbyterian Church of Cameroon, Union des Eglises Baptistes du cameroun, Union des Eglises Evangéliques au Nord-Cameroon and Anglican Church of Cameroon)have already the Federation of Protestant churches and Mission of Cameroon. This could be used as an appropriate channel to acknowledge the scale of the HIV/AIDS problem and to help churches maximise resources to find out creative solutions responsive to their needs, since many of the church members are still facing the realisation that they urgently need guidance in dealing with the epidemic.

> *" The HIV epidemic actually comprises multiple epidemics, such as poverty, gender inequalities, resurgence of controllable diseases: Tuberculosis, social injustice which increase the people's vulnerability to HIV/AIDS. As far as HIV/AIDS is concerned, we are facing a terrible epidemic because HIV/AIDS is erasing the hard won development achievements. The anti-retroviral drugs might be available. But, they cost 25,000FCFA. Still are Cameroonians who are unable to earn that much per month. As a result, people are loosing their immunity to this dreadful virus and disease".*
>
> *Rev. Dr NJAMI-MWANDI Simon, Executive Secretary of FEMEC.*

> *"We are planning to combat HIV/AIDS with substantial contributions of the World Council of Churches and other potential partners. HIV/AIDS problems require love, tolerance and compassion. The money could be used as tool in order to implement what we feel inside of ourselves. HIV/AIDS should be considered as any other disease with which one could live positively. Like it or not, everybody will die anyway"*
>
> *Rev. Pastor AMTSE Pierre SONGSARE, President of FEMEC.*

Methodist Church of Cameroon

This church is about to launch its activities including the HIV/AIDS activities in Cameroon.

> *"There is no doubt that sub-Saharan Africa is by far the worst affected region in the world. Therefore, the AIDS epidemic has a profound impact on economic growth, income and poverty. As a result women and girls are more vulnerable to HIV/AIDS and are disproportionately affected and infected by the epidemic. In both rural and urban areas, the epidemic adds the already heavy burdens women bear as workers, caregivers, educators and mothers. I will do my best to persuade this new church in Cameroon to also deal with HIV/AIDS epidemic".*
>
> *Rev. Dr Catherine AKALE.*

Comments on the perceptions of Faith-based organisations

From the results of the above perceptions, it is clear that faith-based organisations are aware of HIV/AIDS and its basic consequences although some misconceptions and misunderstandings were found during in-depth interviews when it comes to probe their knowledge. In addition, this mapping results also shows that church leaders are concerned with HIV/AIDS because it entails loss of productivity, wipe out the hard-won development achievements, worries, discrimination towards people living with HIV/AIDS.

Though, the results showed increased tendencies to stigmatise attitudes, partly due to the fact church leaders see HIV/AIDS as a consequence of sexual immorality, most of church leaders felt that, should any Christian/Muslim have the disease, they would care. This attitude was obvious especially to those who have lost parents, brothers, sisters or close friends. The challenge remains between the acquisition of relevant knowledge and the care of the HIV infected and affected people in the religious circles. Most of church leaders do not know how many orphans and widows those are needy in their congregations. Therefore, they could not undertake sound advocacy approaches to lobby resources neither to the government authorities nor to other stakeholders interested in the field of HIV/AIDS.

Involvement of Churches in Addressing HIV/AIDS

Evangelical Church of Cameroon (ECC)

Among many other churches, the Evangelical Church in Cameroon remains one of the main pioneers in HIV/AIDS work in Cameroon.

Its programme has a range of objectives including:

- To raise awareness on HIV/AIDS in the general population
- To reduce the risk of HIV/AIDS transmission

Main activities

The church's efforts have focused on the Youth and Women's ministry in:

- conducting awareness campaigns to the disseminate information and educate the population
- undertaking the training of trainers through seminars and workshops.

Outcomes

- Despite the church leader's good intentions and perceptions on HIV/AIDS, this is still perceived by the general population as a taboo, curse made by witchcraft etc. In order to build up the EEC's capacity, two aspects need to be reinforced: The first one is helping the general population to gradually change their attitudes and behaviour about their perceptions on the disease in order to help them accept people living with HIV/AIDS as normal people either in their families or in the community at large. The second is about the coordination mechanisms. In my opinion, there is little coordination between the different programmes within the same church. The EEC headquarter should make sure that all the necessary activities are coordinated to avoid unnecessary duplication and frustration among the staff.

Lessons learnt

- Increased stigma and discrimination towards people living with HIV/AIDS impede the efforts of those who are willing to get tested for fear of rejection. The process to reduce stigma should lie on transforming the general public perceptions on HIV/AIDS. At the Health Centre of Garoua, there is a great number of anonymous screening of seropositive compared to those asking for testing and counselling on a voluntary basis (Personal communication). In additional, staff would be reluctant to disclose HIV results to the concerned client since they are not trained to do that.
- Visit exposure is a clue to help people change their mind about HIV/AIDS as they become actors rather than spectators. A couple young people went from ECC to the Democratic Republic of Congo particularly to the Youth department of Eglise du Christ du Congo. After completing their visit exposure and the training of trainers workshop, they went back home. They submitted their project proposals to various donors. They received funds which are helping to do a great job to train others on prevention measures and voluntary counselling and testing, etc. Young people are now willing to be tested.
- During the mapping, I met in Cameroon the Executive Secretary of the United Evangelical Missions based in Wuppertal. In his talk, he made it clear that HIV/AIDS is still a priority within the UEM's mandate. This helped the EEC's leaders to understand that HIV/AIDS is an issue worth to be concerned about.

Cameroon Baptist Convention (CBC)

The Cameroon Baptist Convention is providing care to all who need it as an expression of Christian love and as a mean of witnessing the Gospel in order to bring people to God through Jesus-Christ. With regard to HIV/AIDS, in close collaboration with the government and other active stakeholders in the field of HIV/AIDS, the CBC health board is running many activities such as:

- Training of pastors, students and the general population at large
- Care of orphans
- voluntary counselling and testing
- prevention of mother-to-child transmission
- Tuberculosis control programmes

a) Training of trainers

This programme began slowly in earlier 1992. In 1996-1997, the training of senior nurses took place for AIDS education in schools, churches and cultural settings. In addition, the CBC launched the training of trainers on community AIDS education. In 2000, 2 key nurses and 2 physicians were trained in Uganda on antenatal AIDS screening.

Table 10: Number of affected and infected seen by the Health Promoters

Affected and infected	Number
People who made firm commitments towards AIDS prevention	3027
AIDS orphans seen	396
AIDS patients seen	65
HIV positive seen	97

Outcomes

- A rise in the population reached was observed in June and November because health promoters took the opportunity of political campaigns rallies to reach more people.
- The most sensitised population were youth followed by women and men
- A drop in the population sensitised were seen in April and August because most health promoters were on leave while health education was given to health units.
- The acceptance of people towards HIV/AIDS is high (98%)
- This helps the CBC Health board to know that the HIV prevalence is 10% in Bamenda.
- Nevirapine is administered to women during labour and afterwards. This reduced the HIV transmission about 50%. This helped children to stand healthier.

b) Care of orphans

The number of beneficiaries at the start of the programme was as follow:

Table 11: Number of beneficiaries

Beneficiaries	Number	
Caregivers	35	
Chosen children	66	
Current beneficiaries		
Caregivers		34
Chosen children		64

Comments

Two of chosen children and one caregiver died. This accounts for the reduction in the number of chosen children and caregivers. In this programme, the CBC Health Board decided to call the orphans “chosen children” in order to avoid the stigma associated with AIDS orphans in the communities.

At present, 623 chosen children were identified and registered. However, it has to be mentioned that this number is constantly increasing as health promoters, counsellors and churches continue to identify them. During the academic 2002-2002 academic year, the analysis of progress of chosen children was:

- 55 out of 65 chosen attended school
- 7 out of 11 chosen that had attended college were promoted to the next class
- 34 out of the 44 chosen children that attended primary school were promoted to the next class
- 1 of the chosen children is attending an apprenticeship workshop
- The other 9 were infants below school age.

In addition, these chosen children received the following assistance:

- School needs: Caregivers were reimbursed as they present receipts of the expenses for tuition fees, books and uniform

- Food subsidies: on two occasions, these chosen children were given food. The AIDS coordinator for North-West Province also provided foodstuff.
- Medical bills: CBC paid medical bills of the children who were ill.
- Christmas assistance: Caregivers were assisted to meet the needs for the chosen children.

c) Voluntary counselling and testing

The CBC is ensuring that voluntary counselling and testing does not stigmatise, debilitate or otherwise negatively affect the dignity of the very people who want to undergo testing. This helped CBC the shift from a medical driven approach to a participatory process. CBC has found a 9% positivity rate in blood donors and an 80% positivity rate in hospitalised patients with symptoms suggestive of AIDS during the period from January to October 2001. HIV/AIDS has been one of the main leading causes of death in 2002.

Table 12. Ten most common causes of death in Bamenda

Position	Cause of Death	Total deaths (N=1475)	Percentage
1	Malaria	186	12.6
2	HIV/AIDS	148	10
3	Meningitis	139	9.4
4	Pneumonia	82	5.5
5	Tuberculosis	78	5.2
6	Cardio-vascular diseases	65	4.4
7	Tetanus	26	1.8
8	Cancer	25	1.7
9	Abdominal problems	24	1.6
10	Post Operation problems	19	1.3

Comments

Like in many other developing countries, malaria is still the leading cause of death. In 2002, HIV/AIDS was the second cause of death in Bamenda. However, since 22% of TB patients were found to be HIV positive and most of the meningitis cases could probably be associated with HIV/AIDS. Therefore, HIV/AIDS and its opportunistic infections could be the main leading cause of death in Bamenda.

d) Prevention of Mother-to-Child Transmission

Because of its expertise and its credibility, the Cameroonian government has chosen CBC to lead the prevention of Mother-to-Child Transmission within 6 institutions namely the CBC health centres, the government, the CDC, the Catholic and the Presbyterian health facilities. In 2002, the PTMTC were operational in 66 sites where 11,881 women received antenatal services and thus were pre-counselled for HIV screening. 805 (7%) women refused to get tested for many reasons including the increased stigmatisation and discrimination. The acceptance rate was 11,088 (93%) women. 91 of 11,088 left without receiving post-counselling for personal reasons. 1,056 (9.5%) out of 1088 pregnant women screened were found to be HIV positive.

4,740 deliveries took place in the 66 sites. 365 HIV positive women and 348 babies were treated with Nevirapine. About 191 babies are listed for follow-up. What is outstanding within CBC is the fact that husbands of women attending antenatal services are encouraged to do HIV test. In 2002, 121 husbands were screened and most of them were negative. What is remarkable in this PTMCT programme is that this programme is being expanded to villages by including trained traditional birth attendants to handle it.

e) TB control Programme

The fight against HIV/AIDS and tuberculosis within the CBC Health Board is in its fourth year. Generally, people in the productive age (14-45 years old) constituted the large number of TB patients during the year 2002. The distribution of patients by their HIV status is presented as follow:

Table 13. Distribution of patients by their HIV status

Status	Frequency	Percentage
Positive	198	22.3
Negative	160	18
Not tested	529	59.9
Total	887	100

Comments

It has been acknowledged from scientific evidence the existence of co-relationship of HIV and Tuberculosis is very close. 40.7% of 887 patients were screened for HIV in Bamenda, while 59.6 refused. Out of 358 tested, 55.3% were found HIV positive. This can be one of the many reasons why in endemic countries, Tuberculosis patients usually show highest prevalence of HIV infection.

This comprehensive programme to fight HIV/AIDS deserves the Cameroon Baptist Convention's attention and encouragements since the CBC Health Board is one of the key players in Cameroon. For such a programme to be successful, among other contributing factors; training at all levels is a prerequisite condition, following by good incentive and the assurance from the church's side that there is the right number of personnel with the appropriate skills available in the right place at the right time. However, from my observations I felt that the current committee formed in 1998 is dormant and need to be replaced with a more dynamic one. Additionally, despite the indubitable managerial qualities and capacities of the current Director of the Health Services, he is overloaded with work and responsibilities.

Eglise Presbytérienne du Cameroon

The Eglise Presbyterienne du Cameroon programme includes the AIDS education, HIV testing, clinical and home-based care. The AIDS education HIV/AIDS promotes awareness and prevention activities among the general public. The EPC emphasised on Abstinence and faithfulness. The condom use is merely recommended within a discordant couple. However, this programme has not taken a comprehensive approach that would include not only the medical demands but also social and emotional needs of persons living with HIV/AIDS. An additional approach would be the encouragement of persons infected or affected to participate in the planning and the implementation of HIV/AIDS programme because this would increase the profile of persons living with HIV/AIDS within the communities and thus reduce the stigmatisation. In my opinion, the programme is not fully structured to bear fruits.

I met the Medical Doctor of the Djoungolo hospital who told me that for medical reasons, "suspected HIV persons" are tested in the hospital without their consent. As mentioned for the Evangelical Church of Cameroon, the health personnel is ill equipped to disclose the result to the concerned client. I told the General Secretary of EPC and the Medical doctor that they should put more effort to undertake those activities aimed at promoting voluntary counselling and testing as opposed to the anonymous screening of samples taken for sexually transmitted infections.

It is necessary to stress that the integration of activities in different areas of HIV/AIDS prevention in the health institutions-that bring together in the antenatal care unit and other diagnostic services, counselling, health education, and surveillance of the HIV/AIDS epidemic could be of strong benefit to the community at Djoungolo. This will help increase commitment of the health centre's and hospital's management and will help stimulate preventive measures at the community level. I appreciated the fact EPC was able to establish a national HIV/AIDS coordination which is led by a Pastor: Rev Aoumou. I hope that the HIV/AIDS programme will be strengthened.

The Catholic Archdiocese of Yaoundé

For the time being, Dr Anne Daban (Medical Director) said that she received time and support needed to start her project from the Bishop of Yaounde and other authorities. Health personnel are now open mind to work on the HIV/AIDS programme.

Objectives

- To provide medical care for opportunistic infections, counselling and support services to facilitate voluntary counselling and testing
- To implement home care that is affordable, accessible and efficient

- To build networks throughout the country among individuals living with HIV/AIDS
- To provide a forum for an open discussion of intimate problems, which are otherwise never shared?

Main activities

The Archdiocese of Yaoundé home-based activities aim at providing treatment for opportunistic infections and psycho-social care to persons living with HIV/AIDS. HIV/AIDS prevention, education, and surveillance are also important parts of the work. The Archdiocese of Yaounde has 4 health centres downtown and 3 in rural areas. People coming to those health centres are very often referred from local clinics. Home-based care begins with the identification of potential clients as a result of HIV testing. If diagnosed HIV positive, the person receives counselling sessions that include assessment of individual needs and wishes. This assessment helps identify appropriate follow-up procedures once the patient has been discharged from the health centre.

Another area is the support activities for the association of PLWHAs. Its service includes training for family members, health care visits to members and referrals, meditation and spiritual support, a weekly club meeting with visiting speakers and professionals.

Outcome

The Archdiocese of Yaounde response has been very encouraging. With courage and compassion, the Archdiocese has contributed to mobilise resources to care for and support those affected and to assist others in remaining uninfected. Particularly, senior people living with HIV/AIDS are providing moral support towards those newly tested HIV positive.

The condom issue is very controversial since it does not provide a lasting solution according to Dr Anne Darban. Instead, she proposed a constructive dialogue that is based on mutual respect, trust, faithfulness, testimony and marriage. 24 youth were trained on peer educators techniques to train others on those positive and Christian social values.

Lessons learnt

- The meeting of people living with HIV/AIDS have improved the quality of life of their colleagues in terms of updated information and experience sharing. Since most of resource persons are HIV positive or have been affected, so they are living examples of active people who have experience positively with HIV/AIDS.
- Alongside meetings, specific issues of coping with infection and taking the responsibility for self and family well-being are discussed in the presence of counsellors. People living with HIV/AIDS appreciate that they have been given time for them to express their concern and to know specialist to whom they can be referred to in case of acute infections.

3.2.5 The Muslim Community

The Muslim Community Programme activities focus on: Prevention and care.

❖ Prevention:

The Muslim circles are blunt that HIV/AIDS is the result of disobedience to God's law. The prophet said: "*when sexual wander and its consequences will prevail in society, God's will punish upon the society*". The Imam said that the World Bank and the International Monitoring Fund have imposed the condom use that encourages sexual promiscuity. According to the Koran, "*…fornication and adultery are forbidden. Whoever does not abstain from sex will fail. Once the humankind is not in good relation with God, the flesh takes the lead. This is where sins begin…* ".

When I asked the question if they had a youth programme to combat HIV/AIDS, the answer was: "*when the youth reaches the reproductive age, he ought to marry*".

Comments

It is clear for the Muslim of Cameroon that abstinence and faithfulness are the two preventive measures that are promoted. However, they should understand that HIV/AIDS can happen to anybody. It is no longer the matter of people who fail to be faithful. Even someone who is faithful, but who is "sero-ignorant" can be infected or can pass on the virus to others. In addition, religious communities that have no policy for the youth interfere in youth projects to the extent that they become obstacles instead of facilitating them to acquire life skills to avoid HIV/AIDS.

For instance, Switzerland promoted condom use and now the result is that many youngsters choose to postpone sexual involvement. Similarly, Uganda did the same by allowing people to talk about all the methods to prevent AIDS. Now increased abstinence among young people is obvious. Uganda remains one of a few African countries to have turned a major epidemic around from 14% in the early 1990s to 8% in 2000. There is no scientific evidence that the more you talk about condoms, the more promiscuous people become.

❖ Care of HIV infected

With regard to people leaving with HIV/AIDS, the Muslim said that they are not abandoned for the Koran recommends to help anybody who is needy, whatever his/her fault. The Muslim circles have hospitals and health centres where these people would be care for.

❖ Lessons learnt

The success of HIV/AIDS programme in Muslim circles includes the following:

- Widening the knowledge of the people about HIV/AIDS
- Making local posters on HIV/AIDS available to schools and communities
- Helping people talk about HIV/AIDS
- Increasing Voluntary Counselling and testing, prenatal and premarital HIV testing
- Active listening during sensitisation workshop
- Adoption of some behavioural change
- Reaching the target in the communities, schools, mosques
- Reduction of the stigmatisation of HIV/AIDS

4. POVERTY AND HUMAN RIGHTS

The AIDS epidemic has a profound impact on economic growth, income and poverty. It is estimated that the annual per capita growth in sub-Saharan countries with a high HIV prevalence, is falling by 0.5-1.2% as a direct result of AIDS. It is obvious that people at all income levels are vulnerable to the economic impact of HIV. However, the poor people suffer the most as the epidemic is driving forward the cycle of impoverishment. As mentioned earlier in this report, HIV/AIDS has risen to alarming levels in many parts of Cameroon among the 15-45 years old who are the most productive workers. The consequences will be felt in all sectors.

AIDS is a costly disease, which requires medical care for patients and an increasingly significant proportion of available hospital beds. As a result, programmes in Cameroon that aimed at combating HIV/AIDS run the risk of absorbing an increasing portion of the budget, at the expense of other activities within the health sector and elsewhere. In addition, public and private health institutions are not able to provide the necessary care for AIDS patients. This means that the significant increasing number of AIDS patients will weaken an already fragile health system.

AIDS pushes people deeper into poverty as households lose their breadwinners to AIDS, livelihoods are compromised, and saving is consumed by the cost of health care and funerals.

When I collected data related to the religious communities' perceptions, I observed that a couple church leaders were talking about the many epidemics that are embedded within AIDS pandemic. On the surface, it looks like those Cameroonian church leaders are getting open to fight AIDS. However, openness of course, must not exist only at talking level. It should be accompanied with concrete actions. A part from, the Cameroon Baptist Convention I did come across any church project which holds a visionary approach to fight both poverty and HIV/AIDS.

> *"Church leaders who use AIDS to control their congregations adopt very often misleading messages and approaches. But church leaders who are using their church to control AIDS become more realistic and competent in the way they approach HIV/AIDS"*

Another aspect that deserves much attention is the lack of knowledge and the effects of harmful traditions. The spread of HIV epidemic is also exacerbated by tradition that stipulate that, while women are prohibited from having sex during their first two years of breastfeeding after each delivery, men are expected to have sex almost daily,

based on the myth that to stay healthy, men need sex. This leads to heavy use of occasional partners and prostitutes, followed by infection of spouses and subsequent children.

With regard to human rights, stigma, denial and discrimination impede efforts to slow down the spread of HIV/AIDS and to improve care and support of PLWHAs in Cameroon. With a HIV prevalence of 12%, the discriminatory attitude of health personnel, the church and the larger community hinder efforts to ensure voluntary counselling and testing and adequate treatment for opportunistic infections. Many programmes run by the religious communities to combat HIV/AIDS have focused on awareness raising, sensitisation workshops and training of youth volunteers. Strategies to fight HIV/AIDS in Cameroon should underline factors which make people silent about HIV/AIDS. Stigma and discrimination of people living with HIV/AIDS should be definitely considered as sins and as human rights violation.

5. Partnership Between Government and Religious Communities

As a component of HIV/AIDS programming, strategic planning has undergone valuable and deep changes in Cameroon. In the early days of the epidemic, strategic planning was largely conducted in a top-down approach fashion within the Ministry of Health. However, this top-down has proved to be unworkable. Religious communities involvement is nowadays seen to be the key to successful planning, and the strategic planning in Cameroon has begun to involve faith-based organisations in quite all aspects of planning, implementation and evaluation. This involvement has strengthened the process greatly by ensuring participation and inputs of faith-based organisations at all levels.

The partnership between government and faith-based organisations is visible. Church leaders were quite fully involved during the World AIDS day to gather information about what works, what needs improvement and where gaps exist within their congregations to strengthen the churches' response to HIV/AIDS.

Additionally, faith-based organisations received funds to start implement their projects. One extremely critical difficult component that strategic planning faced in Cameroon was the development of budget scenarios. Most of the faith-based programmes did not prioritise their plans according to available funds and resources. Therefore, it was difficult for the National AIDS Control Committee to ensure a consensus on the priority interventions and on the funding and resource available to implement them. In order words, most budgets were overestimated. There seems to be a clear consensus that the resource available for HIV/AIDS programming has been grossly inadequate to produce an effective response. However, many churches are still turned to their traditional donors while recently at the Abuja Summit on HIV/AIDS, African leaders committed to spend 15% of their gross national product for health care and a response to HIV/AIDS. This is an illusion for many African countries including Cameroon.

However, Cameroon deserves encouragements since the government did its best to distribute the money that should help religious communities to fight AIDS (see the list page 8). Here are some of the problems that faith-based organisations faced to lobby resources towards the government:

- Some of the faith-based organisations have no experience writing project proposals
- Not all the faith-based have the same level of experience in project development
- Faith-based organisations tended to overestimate their capacity to implement and their proposed coverage of populations, geographic sites and budget
- A considerable amount of times in terms of back and forth was required before a mutually satisfactory budget and programme of activities was finally agreed between the National AIDS Control Committee and the concerned faith-based institution
- Some faith-based implementing partners never implemented HIV prevention programme and did not receive training of the basic principles
- There were limited financial resources in the government institutions
- Some faith-based organisations did have appropriate and skilled human resources
- Communication was difficult within resource-poor setting in rural areas
- Because of lack of effective network among and between faith-based organisations, they are still working in isolation. Instead of reaching concerted efforts, the money divided the faith-based organisations to fight HIV/AIDS collectively
- Strategic errors in occur in the rush to select great geographic areas and populations.

6. ECUMENICAL ORGANISATIONS AND HEALTH FACILITIES

Ecumenical organisations

FEMEC (Federation of Protestant Churches and Evangelical Missions in Cameroon)

FEMEC has been acknowledged by most of the church leaders as a required channel that would bring most of the protestant churches to combat HIV/AIDS altogether. This is true because protestant churches are working with the same objectives when it comes to preventive measures (abstinence, faithfulness and condom use) since recognising the magnitude of HIV/AIDS, church leaders have declared HIV/AIDS as one of the many security and development issues, Cameroon is facing today. However, resource allocation remains a key challenge for success. While a growing number of effective clinical and behavioural interventions are being made available to reduce HIV transmission and improve care and support for those living with HIV/AIDS in government departments, the resources available for churches to effectively implement these interventions is insufficient. In addition, Catholic and Muslim were still uncomfortable to deal with these HIV preventive issues.

CLE editions

To combat the HIV effectively, new partners and stakeholders should be identified and brought up to date on state-of-the art knowledge about HIV/AIDS. CLE editions would be on of the new partners since it has many years of experience to publish books and literature that people are able to read and understand as they are written in their own languages. The Director of CLE went on commenting that interventions targeting individuals have shown success. But individual behaviour is strongly influenced by broad factors such as a societal norms, access to programmes and services influences and public policy. In my opinion, I think that for HIV/AIDS programmes to be successful and sustainable, information must occur on multiple levels to influence individual and societal norms, improve health services, and alleviate structural and environmental constraints to prevention and care.

The Bible Society of Cameroon

Experience has shown that consistent messages from a variety of legitimate sources must be disseminated in an interaction fashion to affect behaviour change. The Bible Society of Cameroon is willing to publish portion of biblical verses of HIV prevention that aimed at changing individual, community and societal behaviour change. I encouraged the staff of the communication and Human Management Resource departments who are willing to publish those biblical verses to avoid judgmental attitudes and verses that would encourage stigmatisation and discrimination of HIV infected and affected. Indeed HIV/AIDS-related stigma continues to inform perceptions and shape the behaviours of PLHAs, which can hamper prevention programmes. The Bible Society of Cameroon will do a great job to develop policies to combat discrimination that is crucial to any HIV prevention. Stigma reduction is both a human rights and a public health issue.

AFCEDD

The “Association des Femmes Chrétiennes Engagées pour le Développement de la diaconie” (AFCEDD) is aware that there is a big deal of lack of awareness of HIV transmission and personal infection in pregnant women, and underdevelopment of voluntary counselling and testing services, including limited integration into the Mother-to-Child Transmission sites, low compliance in taking longer-course ARV and inconsistent care for mothers living with HIV/AIDS. Additionally, AFCEDD acknowledges that once HIV prevalence reaches 10% (as it is currently in Cameroon), it can surpass 50% in just one to five years. That is why AFCEDD is fighting poverty which is the leading cause of HIV/AIDS transmission in Cameroon. This programme has proved to be very effective in disseminating messages about HIV/AIDS. It is evident that, in order for women to make headway in combating the epidemic, there is a need for collaboration of other stakeholders that are influential in the community. Though women are still considered as key players to fight HIV/AIDS, they are continuously undermined by men. This must change since women have the potential to be a substantial resource in the struggle against HIV/AIDS.

Presbyterian Theological Seminary of Kumba

HIV/AIDS is being taught in an interdisciplinary ways in Old and New Testament, Systematic Theology, Practical Theology and African Traditional Religion. The course is aimed at making students familiar with the phenomenon of AIDS, its history, including its transmission and possible prevention measures and its current magnitude especially in Africa and elsewhere. Students are expected to develop in creative and critical ways a Christian and pastoral

response towards attitudes and policy concerning HIV/AIDS of various churches and especially the Presbyterian Church of Cameroon. This includes perspectives on new sexual ethics, theological perspectives in response to AIDS and pastoral care and counselling for people affected by AIDS. This initiative is worthwhile to be replicated elsewhere.

Faculty of Protestant Theology of Yaoundé

Having organising the Theological workshop on HIV/AIDS in close collaboration with the Theological Consultant for Africa, the Faculty of Protestant Theology in Yaoundé is looking forward to running HIV/AIDS modules for theological students. What is outstanding is the "Ecumenical space" that teaching has taken. In fact, a national committee was set up after the workshop. This committee is constituted of the Dean of the Protestant Theology of Yaounde, the Dean of "Faculté de Théologie de l'Université Catholique d'Afrique Centrale", the Dean of Presbyterian Theological Seminar of Koumba and the Dean of Theological School of Kaélé. The committee has been given the mandate to integrate the module of HIV/AIDS in the curriculum of their respective institutions. Contrary to common understanding of theological institutions in Africa, the network of theological faculties in Cameroon has made a substantial commitment to the spiritual journey of hope for those both infected and affected by HIV/AIDS by training accordingly future pastors.

Health Facilities

Central Hospital of Yaounde

Experience has shown that people living with HIV/AIDS may live longer before their HIV infection leads to secondary and eventually AIDS. Antiretroviral treatment has demonstrated impressive results. Antiretroviral are now available in many developing countries including Cameroon. However, they are still available to a very small and mainly wealthy minority. ***Hopital Le Roseau***, a private hospital run by a team of private medical practioners and ***Laquintinie***, one of the public hospitals in Douala have established special services to offer ARV treatment and counselling to persons who seek clinical care.

Hopital du Jour

Hopital du jour which is the HIV/AIDS treatment and counselling centre at Central Hospital of Yaounde is managed by Dr Tardy Michele who felt the need to facilitate the acquisition of ARV drugs at lower-than-market cost by people living with HIV/AIDS. Before then, ARV were available at a very cost (approximately 450,000FCFA or about 650USD). Since the Cameroonian subsidised prices, the cost is about 25,000 FCFA). Counselling within the Hopital du jour is done by people living with HIV/AIDS. However, there were shortcomings in terms of :

- drugs were accessible to a very small and mainly wealthy minority
- biological testing were still expensive as ARV (85,000 FCFA) that are needed to be renewed each six months
- ARV treatment is still misunderstood by both health professionals and the general community
- compliance: therapy requires a strict individual protocol and reliable psycho-social support. A good compliance remains a challenge since ARV is expected to be administrated for life.
- the re-emergence of HIV strains resistant towards ARV is still a public concern.
- Drugs were obtained in an irregular manner and very few medical practitioners had clinical experience on their use.

Banso and Mbingo Hospitals

It is too soon to conduct a formal evaluation process. However, from testimonies of patients and according to the Health Personnel, the efforts of the two hospitals of the Cameroon Baptist Convention have assisted in achieving among other things, increased and adequate HIV/AIDS care and treatment, changes in policies regarding safe dispensing and good adherence to treatment protocols. The psychosocial support provided to people living with HIV/AIDS in collaboration with the HIV/AIDS coordination in the Northwest Province has had an added advantage to relieve their emotional and social problems. However, most patients complained about the cost and said that until now ARV treatment is accessible to a very minority of people. They proposed that the government should allocate more public funds to finance anti-retroviral therapy drugs more affordable and available for the growing number of people living with HIV/AIDS in Cameroon irrespective of their socio-economic situations.

Cameroon National Association for family welfare (CAMNAFAW)

CAMNAFAW's goal is to support and re-enforce the efforts of the government in promoting in promoting the welfare of the Cameroonian population in the area of Sexual and Reproductive Health and Family Planning. Some achievements of CAMNAFAW are as follow:

- A model reproductive Health/Family Planning Clinic in Douala and Yaounde
- Youth guidance and counselling centres in Yaounde, Bamenda, Douala, Buea and Ebolowa
- A training centre for young girls in Yaounde called skills development unit.

CAMNAFAW also works in close collaboration with churches and church related organisations which share its views and concerns on health in general and reproductive health in particular.

7. ORGANISATIONS OF THE CHURCHES INTO A NETWORK

Federation of Protestant Churches in Cameroon

The epidemic is demanding churches to find better science, better ways of moving the government to action for his own people, better ways for carrying for each other, better ways of ensuring that others do not have to endure the night mare. However, despite the existing of this platform of churches (FEMEC) did not have a coherent HIV/AIDS policy. Each individual church submitted project proposals in isolation. FEMEC needs to be revitalised!

CONCLUSION

The only institution in our society that has large numbers of people gathering on a regular basis, with a common set of altruistic values, and intact system of communication are the churches. They should coordinate among themselves so that the needs of the people living with HIV/AIDS can be met. During the mapping in Cameroon, I saw thousands of volunteers of Cameroon's religious care for the sick, take people with AIDS to hospitals, clean homes, conduct rituals of remembrance and loss, provide a loving ear and a tender heart to someone facing uncertainty of the journey called AIDS.

However, for those involved in the day to day life of AIDS ministry it is clear that much harm has been done to persons with AIDS by segments of Cameroonian religions. Campaigns of hate, bigotry and discrimination have caused serious damage to the hearts and souls of people already stigmatised by a fatal disease. Therefore, it could be partly understood why some individuals want to distance themselves from the "churches" because of the acute amount of pain inflected on them by some church leaders who condemn them "intrinsically evil". I have come myself across people infected or affected by HIV who considered the churches as their enemy. As one woman living with HIV/AIDS said to me:

> *"…we only trust health professionals because they do their best to understand our condition. They are often available to answer our questions. Here in Cameroon, if you disclose your status, you will lose your membership in the churches, you will lose your job and family members, and the society and the church will reject you. In Cameroon HIV/AIDS is a taboo, it is shameful, and it is a curse. We would like to learn how other countries people managed to accept those who are HIV positive and speak about HIV/AIDS openly.."*

Churches should understand that the advent of HIV/AIDS has also provided a means of re-examination of what faith means for us, how we find it, and how nurture it and how we can share it with others in the HIV/AIDS era. Churches must take the significance of the AIDS problem even more seriously than they have done up to now. There is no doubt that the way churches will handle the AIDS infected and affected will determine if they are churches of Jesus-Christ or not.

Time is come to welcome the infected and affected in a spirit of love, acceptance, tolerance and openness. This will help the churches to overcome judgemental attitudes and not ask where a member has become infected but rather how the church can support him or her. As followers of Jesus-Christ, church leaders/lay people need to become

forerunners because of stigma and denial which is an important aspect of undermining prevention, counselling and care. Additionally, denial and silence are still prevents people speaking openly about HIV/AIDS.

Having exchanged views on the notion of ecumenism, I felt that there are numerous conflicts not only within the churches and religions but also among churches and religious. Christians should understand that HIV/AIDS can only be defeated if they work closely among themselves and among other religious. The faith in God that churches proclaim is a source of hope, empowerment and communion that surpasses all human understanding and experience, even in the face of suffering and death due to HIV/AIDS.

RECOMMENDATIONS:

Based on the above findings, my recommendations are as follow:

Policy

- Based on the Plan of Action of the Ecumenical HIV/AIDS Initiative in Africa or not each individual church should have its own Plan of Action in order to avoid the "church double-standards" regarding the HIV/AIDS issues
- Church leaders should also launch a solemn to all political, economic and social actors to combine their efforts in the formulation of efficient and sustainable policies and programmes as well as in the mobilisation of adequate resources to combat HIV/AIDS
- Church should pledge to establish systems of information, of collection and dissemination of information, statistical data and pertinent indicators on the impact of HIV/AIDS on national level in order to enable positive action
- A realistic compromise of condom is required among churches/religions in order to help them conduct a vast programme of education, sensitisation, training. and communication for church members and the population at large
- Church should become welcoming communities of care and support for people infected and affected by HIV/AIDS and affirm and value their participation in all church activities and programmes.

Congregations

- The many church leaders who attended theological reflections and workshops must equip others in pastoral care and social ministry to tackle HIV/AIDS
- Should break the silence that surrounds issues of sex, sexuality and sexual relationship by developing and sharing experiences, strategies and educational material that enable open discussion on issues related to HIV/AIDS
- With regard to HIV/AIDS, congregations should proclaim message of hope, healing, compassion, perseverance and courage instead of promoting judgemental attitudes.
- Have the responsibility to ensure follow-up of lessons, material and personnel activities in the field

Communities

- Need that the necessary, accurate and updated information are given in a creative ways because people still have little or incorrect information of this disease
- Should disseminate preventive education to their constituencies by using theatre groups, seminars for women and youth leaders, pastors and evangelists
- Need to understand that people infected and affected of AIDS are their parents, children, brothers and sisters, all members of the body of Jesus Christ
- Therefore, they must accept them as resource persons and crucial allies in the fight against HIV/AIDS
- Must encourage people to take care of those infected and affected by HIV/AIDS, rather than blaming them.
- Must warn young people in affective way against the risks of uncontrolled behaviour

Counselling

- The major barrier to voluntary counselling and testing is fear of stigma. It is particularly important for churches to ensure that testing is performed and results given without breaches in confidentiality

- Voluntary counselling and testing instead of anonymous screening of samples taken for Sexually Transmitted Infections should be promoted at the national level
- Wherever counselling takes place, whether at home or in clinic, it must be held privately and confidentiality should be given priority
- Significant positive results can be achieved by moving counselling interventions closer to target populations and actively involving infected and affected people in counselling delivery
- Counselling services should be intended to provide comprehensive care for clients in the home and thus reduce the need for hospital admission
- Churches should make sure that drugs, psychological support and clinical care are available for people who test HIV positive
- Whatever approach is taken, the voluntary counselling and testing interventions must be evaluated regularly to determine whether it is being provided in accordance with the predetermined national protocol and is satisfying clients needs.

Advocacy

- Leaders of Faith-based organisations should be effective in calling upon government's responsibility to make HIV/AIDS a real priority and mainstream it into poverty reduction strategy which bears fruits at the grass root level
- It is the duty for church leaders to pledge for many infected persons who are currently lacking access to palliative care services and medications. Palliative care should be provided in hospitals and in the home environment
- Church leaders should play an active role in disseminating non-stigmatising and discriminative preventive messages, and in leading the fight against stigma wherever it occurs
- Church leaders should understand that caregivers also need support to help them do their jobs well, avoid "burnout" and keeping going, free of HIV infection
- Social exclusion is at the root of HIV vulnerability. Extending dignity and respect to all people is therefore key to responding to HIV instead of exclusion of people from social support and networks because of their religion, social standing, HIV status etc.

Networking

- Alliance-building across denominational and faith organisations and the revitalisation of FEMEC will be a key strategy for expanding the churches' responses to the many challenges of HIV/AIDS and to lobby resources towards donors accordingly
- Educational and learning materials are already produced locally. In addition to any external one Churches should encourage its adaptation and distribution especially in local languages.
- A unified effort of churches is needed to fight HIV/AIDS since most of them have valuable experience, best practices and lessons to share, and these can accelerate this shared response.
- Prevention and care are complementary and not competing priorities. Effective prevention efforts that combine education, information, services and structural change to the social environment are needed on a massive scale around the country
- With regard to the condom use, Protestants seem to be close to the government's policies to combat HIV/AIDS. However, they should avoid the language of triumphalism
- and seek ways to live in peace with those from other religions.

World Council of Churches and other partners

- The World Council of Churches and other partners have gained a vast amount of knowledge and about effective strategies against HIV/AIDS from the many international conferences organised, mapping of HIV/AIDS and community mobilisation. This knowledge must be used to translate commitments into action.

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CHAD

"AIDS is everyone's problem, let us fight it together!"

Rév Canon Gideon BYAMUGISHA

1. GENERAL AND EPIDEMIOLOGICAL DATA

1.1. General data on the Republic of Chad

1.1.1. The Republic of Chad country profile

Chad is located in Central Africa region and it has a total of 1,284,000 square kilometres. Chad is bounded to the East by Sudan, to the South by Central Africa Republic, to the North by Libya and to the Northwest by Niger. The Republic of Chad is divided into 11 provinces of which Ndjamena is the Capital city. A Préfet nominated by the government administers Chad's 11 administrative regions. Regions are sub-divided into districts, headed administratively by *sous-préfet*. Apart from its huge superficial area, Chad is landlocked country since it does not have access to the sea. As far as the access by port is concerned, Chad relies on Cameroon, Central Africa Republic and Congo/Brazzaville's ports.

1.1.2. Population

Based on the 1999 population census, the population was estimated at 7,5 million people of whom 44% are 15 to 49 years old and 42% are under 15 years old. Old people represent 5%. Taking into account the high birth rate of 2, 4%, this has led to rapid expansion. Ethnic groups are numerous. Sara's people are located mainly in the South whilst Arabic, Peulhs, Baguirmians, Kanembous at the Centre. Kotokos and Boudoumas and other Saharan people are nomadic and rely mainly on cows and trade market products.

There are 12 African languages, with French and Arabic as official languages. Intellectual people mainly speak French in urban areas whereas Arabic and Sara are the vernacular languages. African religious beliefs influence both Muslims who constitute 60% (concentrated in the north and in the centre) and Christians (Catholic and Protestant) 40% are concentrated in the South. Indigenous beliefs are still prominent in the communities.

Table 1: Demographic Indicators

Demographic Indicators	*Year*	*Estimate*	*Source*
Total population (thousands)	1999	7458	UNPOP
Population aged 15-49 (thousands)	1999	3283	UNPOP
Annual population growth	1998	2.9%	UNPOP
Annual growth rate of urban population	1998	3.7	UNPOP
Population urbanised	1998	22%	UNPOP

1.1.3. Economy

Chad is one of the poorest countries with a GDP estimated at USD: 230. The life expectancy is 47 years. Obviously, this will be dramatically reduced with the explosion of HIV/AIDS. The economy, which depends highly on the subsistence agriculture, remains fragile and is not properly industrialised. Suffice is to say that nearly 80% of Chadians are relying on this economy. The second sector is less developed because of the highest cost of petroleum and energy. Agricultural products are being transformed by a few industries namely COTTONCHAD (for cotton and soap), SONASUT (for sugar) and breweries. The third sector is dominated by the informal sector.

However, this is undermined by lack of road infrastructure, less air flights liaisons and the fact that the country is landlocked. Much of infrastructure has been destroyed during the long civil wars and political unrest that prevailed in the country. The country has been stabilised in 1990 whilst the economic production started in 1997. The Chadian's currency is the *"Communauté Financière Africaine Franc",* note-responsible authority of the Bank of the Central Africa States.

Table 2: Economic Indicators

Economic Indicators	*Year*	*Estimate*	*Source*
GNP per Capita (USD)	1997	230	World Bank
GNP per capita average annual growth rate	1997	3.5	World Bank
Human Development Index rank (HDI)	2000	167	UNDP
Population economically active	1993	43.9%	ILO

1.1.4. Education

Chad has had an education system characterised by low participation and low literate rates by Sub-Saharan Africa standards. Roughly ¾ of women in Chad aged 15 to 49 have no schooling, 80% marry while in their teens. Although, Chad committed itself to revitalise the education system that was heavily deteriorated during civil wars that affected the country from 1972-1982 before adopting Education-Training-Employment, it has be noted that virtually little progress has been achieved since skilled personnel are lacking in many areas of social life. This situation is due to difficulties listed below:

- Enrolment levels and the quality of education have been deteriorating for over a decade
- Insufficient of scholarly infrastructure
- Insufficient and lack of qualified personnel
- Scarcity of learning and teaching material
- High disparity between regions and sexes

In addition to the above shortcomings, the economic crisis that prevails in the country and the subsequent high demographic pressure (2, 4%) make it difficult for the government to provide appropriate financial and material resources that can solve the education problems with the existing infrastructures. Primary, secondary school and vocational institutes are under-resourced, of insufficient quantity and low quality particularly in rural areas.

The depleted condition of state education in Chad is alarming in terms of many schools that need rehabilitation. Additionally, technical and vocational training are characterised by:

- Shortage and under qualification of teachers
- Tendency to conduct traditional training that is no longer relevant to the communities needs. A baseline study would be necessary in order to match the training with community needs.
- Drop-out of both rural and urban areas are due partly to a combination of parent's poverty, teacher shortage and the poor quality of education.

Table 3: Education Indicators

Education *Indicators*	*Year*	*Estimate*	*Source*
Total adult literacy	1995	48	UNESCO
Adult male literacy	1995	62	UNESCO
Adult female literacy	1995	35	UNESCO
Male secondary school enrolment ratio	1996	16,2%	UNESCO
Female secondary school enrolment ratio	1996	4,1%	UNESCO

1.1.5. Health

The government is committed to promote Health for All in Chad. However, despite this political will, there are increasing difficulties from professional and resources perspectives. The current health coverage does not match with the general population demand of 1, 4 medical doctors for more than 100,000 people. Additionally, medical and other paramedical specialists are heavily lacking in the field of health. Training institutions are falling short of the population needs. Vehicles for urgencies and biomedical material such as microscopes, radios etc are badly needed. Donor and partner's contributions helped Chad to rehabilitate and equip partly the deteriorated infrastructure by the civil wars during 1979-1992.

Additionally, the partner's inputs contributed to implement projects and programmes for disease control namely: malaria, onchocerchiasis, trypanosomiasis, leprosy, tuberculosis, paediatric disease, respiratory truck diseases, diarrhoea and HIV/AIDS. According to the Ministry of Health, more than 50% of people living with HIV/AIDS are 15 and 45 years old.

Despite such efforts, Chad's health care system is woefully unprepared with AIDS or any other serious medical problems. For instance, the main hospital in Doba, a major town in the oil region, has no electricity and is lighted at night by kerosene lamps. Medical material are not sterilised, but rather washed in warm water, and disposable syringes are routinely reused, say health specialists who recently visited the hospital (personal communication).

Table 4: Health Indicators

Education *Indicators*	*Year*	*Estimate*	*Source*
Crude birth rate per 1000	1999	43	UNPOP
Crude death rate	1999	17%	UNPOP
Maternal mortality rate per 100 000 live births	2001	900	MOH
Life expectancy at birth	1998	47	UNPOP
Total fertility rate	1998	6%	UNPOP
Infant mortality rate	1999	110	UNICEF
Contraceptive prevalence rate	1999	4%	UNICEF
% births attended by a trained health personnel	1999	15%	UNICEF
% of one-year-old children fully immunised	1998	24%	UNICEF

1.1.6. Poverty and vulnerability

Nine of ten HIV infections in Chad are caused by sexual activity. Therefore, most of factors related to sexual promiscuity that happens in some areas of Chad are leading to the spread of HIV/AIDS. This is not limited to those outside the church. AIDS is real and it is in denominational churches. Poverty is the leading cause of HIV infections particularly among the youth. In early days of the onset of HIV/AIDS, wealthy men who used to visit sex professionals are now looking for young girls in schools, believing that they are HIV/AIDS free. In addition, Chadian culture often creates a feeling of inferiority in girls. Since, sex education is no longer available either in family or in school; girls do not find it easy to reject a man's advances. Therefore, young girls are particularly in great risk of getting HIV infection.

In many areas of Chad, ignorance about AIDS is profound. I think that ignorance is one of the main reasons why the epidemic is still prevailing. Because of the increasing number of burials of young adults, Chadians are beginning to observe that something sinister and catastrophic is happening. In addition, there are many people who are living with HIV/AIDS without having a clue of having the virus. Some people do know that they have the virus but do not know how they got it. Although, surveys revealed that many Chadians had the opportunity to acquire basic facts or to attend a workshop on HIV/AIDS, because of high degree of illiteracy (80%), a few Chadians had the chance to read pamphlets or books on AIDS. Schoolteachers hold little information about HIV/AIDS.

s infected with HIV, often s/he is ashamed and frightened. S/he may deny his/her illness and s/he will hide his or her condition from others in order to lessen the risk of becoming outcast from the family and of being rejected by neighbours.

Additionally, affected family rarely does not admit that AIDS was the cause of a beloved one's death. If you ask questions to probe why somebody dies, they say that it was from malaria, tuberculosis or witchcraft. In a country where levirate marriage customs, the marriage of young orphan girls, particular sexual practices allowed in traditional society, the belief in witchcraft could be enabling causes of the spread of HIV/AIDS.

Recent oil found in Doba province in Chad could also provide an opportunity for HIV to be spread. As the consortium was gearing up for construction in 2000, Chad and Cameroon used a World Bank loan to hire a health consultant to analyse the pipeline impact on AIDS cases. He predicted that unless aggressive measures are taken, the pipe line project would lead to 100 additional AIDS deaths annually within several years. He went on stressing that the pipeline would cause an HIV rate increase because that is what happened with previous projects in Africa. The promise of jobs drew thousands of truck drivers and workers from local areas and neighbouring countries. Since tons of material was trucked to the Chadian oil fields from Douala, a Cameroonian port town, where tests found that 17% of truck drivers are HIV+, at a boarding crossing on the M'Bere River were trucks stop to clear customs, 55% of the commercial sex worker in a pipeline shantytown were HIV+. *You had all the conditions for HIV to work its way into Central Chad with the truck drivers*", Jobin said.

1.1.7. Politics

With regard to public health, Chad does not have its own written policy. Instead, Chadian government is heavily relying on French public health policy which does not take into facts and realities of Chadian context on the ground. This shows that Chad is one of the poorest countries with a precarious health system. In 1990, 25 % of Chadian was estimated to have access to Health for All package compared to 30% in 1995.

In terms of health personnel, the health system is largely deficit in quantity and quality. For instance, Chad had only 250 medical doctors of whom 50 are expatriates (Annuaire des statistiques 1997, Tome A).

As part of its health policy, the Chadian government is committed to reduce the morbidity and mortality rates due to HIV/AIDS. Special attention is given to prevention and care of people living with HIV/AIDS. This prompted the government to set apart a budget worth of 400 million of Francs CFA for the care of the infected.

1.2. Epidemiological data

1.2.1. Epidemiological data of HIV/AIDS epidemic in Chad

As in many countries of Africa, the first cases of AIDS were reported in Chad in the mid-1980s, but the disease has not spread as widely as it did elsewhere on the continent, probably because of the country's isolation. In 2000, it was estimated that Chad's adult AIDS infection rate was 6%. From 1986 up to 2000, the National AIDS Control Programme estimated 13,385 HIV/AIDS cases reported.

Table 5: HIV/AIDS reported cases from 1986 to 2000 in Chad	
Year	Number
1986	02
1987	02
1988	07
1989	10
1990	38
1991	165
1992	363
1993	1,010
1994	1,268
1995	1,132
1996	1,242
1997	2,748
1998	2,030
1999	1,664
2000	1,704
1986	02
Total	13,385

Source: Etude sur la législation en matière de lutte contre le VIH/SIDA/IST au Tchad 2001, page 16.

Comments

In my opinion, these figures are not reliable. In fact, during the onset of AIDS, the government stances towards the AIDS pandemic was characterised by denial of the disease. The government seriously took its responsibility when AIDS cases increased from hundreds to 1010 in 1993. This subtle increase could be the consequence of the 1980s when many stakeholders including the government did not properly deal with the epidemic. As a result, from 1993 to 1996, the National AIDS control Programme has diagnosed more than one thousand of AIDS cases per year. And ever since, this is on the increase. In December 2000, 1704 cases were diagnosed within the national territory of which 63, 2 % were 15 to 49 years old.

The above table shows the evolution of HIV/AIDS as a result of the long civil wars and the notification of the number of AIDS cases has not been carried out systematically for many years. In many rural areas, there are little testing facilities and record keeping. Some statistic gathering in the National AIDS Control Programme is partly guesswork since the years following 1990 were years of violence, including large scale of sexual violence and disruption of the health system. This suggests that the current HIV prevalence of 6% is much lower than the reality on the ground, as a result of some studies. An estimate of infection rate of between 8 and 10% may be true bearing in mind that if the HIV/AIDS is still unchecked; this epidemic will erase the benefit of peace and post-war reconstruction in Chad.

1.2.2. Sentinel Surveillance

Ndjamena and Doba have been considered as the major urban areas where many studies have been carried out. The median HIV prevalence rate among the antenatal clinic attendees in Ndjamena increased from around 2% in the late 1995 to 6% in 1999. Outside of Ndjamena, a mean of 5% of antenatal clinic women tested HIV positive in

ABECHE, BOL, BONGOR, and SARH in 1999. In 1995, 13% of commercial sex workers tested in Ndjamena were HIV positive. Additionally, 10% of military personnel tested in Ndjamena were HIV positive. Due to low level of HIV testing and counselling in Chad, most people do not know their HIV status. No further information for vulnerable groups was available due to the economic turmoil and the civil wars that took place in the country. At the end of 1999, an estimated of 13,000 adults were reported to be living with HIV/AIDS of whom 53% were women.

During the previous 5 years, since the surveillance system did not exist, thus the accuracy of the epidemiological data is questionable. Therefore, the existing data do not reflect the reality of the pandemic on the ground taking into account the many contributing factors that are likely to spread the HIV/AIDS. However, limited information is available on HIV prevalence among the general population.

1.2.3. Contributing factors to the spread of HIV/AIDS

There are many contributing factors to the spread of HIV/AIDS. They include:

- The refusal to admit the presence of HIV/AIDS in Chad for a long time
- The failure of political and religious leaders to mobilise the resources at their disposal to establish effective structures which would respond to the crisis and bring hope to the people
- The persistent culture of silence within the faith-based organisations
- Poverty that hinds control effort
- Wars, armed conflicts and insecurity and its consequences (violence and uncontrolled migration)
- Socio-cultural issues:
  - Negative cultural and perceptions issues that make women and young girls vulnerable to HIV
  - Discussion about sex and sexuality is a taboo
  - Stigma, discrimination and rejection attached to HIV/AIDS that force people who test HIV positive to remain inadvertent killers by spreading the disease and the hiding away of AIDS suffers
  - Gender inequity: women continue to be subject to widespread discrimination at home, in the workplace, before law, and in public institutions
- Global economic and injustice
  - Heavy external debt
  - Structural adjustment with its cut in government health and education spending
  - Inaccessibility to anti-retroviral and, to voluntary counselling and testing: For those with HIV/AIDS, effective treatment is available in N'Djamena hundred miles from remote rural areas.

1.2.4. Impact of HIV/AIDS in Chad

Despite the fact that the HIV/AIDS situation is a looming national catastrophe with an adult infection in 2000 of 3, 6% and rising since then, no empirical data on Chad were found in the literature review. However, like in many other sub-Saharan African countries, the impact will obviously be felt in sectors such as: agriculture, education, medical, economic, etc.

In household and in the agricultural sector, illness and death due to HIV/AIDS will lead to increased expenditure, reducing saving and productivity. Despite the relative potential for agriculture, structural weaknesses, notably destroyed road infrastructure and climate variations render Chad an importer of food since only little of arable lands are currently cultivated.

In 2000, the education model developed by UNAIDS and UNICEF shows that, of around thousands primary schoolchildren, many of them would have lost a teacher to AIDS in 1999. This increasing mortality rates among schoolteachers leads to discontinuity in teaching with many schoolchildren that are forced to change their teachers.

In 2001, a United Nations' study found that AIDS patients occupied many beds in urban and semi-urban hospitals. Additionally, based on limited studies in the N'djamena morgue, the proportion of adult female AIDS cases is significantly higher than the proportion of male cases.

In response to the warnings about AIDS, the World Bank and the consortium sponsored a prevention programme that includes distributing free condoms, steering women away from prostitution, and treating sexually transmitted infections that increase the risk of HIV. But the programme offers HIV testing only to pipeline workers and provides no treatment for AIDS. HIV/AIDS is still considered as a biomedical issue. Therefore, the country has taken few steps to improve existing Anti-AIDS programmes, which are under funded and mostly ineffective.

In conclusion, further data is required for an understanding of how the pandemic is affecting the agriculture, education, health and economic sectors for the implementation of the national strategic planning which is underway.

2. THE NATIONAL HIV/AIDS CONTROL PROGRAMME E

2.1. Background to the AIDS Control Programme

The interest of the government, which while starting information and awareness building activities, approached the World Health Organisation for technical assistance. Under this technical assistance, it was decided that the National AIDS Control Programme (PNLS) would be established within the Ministry of Health. Chad's government runs a limited testing programme and reported 1,704 new AIDS cases in 2000. The World Health Organisation estimates that 3, 6 % of adults in Chad are HIV+.

2.1.1. The National Response of Chad

The Chadian's response in the fight against HIV/AIDS has not been effective before the 1990s since Chad national authorities found unable to admit the existence of HIV/AIDS in Chad. This has been worsened by the economic turmoil and the two civil wars. Currently, little is done to reverse the spread of HIV/AIDS. The box bellow will provide important dates and significant events.

Table 6: Dates and major events of the National Response

Date	Events
1983	First AIDS cases reported
1988-1998	Elaboration of the first and medium Term Plan
1988	Creation of Diagnostic and Prevention Unit (*cellules de lutte contre le VIH/SIDA*)
1991	Creation of the Service National de lutte contre le VIH/SIDA
1994	Creation of the Fonds de Soutien pour les Activités en matière de la population (FOSAP)
1995	Creation of the National Committee against HIV/AIDS and Commission Technique de lutte contre le VIH/SIDA
1995-1999	Elaboration of third medium term
1998	Creation of the Programme National de lutte contre le VIH/SIDA
1999-2003	Elaboration of the National Strategic Plan
2004-2007	Triennial Planning
1983	First AIDS cases reported
1988-1998	Elaboration of the first and medium Term Plan
1988	Creation of Diagnostic and Prevention Unit (*cellules de lutte contre le VIH/SIDA*)
1991	Creation of the Service National de lutte contre le VIH/SIDA
1994	Creation of the Fonds de Soutien pour les Activités en matière de la population (FOSAP)
1995	Creation of the National Committee against HIV/AIDS and Commission Technique de lutte contre le VIH/SIDA

Comments

As in other parts of Africa, the AIDS epidemic has led the government in Chad to reassess its national health priorities, and in particular focus on the difficulties facing by the general population to address the issue of AIDS. However, the general public has been very critical of the government inadequate response to prioritise HIV/AIDS as a top issue and its inability to address stigmatisation, discrimination and rejection attached to HIV/AIDS. Therefore, leaders at all level not only in government but also religious and even traditional have the responsibility to create a more open society that is free from stigma, silence or denial about the epidemic.

In Chad, it took many years before of the first voluntary Counselling and Testing centre was established and the Mother-to-Child Transmission treatments are still in their infancy stages. Additionally, accessibility, availability and affordability of anti-retroviral therapy remain a major obstacle except for those with sufficient financial resources to by-pass the informal system.

In response to these challenges, the Chadian government with outside donors developed a national health strategy, and a National AIDS Control Strategy Plan. To support this, the World Bank is providing the government with financial inputs both under a Health Sector Support Project and for a population and AIDS Control project. According to many testimonies, these two structures are not enabling the multisectoral approach that the government wanted to put in place for HIV/AIDS prevention and care at the community level partly because of bureaucratic attitudes.

The above dates and major events of the National Response are self-explanatory that Chad lacked the political commitment from the onset of HIV/AIDS to combat the epidemic. Taking into account the culture of silence and denial of the disease associated with HIV/AIDS; this could justify why Chad has become one of the countries hit by HIV/AIDS in Central Africa.

Despite these above plans that aimed at consolidating and expanding interventions on HIV/AIDS, monitoring behaviour change and epidemic through epidemiological prevalence, the National AIDS Control Programme faced many shortcomings namely:

- Insufficient coordination mechanisms between stakeholders and programme partners
- Little resources allocated to the programme especially in church settings
- No or little implication of the government sectors other than health sector to effectively combat HIV/AIDS
- Increased HIV/AIDS prevalence especially among the 20-39 years old

2.2.2. Partnership

An initial population and AIDS project, which became effective in 1995, helped the government to put in place a multi-sector AIDS prevention plan and trained more than 40 local non-governmental organisations in project development and management. They are some NGOs involved in the fight against HIV/AIDS in Chad. They are either secular or denominational established in the capital city and in major urban areas such as DOBA, Abéché, etc. Most of the associations intervene at different levels in the struggle against HIV/AIDS and are active especially in awareness raising and sometimes the care of people living with HIV/AIDS, etc.

The National AIDS Control Programme works in collaboration with the following partners such as WHO, UNAIDS, UNDP, WHO, World Bank, GTZ, French Cooperation, UNICEF, OXFAM, Red Cross, FNUAP, WFP, European Union and USAID, etc.

2.2.3. Faith-based organisations

The partnership between the Chadian Government and the faith-based organisations is nation-wide through the Catholic, *the Entente des Eglises et des Missions Evangéliques au Tchad, the Organisation des Eglises Pentecôtistes* and the Muslim. I would like to suggest that its utmost important role would be at grass root level, where it would support national plans to fight AIDS and boost existing initiatives. With the various faith-based organisations sharing their experiences and successful stories, the partnership can help transform isolated actions into coherent plans of action. The venture should build on the strengths of each religious community to provide national leadership.

3. FAITH-BASED ASSOCIATIONS: PERCEPTIONS AND INVOLVEMENT IN ADDRESSING HIV/AIDS

3.1. Faith-based organisations in Chad

With regard to the mapping exercise, I met religious leaders and heads of health services of the following religious communities: *Eglise Evangélique du Tchad, Eglise Evangélique Fraternelle Luthérienne du Tchad, Eglise Adventiste du Tchad, Eglise Baptiste Mid-Mission du Tchad, Eglise Catholique, Assemblée Chrétienne du Tchad, Communauté Islamique du Tchad, Eglise Pentecôtiste du Tchad, Eglise de la Coopération and Entente des Eglises et Missions Evangéliques du Tchad (EEMET)*.

3.2. Perceptions of HIV/AIDS

AIDS remains a major concern for the many church leaders and heads of health services that I met in Chad. Many of them are still acknowledging that HIV/AIDS cases have been increasing at alarming rates during the past decades. In addition, they know that as far as the HIV/AIDS is concerned, there is neither cure and nor vaccines. They also know the name of the virus that causes AIDS, its mode of action and the principal modes of transmission. This could be partly the result of a recent HIV/AIDS workshop that was organised by EEMET in collaboration with the National AIDS Control Programme.

3.2.1. Eglise Evangélique du Tchad

PLHA are highly stigmatised in the Eglise Evangélique du Tchad because of the association of HIV/AIDS with certain sexual behaviours. Fear of stigma and discrimination means that few individuals are willing to divulge their HIV status or find out their status through HIV testing services which are not widely available. In addition, access to antiretroviral is limited to those with money or international contacts.

> *"The Evangelical Church of Chad has already buried people dying of HIV/AIDS. AIDS is no longer a disease to be hidden although our unease to deal with sexuality issues that surround HIV/AIDS"*
>
> *Pastor Djedouboum Moise, Deputy General Secretary of Evangelical Church of Chad.*

3.2.2. Eglise Evangélique Luthérienne du Tchad

One promissing development in the Eglise Evangélique Luthérienne du Tcahd has been the growth of anti-AIDS clubs for young people in schools and the community. Anti-AIDS clubs organise and conduct recreational activities, especially football games, drama, red ribbon campaigns, and community outreach. In addition, church leaders could describe main ways of getting and transmitting HIV and consequences of AIDS resulting from the respective social and cultural background. This could be the result of the many seminars and workshops that are going on. During the mapping, the church was running an important workshop on the implications of HIV/AIDS and the responsibility of Christians to develop appropriate response to HIV/AIDS.

> *"We are good at saying that God is everywhere, all the time, and sees and knows every thing-which means he is always with us. However, when we face the realities of life especially HIV/AIDS, things do not seem always so simple. That is why the Eglise Evangélique Luthérienne du Tchad decided to stop searching somebody else to blame as many people in this country blame the devil, the ancestors, witchcrafts or the Americans for spreading AIDS. Other people blame God and affirm that HIV/AIDS is God's punishment for evil or a result of breaking spiritual laws. I know that this is wrong. In my opinion, I do not think that somebody who is HIV+ is guilty."*
>
> *Pasteur Bourdanné KEREO*

3.2.3. Eglise Adventiste du Tchad

The devastating impact of HIV/AIDS is felt most acutely at the community level. Church leaders acknowledged that with thousands of people infected of whom most are youth and children orphaned by HIV/AIDS; Chad is facing a growing strain on its economic and social resources as it tries to meet the rapidly expanding need for services.

"HIV/AIDS is a social catastrophe which makes victims in our society as a result of humankind's disobedience towards God's and health principles. Romans 1: 24-30. However, God is love and merciful that is why he faces HIV/AIDS by limiting the increased number of AIDS victims and propels us to help those who are already caught in HIV/AIDS pitfalls".

Pastor Rubens R. Da Conucao

3.2.4. Eglise Baptiste Mid-Mission du Tchad

Faith-based organisations should play a vital role in reaching affected communities with prevention, care, and support services. Recognising this, the Eglise Baptiste Mid-Mission of Chad is on the front line of the war against HIV/AIDS although they find it difficult to obtain the resources they need to continue their valuable efforts.

"I resisted HIV/AIDS education at first, but my attitudes changed when church members started becoming infected and fell ill as a result of HIV/AIDS. Indeed, HIV/AIDS is a dreadful disease which claims life of many young people. Most of those who die from this disease are also churchgoers and Christians. The most disturbing is the fact that the epidemic and its impact are for the most part still hidden because of the epidemic's prolonged latency period. Most people do not know they are even infected. The worst of the epidemic is yet to come as HIV infected people may infect others and develop full blown AIDS"

Pastor Tompte Pierre, Eglise Baptiste.

3.2.5. Eglise Catholique du Tchad

While Catholics around the world hold different views on how best to prevent HIV infection, many Bishops in Chad have developed relevant information on HIV/AIDS and compassionate care for the sick as core values. Additionally, Catholics operate in clinics, hospitals and teaching facilities. As the HIV/AIDS programmes are expanding in Chad, Catholics and other faith-based organisations will be important partners in providing voluntary HIV counselling and testing, home care, clinical services and advanced treatments.

"In 1986, two AIDS cases were mentioned whereas there is steady overall increase since nearly 13,000 people were suffering from AIDS at the end of 2000. This is on one hand of great challenge in Chad where the AIDS situation is alarming. On other hand, AIDS is not God's punishment. AIDS could be an opportunity that draws one near God in a true and sincere confession for one's salvation. Christians need to examine theologies of hope so that they can hold on to hope and care for people who need healing."

Chadian Bishop's of declaration on HIV/AIDS.

3.2.6. Assemblée Chrétienne du Tchad

Church leaders are aware that millions of people in developing countries including Chad are already infected by HIV and millions are at risk of infection. Stigma and discrimination breed the silence in which new infections take place and contribute directly to the denial that make life and death with AIDS more difficult than it has to be. As shapers of the community behaviours and values, churches can significantly reduce stigma by promoting respect for life, fidelity in committed relationships, valuing and providing life skills and education. Although some other agencies may not endorse all approaches to HIV prevention promoted by faith-based organisations, but some of the prevention measures can entail the reduction loss of life due to HIV.

"I am aware that AIDS is wiping away the last century's advances in many areas of life. Important people such as schoolteachers, health professionals, businessman etc. are dying thus reducing the quality of national services. Since HIV/AIDS is confounded with sexuality, it cannot be denied that the church has always taught abstinence for the youth and sexual activity for married people only as recommended by the Bible.

Condom use is merely advised for married couples as a mean of contraception. I still believe that if condom use has to be openly promoted for the youth, sexual promiscuity in terms of fornication and

abomination will be found everywhere. It has to be mentioned that neither fornicators, nor adulteress will enter the kingdom of God, despite the impact of HIV/AIDS that is felt most acutely at the community level."

Pastor Lawman Moverna Esaie DE-SIA, National Secretary General of the Assemblée Chrétienne.

3.2.7. Muslim Community of Chad

The Muslim community has not remained in the margin of the struggle against HIV/AIDS. Imams are doing their best to inform, train and enlighten their audience about the HIV/AIDS phenomenon and its socio-economic impact on individual and collective well-being.

"In Chad, HIV/AIDS is a reality which spares no religion, particular gender, age, social or ethnic groups and races, etc. HIV/AIDS could be a divine test that has been given to the humankind. The root causes could be the result of disobedience to God's laws and sexual wanders. According to the Koran, in the end of the days a certain number of sufferings will rise. This constitutes a warning message for the humankind to get back to their Lord Allah, since the Prophet Mohammed said people who will practise fornication would experience a dreadful disease that their predecessor did not know before. Therefore AIDS could be the prophesied disease. "

Cheikh Ahmat Kinder, member of the High Council of Islamic Affairs.

3.2.8. Eglise Pentecotiste du Tchad

The Pentecostal Church of Chad looks forward to strengthening its efforts with community initiatives at the grass root level where people live, struggle and die as a consequence of HIV/AIDS infection. This helps the church leaders to meet the needs of those infected or affected by HIV/AIDS.

"When we discuss statistics about AIDS, we often forget that behind these figures, there is a person or a family who are experiencing great suffering. Statistics mean nothing when it comes to consider the nightmare and tragedy that faced couple affected families that lost beloved within my church. This gave me the opportunity to have a new look on the suffering that AIDS brings into family, church and the society at large"

Pastor Yamtoingar D.Antoine Issa, Eglise de Dieu au Tchad.

3.2.9. Eglise de la Coopération du Tchad

HIV/AIDS kills in slow motion, claiming one life after the other whilst spreading quietly and secretly making more and more victims. And yet, there is no end in sight. In Chad the fight against HIV/AIDS has just started because of many speculations during several years. These include the widespread belief that condom use would be the appropriate way to fight HIV/AIDS. Additionally, HIV would be released from a western laboratory to destroy African population. Finally, God invented the virus to punish the wickedness.

"Condom promotion has raised controversial and hot debates in Chad. Though condoms are now available and accessible since they are not combined with media campaigns that use culturally appropriate educational message to promote condom use and other forms of risk reduction, HIV/AIDS is still on the increase. Therefore, many people are still thinking that HIV/AIDS is either a divine punishment or a virus that was released in Western laboratories to destroy Africa."

Pastor Altana Jérôme, Eglise de la Coopération au Tchad.

3.2.10 Entente des Eglises et Missions Evangéliques du Tchad

11 mainline churches namely Assemblée Chrétienne au Tchad, Eglise Evangélique au Tchad, Eglise Fraternelle Luthérienne au Tchad, Eglise Evangélique des Frères du Tchad, Eglise Evangélique en Afrique Centrale and Eglise Missionnaire au Tchad, etc have already formed the *Entente des Eglises et Missions Evangéliques au Tchad (EEMET).* This could be used as an appropriate channel to acknowledge the scale of the HIV/AIDS problem and to

help churches maximise resources to find out creative solutions responsive to their needs, since many of the church members are still facing the realisation that they urgently need guidance in dealing with the epidemic.

> *"I believe that HIV/AIDS is steadily breaking down health, economic and social structures of countries throughout sub-Saharan Africa. Chad and Central Africa at large are still behind these countries in experiencing much of the ruin that AIDS brings. Therefore HIV/AIDS should be an opportunity that churches must take to demonstrate Jesus' teachings and deeds in a hopeless world because of the complexity of HIV/AIDS issues."*
>
> *Pastor Bako Ngarndeye, General Secretary of EEMET*

Comments on HIV/AIDS perceptions by faith-based organisations

The need to distance the religious communities from the Angry punishing God and the "if you would like to avoid AIDS, abstain from fornication" attitude is critical. It must be addressed energetically and repeatedly at every level of the religious communities. This was seen particularly in the Muslim community.

In Chad, decisions related to sexuality, such as when to first engage in sexual activities and when to have children, are influenced by the church, the family and community as well as the individual. More importantly, in most cases old people and church leaders are very influential. Therefore, churches and families should play protective, safe and supportive role in the lives of young people as they have to face early important decisions about their sexual lives. However, evidence suggests that families and church leaders themselves often do not feel comfortable discussing sexuality with their children and their church members for a variety of reasons raging from cultural or social shame associated with sexuality and sexual practices. As a result, parents and church leaders are unfortunately perceived as real barriers to the adolescents' sexual decision-making process. Church leaders and families must seek appropriate language to address sexuality and HIV/AIDS issues.

Another issue of concern is the position of girls/women in Chad where men are expected to be the breadwinners. Boys are commonly considered as an asset and an investment for parents when they get old. This could be why boys get preferential treatment in many aspects of life including schooling or education. Therefore, the social preference for boys by family, community and the legal system gives them more options to succeed in life than girls. Many families still perceive girls merely as people who should get married with the family benefiting from the bribe price paid by the husband's family. This makes girls more vulnerable to HIV/AIDS. In order to curb and slow down the HIV/AIDS epidemic, church leaders must advocate for social transformation towards gender equality and equity, equal opportunities and equal access to resources by women/girls etc.

Most of church HIV/AIDS programmes visited were led by clergy with little or not inputs from professionals belonging to fields other than theology. Church leaders should understand that HIV/AIDS is a technical issue that requires multidisciplinary and multisectoral approaches if we have to make a difference in combating the pandemic.

Faith-based organisations should be given support to do what they prefer to do, and what they do best: promote what they call abstinence and fidelity. The attempt to force FBOs to work in condom promotion risks alienating them from AIDS prevention efforts, and thereby losing the great potential they bring to such an effort. However, condom use can reduce the risk of HIV/AIDS and, in conjunction with other behaviour changes such as delayed sexual debut and sexual partner's reduction; they are key components of effective AIDS prevention programmes. In an interview entitled "the church has AIDS", Bishop Kevin Dowling makes the following statement:

> *"If we simply proclaim a message that condoms cannot be used under any circumstances, then I believe people will find it difficult to believe that we, as a church, are committed to a compassionate and caring response to those who are suffering, often in appalling living conditions. For me, the condom issue is not simply a matter of chastity but of justice."*

3.3. Involvement of churches in addressing HIV/AIDS

3.3.1. Eglise Evangélique du Tchad (EET)

Among many other churches, the Evangelical Church in Chad remains one of the main pioneers in HIV/AIDS work in Chad.

Prevention:

EET's prevention strategy values the role of community participation, peer outreach, and involvement of people living with HIV/AIDS to make behaviour change messages more acceptable, understandable, and effective. Although not quantifiable, these activities would have helped congregations to create economic safety nets for vulnerable and families. When it comes to preventive measures, abstinence from sex before marriage and faithfulness in marriage, are promoted as the only God's way of avoiding AIDS. Despite their advantages in some situations, condoms are not considered the only answer to the AIDS public health problem, either from the medical, social or Christian standpoint.

Care

Through its health services, the Eglise Evangelique du Tchad provides a significant portion of health care and social services, outreach clinics and home based-care.

Support:

EET's interventions have trained community volunteers to provide home-based care and psychosocial support to those with HIV/AIDS and assistance to vulnerable children.

Comments

If it is true that condoms do not guarantee absolute protection, it is also true that promoting condom use as the total answer to HIV is not right. However, I see a real danger for churches that become anti-condoms instead of being anti-AIDS. In Chad, Christians became so divided about condoms that there is still a danger of losing focus. For a period of nearly 2 decades, condoms became evil rather than the sexual acts that are taking place outside the bond of marriage. In my opinion, church leaders should avoid wasting time and energies over condoms issues as it should be dealt on justice rather than on moral grounds.

3.3.2. Eglise Catholique du Tchad

In Chad, one of the most supporting activities within Catholic settings is focused on supporting the "Reach out, show compassion" campaign to reduce stigma and foster support and compassion for those living with HIV/AIDS. With the cooperation of Bishops in Chad, the campaign aimed at increasing the number of dioceses and parishes, and humanitarian groups advocating for or engaged in care and compassion activities in the communities. Training of 1,296 clergy and laity has been conducted throughout the country to establish compassion and support programmes. National television and radio spots also incorporated quotes directly from the Bible that demonstrated compassionate behaviours. In their declaration on HIV/AIDS, Bishops committed themselves to working alongside the governments and other stakeholders in a united front against HIV/AIDS.

In this regard, the *Centre Diocesain d'Information et d'Accompagnement des Malades* (CEDIAM) is a highly successful initiative to help the dioceses care for HIV/AIDS affected families and individuals. Activities carried out in 2002 are presented as follow:

Table 7: Activities carried out by CEDIAM in 2002

Designation	Number
Home-based care	13
Clergy and laity trained on home-based care	17
Grass root initiatives reached out by dioceses	09
Adolescents, youth and adults trained	1583
Accompanied couple for pastoral counselling	103
Men and Women counselled	193

Voluntary Counselling and testing

People living with HIV/AIDS have a critical role to play in designing and implementing HIV/AIDS prevention, care and voluntary counselling and testing programmes. Though HIV testing facilities in Chad are not readily and widely available, Centre Notre Dame des Apôtres (CNDA) offers a unique opportunity to involve people living with

HIV/AIDS to make voluntary counselling and testing more effective, appropriate and meaningful. CNDA counsellors work one-in-one with clients to help them assess their individual risk for HIV and engage them in a focused discussion of realistic ways to reduce the risk. Moreover, CNDA can help to connect clients with services including hospice care, support for orphans and vulnerable children.

CNDA faces a number of challenges namely:

- Stigma and discrimination make it difficult for a person to disclose his or her HIV status or become actively involved in community HIV/AIDS activities
- CNDA is unprepared to involve people living with HIV/AIDS especially at the decision-making level because of the lack of experienced, trained and skilled personnel since the only expatriate medical doctor who runs the programme is on leave for personal reasons
- Some people living with HIV/AIDS who wish to become involved in the programme need to develop new skills such as advocacy or counselling. Such programmes seeking to create an enabling environment in which people living with and affected by HIV/AIDS could come forward as educators, community mobilisers, and active participants in community and country programmes are rare.

Table 8: HIV testing results provided CNDA

Categories	*Men*			*Women*			*Children*			*Total*
	P	N	U	P	N	U	P	N	U	
Voluntary	7	30	3	6	7	0	0	4	0	57
Estimated	1	1	0	5	0	0	2	4	2	15
Control	5	7	1	2	2	0	0	0	0	17
Total	13	38	4	13	9	0	2	8	2	89

Legend

P = Positive / N = Negative / U = Unspecified

Comments

The above data are self explanatory in terms of the seriousness of tasks undertaken by the Roman Catholic to address in concrete and pragmatic ways the HIV/AIDS issues in Chad. However, little is done to avoid the caregivers' burn out, which constitutes a vulnerable population with regard to HIV/AIDS. In addition, the National AIDS Control Programme promised without success to help scaled-up CEDIAM's activities.

However, the Bishops' Pastoral letter related to HIV/AIDS that aimed at mobilising the church community and empowering individuals and families to prevent HIV/AIDS was welcomed in 2002 by many Christians. As a result, many people including Muslim paid visits to CEDIAM in order to find out more information and HIV/AIDS facts in Chad. This is suffice to demonstrate that church leaders have extensive geographic reach, unmatched staying power as well as developed infrastructure to reach the community at the grass root level. There is no doubt that church leaders are keys to shaping values and behaviours with regard to HIV/AIDS as they can build awareness raising to confront stigma and mobilise community responses.

In service training for school teachers was provided by CEDIAM's staff. However, most of school teachers felt that they are not appropriate channels to teach HIV/AIDS to their school children. Others said that health professionals should do this. A few schoolteachers of whom half were women felt that they need incentive (in financial terms) to teach health education to school children.

While young schoolchildren are at great risk, they are also leading the way in reducing behaviours that increase the risk of HIV infection. This demonstrates the necessity of training schoolteachers since studies have shown that decreasing infection rates among young people are usually the first sign of an overall decline or stabilisation in HIV prevalence in the general population.

In addition, adolescents who become sexually active often do so without appropriate information and skills to protect themselves from HIV infection. Many young people that I met and talked to in Ndjamena did not believe they are at risk of attracting HIV. When it comes to obtain information and services, some young people reported that they often encounter prohibitive costs, insensitive health care providers, restrictions on providing services to

unmarried adolescents, and lack of confidentiality. This pledges for teachers to become change agents to respond to the many HIV/AIDS challenges in Chad and elsewhere.

3.3.3. Eglise Adventiste du Tchad

The Adventist Church of Chad implements HIV/AIDS programmes for young people innovative strategies to reach youth with appropriate and effective messages. These messages encourage continued abstinence for youth who are not yet sexually active and faithfulness for married couples. The Adventist Church delivers these messages in a variety of ways, including mass media campaigns, multisectoral programmes, peer education, and film projections and combinations of these approaches. These campaigns and other Adventist programmes work to reduce the vulnerability and develop the great potential of young people in KELLO region by giving them the information, services, and support they need to make healthy choices. As a result, these campaigns have contributed to behaviour change such as delay onset of sexual activity.

The multisectoral approach coupled by strong collaboration between health and societal sectors to implement activities such as HIV/AIDS training for sex professionals, life skills training for young people has proven to be of considerable and practical value. The Adventist church leader in KELLO region reported that some sex professionals decided to stop the sexual work they were doing since they were given micro-credit to generate income schemes in order to help them meet their basic needs whilst many other sex professionals were complaining about the decline of sexual clients. The Adventist church also works with education personnel to establish a positive environment for HIV prevention in schools.

3.3.4. Eglise Fraternelle Luthérienne du Tchad

Church leaders acknowledged the greatest challenge to public health that HIV/AIDS represented since the nineties. That is why the brochure entitled “What is AIDS?” was translated in many vernacular languages since 1995. This brochure provided to church members considerable information on HIV/AIDS basic facts. Currently, this brochure is under revision in order to include section of sexual transmitted infections. In this regard, the National AIDS Control Programme is committed to provide funds.

In addition, through its HIV/AIDS programme led by *Centre Chrétien d’Appui au Développement communautaire*, the Lutheran Church works to prevent and counter the misinformation, misunderstanding and stigmatisation that continue to foster the perceived relationship between HIV/AIDS, sins and death. In 1998, the Lutheran church leaders were invited to attend a workshop organised by the National AIDS Control Programme. As a result of the above workshop, church leaders were motivated to organise a vast campaign targeting the youth within their respective parishes. These campaigns used drama and music video in order to reach youth with prevention messages in PALA and ABECHE parishes. Currently, the Lutheran church leaders have submitted a comprehensive HIV/AIDS project proposal to local donors without success.

3.3.5. The Muslim Community

The Muslim Community Programme activities focus on: Prevention and care. The programme objectives are to slow down the HIV infection through teaching HIV/AIDS information related to Islamic religious on how to avoid getting the HIV infection. The Supreme Council for Islamic affairs is contributing to fight HIV/AIDS in a pragmatic ways namely by:

- mobilising Imams and the Muslim community for a commitment to fight HIV/AIDS
- the care rendered to orphans
- And the support towards PLWHA.

The results acquired so far include the recognition of the HIV/AIDS existence and the threat of human violation that HIV/AIDS represents. Many Islamic people have shown both great respects towards people living with HIV/AIDS and righteousness to AIDS “victims”.

The challenges are that Muslims are convinced that HIV/AIDS is a result of sexual promiscuity although some people are still ignoring the existence of HIV and the impact of AIDS.

Comments

- The Muslim community in Chad could do a great deal by initiating frequent contacts with its members in order to help create a constructive and non-threatening environment within which pragmatic advice could be

offered for the timely identification of HIV/AIDS issues. This also will facilitate the processes of ownership by its church members.

- Strong Information Education and communication are critical to the effective implementation of a population policy. In order to better design the IEC activities, knowledge, and attitude and practice (KAP) surveys need to be systematically carried out and their findings factored into the IEC tragedy.
- In order to correctly monitor or evaluate the impact of Information, Education and communication, indicators need to be included in the design of the programme. For the time being, this is not the case.
- During the mapping exercise, I found an apparent good relationship between Muslim and Christian Leaders. This could be a good opportunity for Chadian leaders to create or reinforce an interfaith HIV/AIDS committee to mitigate the adverse effects of HIV/AIDS in pragmatic ways. Right now, religious communities are fighting HIV/AIDS in isolation.
- The fight against HIV/AIDS requires not only the availability of resources, but all a comprehensive and shared vision.

4. POVERTY AND HUMAN RIGHTS

Many people today will agree that September 11th 2001 marked a turning point in our world's history. The terrorist attack of the twin towers in New-York warned the entire world that peace cannot be taken for granted. However, the world viewed with admiration the outpouring of sympathy and practical assistance that followed the bombing. Surely there is no comparison with the enormity of the AIDS situation in sub-Saharan Africa. But the proportions of the sympathy and help, both within and outside the country are minute compared to the tragedy.

Though the terrorist attack on New-York could not be dated as accurately as possible, but it has had and is having more terrifying consequences. Similarly, this plague called HIV/AIDS is claming millions of lives of men and women, children and adults, rich and poor. HIV/AIDS respects no tribe or race or national boundaries. It is true that poorer countries are much more vulnerable and are experiencing much larger number of casualties. It has to be noted that poverty does not cause AIDS per se, but it creates an enabling environment which militates against treatment and alleviation of suffering.

In many developing countries including Chad, HIV/AIDS pushes people deeper into poverty as households lose their breadwinners, livelihoods are compromised and savings are consumed by the cost of health care. The pandemic also adds to the strain on national institutions and resources, and undermines the social systems that help people to cope with adversity. In Chad, HIV/AIDS is eroding human security and productivity, undermining economic development, and threatening social development.

Poverty means lack of proper food, clothing, shelter, poor sanitary conditions and sufficient medicine. Poverty brings deterioration and death more quickly. Further, it destroys human and economic resources for development which promote further poverty. What is the Christian response to HIV/AIDS pandemic which is already responsible for more deaths than all the wars of history combined? Of course, death brought by war and terrorism comes through swords, bullet, bomb and atomic power. The so-called wealthy countries invest vast fortunes in sophisticated defence systems. But the terrible power of AIDS comes from its power to destroy the human immune system.

Sadly, Chadian government authorities and some church leaders were slow in educating citizens about how AIDS spreads and encouraging them to protect themselves by necessary personal behaviour change. This was due to the refusal to admit the presence of HIV/AIDS in Chad and the hiding away of those living with HIV/AIDS and tragically the incoherent response of the Chadian government response to develop an effective strategy to fight the disease.

Meanwhile the epidemic spreads and Chad as a poor country with weaker economy and meagre resources for health care is being devastated. One response to this frightening scenario should be directed to those who contracted HIV/AIDS. It is a community response to suffering. At the conclusion of the Paris AIDS Summit in 1994, 42 governments issued a declaration supporting great involvement of people living with HIV/AIDS in policy formulation and delivery. Despite growing recognition of its importance, little has been done to enable the involvement of PLHA in the delivery of prevention, care and support services particularly in the area of human rights.

To address this gap, Fraternité Plus, a Non-Governmental Organisation comprising 50 people living with HIV/AIDS was formed in order to achieve meaningful involvement of PLHA since they were highly stigmatised because of the association of HIV/AIDS with certain sexual behaviours and population groups. Fear of stigma means that few individuals were willing to divulge their HIV/AIDS or find out their HIV testing. In Chad, the main impetus for greater

PLHA involvement has come from International donors, NGOs, and activists, which has supported the development of PLHA organisations and networks and encouraged the Chadian government to give priority to PLHA involvement in the response to the epidemic.

At first stage, PLHA learn not only about HIV/AIDS but also how to accept their HIV status and cope with infection, which can help motivate them to help others within Fraternité Plus.

> *"When I tested positive for the first time, I wish I could die. I felt so alone that I thought I was going to die soon. But the group of Fraternité Plus has been a great psychosocial support. Of course, I have been to a psychologist but I have been much helped by seeing and sharing my concerns with a group of people in the same situation; this has helped my self-esteem."*
>
> *HIV-positive member of Fraternité Plus.*

Support groups also provide an opportunity to share intimate problems, offer mutual support and furnish a safe space for PLHA to become visible by overcoming stigma. Support group in Fraternité Plus has empowered PLHA by building their self-esteem and preparing them to be open about their HIV status.

"*The fight against HIV/AIDS is slow because of the persistent culture of refusal to admit the existence of HIV/AIDS in Chad. When I decided to disclosure my serostatus, many people were gossiping at me saying that I have been paid by the National AIDS Coordinator to talk about these bloody things of AIDS*."

One can understand that complacency and "AIDS fatigue" at government, religious communities and individual levels are contributing to this situation. Failure to maintain a balance between treatment and prevention has also weakened efforts to combat HIV/AIDS in Chad. As a result, more people with HIV/AIDS have little or no access to treatment and HIV/AIDS related illness and death are commonplace.

Bearing in mind this, "Ethique, Paix and Justice" which is a specialised branch of EEMET was created with the aim to avoid the fatalistic attitude that compelled HIV prevention and care initiatives and service to be allowed to run down. This has contributed to increase rate of unsafe behaviours and rising HIV/AIDS infection rates. This unfortunate situation is further compounded by illiteracy, poor access to radio and print media, superstition, widow inheritance, poverty. Given its credibility, "Ethique, Paix and Justice" has ecumenically trained pastors, youth and church elders. These people who were trained are expected to replicate what they learnt at the grass root level.

As a result of AIDS, education system and standards too are being affected as more people are forced to leave school in order to look after their siblings. More than 5000 children have lost one or both parents to AIDS. The spread of HIV and the impact of AIDS are disproportionately affecting people, and therefore the future of the nation itself. In 2002, "Ethique, Paix and Justice" staff did a census where they identified 220 orphans of whom 22 are leaving under extreme poverty conditions. These 22 orphans are given contribution in terms of pastoral care, social ministry activities and school fees without which many of them would not have gone back to school. "Ethique, Paix and Justice" therefore has a huge potential for the fight against HIV/AIDS provided by pastors who used to think that HIV/AIDS is a disease for prostitutes. Currently, pastors who are in daily touch with the Christians and their communities are well trained to handle HIV/AIDS issues.

> *"I came to realise that people living with HIV/AIDS were normal people just like any other human being. Now I could eat with them and share the same plate with them. Now I think that I have understood HIV/AIDS much more than I did before"*
>
> *Pasteur Chrysostome MATALOI, Director of the High Biblical School of DOBA*

With regard to human rights, there was a legal blank in Chad since HIV/AIDS was dealt purely as a biomedical issue. In 2001, a baseline study was convened and carried by a designated Commission Members of Parliament. This study provided some hints on how the HIV/AIDS issues should be dealt in Chad. However, the "*Commission des Parlementaires Tchadiens*" will do a great job to develop policies to combat discrimination that is crucial to any HIV prevention. Stigma reduction is both a human rights and a public health issue.

5. PARTNERSHIP BETWEEN GOVERNMENT AND RELIGIOUS COMMUNITIES

The Chad Population and AIDS Control project became effective in 1995. The project objectives were: (i) to advance fertility decline; and (ii) to mitigate the adverse effects of HIV/AIDS. It is being implemented by the Ministry of Plan and Regional Planning with the Ministry of Health providing technical support. The project addresses both population and HIV/AIDS issues through a two-pronged approach: policy-related activities are being implemented by the Ministries of Plan and Public Health, while NGOs and religious communities are being assisted through a social fund (FOSAP), to develop and implement grass-root activities.

According the National AIDS Control Programme, the effort of the religious communities particularly Christians has become visible since 2000. However, condom use is widely disapproved especially in the Muslim settings. This is in contrast with the Islamic Medical Association of Uganda which has taken the lead in educating Muslim religious leaders on the education about the responsible use of condoms. After negotiations, the topic was reinstated and was acceptable within Islamic teachings.

In the context of FOSAP, more than forty local NGOs including churches have received training in project development, management, and implementation and are currently implementing population and HIV/AIDS prevention initiatives at the grass root level. In general, the partnership between the government and the religious communities is good and needs to be strengthened in order to help the capacity building of church leaders to respond to HIV/AIDS challenges without complacency.

6. ECUMENICAL ORGANISATIONS AND RESOURCE FACILITIES

6.1. Ecumenical organisations

6.1.1. EEMET (Entente des Eglises et Missions Evangéliques du Tchad)

EEMET has been acknowledged by most of the church leaders as a required channel that would bring most of the protestant churches to combat HIV/AIDS altogether. This is true because as a result of the workshop organised by EEMET in collaboration with the National AIDS Control Programme, protestant churches are currently working with the same objectives when it comes to preventive measures (abstinence and faithfulness). Having recognised the magnitude of HIV/AIDS, church leaders have declared HIV/AIDS as one of the many security and development issues Chad is facing today.

> *"Africa is home of the world's 2/3 of people living with HIV/AIDS. I am not scared by these statistics because many African governments have failed to deal properly with this epidemic. Communities are stretched beyond their capacities to cope with PLHA and orphans. Given the magnitude of HIV/AIDS, Christians should not be pessimistic rather optimistic and realistic in order to proclaim hope and compassion messages and provide pastoral care and support to the affected and infected.."*
>
> *Pastor Bako Ngarndeye, Secretary General of EEMET*

However, resource allocation remains a key challenge for success. While a growing number of effective clinical and behavioural interventions are being made available to reduce HIV transmission and improve care and support for those living with HIV/AIDS in government departments, the resources available for churches to effectively implement these interventions are insufficient. In addition, Catholic and Muslim were still uncomfortable to deal with these HIV preventive issues especially condom use.

❖ Comments on church networking

Every community, no matter how poor, possesses both strengths and weaknesses which affect its ability to respond to disaster such as HIV/AIDS. In Chad, church leaders acknowledged to be working in isolation partly because of dogmatic reasons. A pastor told me: "*how can we work together, when Catholics for instance are addressing their prayers to God through Mary and Jesus whereas Protestants praise God through the only Jesus*." These are issues that must be addressed if meaningful results have to be reached since if weaknesses within a community are seen as vulnerabilities, then strengths can be considered as the capacity to cope, and recover from hazards such as HIV/AIDS pandemic.

6.1.2. The Bible Society of Chad

Experience has shown that consistent messages from a variety of legitimate sources must be disseminated in an interaction fashion to affect behaviour change. The Bible Society of Chad is willing to publish portion of biblical verses of HIV prevention that aimed at changing individual, community and societal behaviour. I encouraged the Director of the Bible Society of Chad who is willing to publish those biblical verses to avoid judgmental attitudes by choosing verses that would encourage stigmatisation and discrimination of HIV infected and affected. Indeed, HIV/AIDS related stigma continues to inform perceptions and shape the behaviours of PLHAs, which can hamper prevention programmes.

6.1.3. Université Evangélique de Ndjamena

The quest for relevant curriculum in theological teaching education to integrate the HIV/AIDS module is needed in Chad. Because in many cases, theological education is too theoretical, academic such as carbon copy of Western culture which does not have anything to deal with the African problems such as HIV/AIDS which affect thousands of people in Chad. The reasons could lie on the content of the curriculum, which is not centred in praxis, people and current issues that are affecting churchgoers and Christians. I met the Dean of the Theological Faculty in order to inform to join the training of trainers that was organised by the theological consultant of WCC in Rwanda. The Dean did not show any interest and he refused. One of the key issues that I realised is the fact that Ecumenism is widely misunderstood in Chad. Some people were very reluctant to share with me their concern as they were afraid of becoming member churches of the World Council of Churches. I told them that this was beyond of the scope of my trip. Instead, I was encouraging the religious community to be involved in the fight HIV/AIDS since AIDS does not discriminate. But men and women do.

6.1.4. Réseau National Evangélique de lutte contre le VIH/SIDA

In September 2003, the interfaith workshop that was held for the first time in N'djamena proved to be of considerable and practical value. For the first time, this workshop brought together church leaders of various faiths namely Catholic, Protestant, Evangelical, Pentecostal and Muslim leaders. The workshop was organised by the *Entente des Eglises et Missions Evangéliques du Tchad* in collaboration with the National AIDS Control Programme. One of the visible outcomes of this workshop was the creation of the *Réseau National Evangélique de lutte contre le SIDA.* This platform comprises only Evangelical church leaders and could later on include people of other faiths.

6.2. Resource Facilities

6.2.1. Association pour le marketing social (AMASOT)

In Chad, many churches have been reluctant to promote the spreading of information about HIV and sexuality because they believe this is contravention with the sixth commandment. However, research in this field revealed that awareness about sexuality and prevention do not necessary lead to increase in sex or unsafe sex. On the contrary, sex education can lead young people to postpone their own sexual debut to a great degree. That is why apart from dealing with disease control such as diarrhoea and malaria, AMASOT initiated the fight against HIV/AIDS and the reproductive health as top priorities on its agenda. Its activities are targeted to youth namely schoolchildren, lorry drivers, women, sex workers, soldiers, enterprises personnel, etc. Its activities range from condom sale and distribution to communication for behaviour change.

With regard to condom use, AMASOT staff mentioned that the Catholic and many Protestant churches are known in Chad for their opposition to modern family planning and therefore against the use of condom. Despite the fact that, AMASOT has sold 27 million of condom since 1996 up to date, different churches have solved the condom issues in various ways. Certain strongly stress on abstinence before marriage and faithfulness within marriage. Others argue against the condom use, emphasising that they are not 100% safe. Given the sensibility of condom issue in Chad, AMASOT does not impose its view towards church leaders and church members. On the contrary, AMASOT staff is pleading that if condoms are correctly and consistently used, they should be of some help to prevent and curb the spread of HIV infection.

6.2.2. Association Tchadienne pour le bien-être familial (ASTBEF)

In the context of HIV/AIDS, men and women should be informed that engaging in sex with a partner of unknown status or with multiple and occasional partners' poses a high risk of sexual transmitted infections. The ASTBEF

found that prevention campaigns reach a lot of people, but they are also missing two many young people. In order to address this, youth and schoolchildren are targeted by using Information, Education and Communication approach.

As mentioned earlier, a market campaign for condom use initiated by a USA's firm was considered as a chock for many churches. Many banners and hoardings that aimed at promoting condom use were destroyed. This could be one of the many reasons that did not lead the churches to take seriously their responsibility in the fight against HIV/AIDS.

The ASTBEF Director was concerned about the negative connections to condom nurtured by many churches which are detrimental to church members and to the general population at large. He went on stressing that if one of the spouses is infected, it is imperative that the discordant couple uses a condom in order to avoid infect the uninfected. In case of both of them are infected, condom use would prevent them to reinfect one another. However, given the many cultural taboos surrounding the issue of sexuality, churches find it difficult to talk about it in Chad. However, for the time being many churches namely catholic and protestant are still in contact with ASTBEF's staffs that are facilitating many church seminars and workshops related to HIV and AIDS.

6.2.3. Conajelus

CONAJELUS stands for "*la Coordination Nationale des Jeunes pour la Lutte contre le SIDA* ». Until recently, many churches in Chad have communicated the message that true Christians will not catch HIV. They stressed that AIDS is God's punishment and judgement on people who have lived a sinful life. In this regard, the church has been part of the HIV/AIDS problem rather than solution since the youth is still vulnerable to HIV/AIDS. As time goes on, the youths realised that they are vulnerable to HIV/AIDS and that fellow colleagues who were affected by HIV/AIDS needed care and support rather than labelled as outcasts, they formed CONAJELUS as a result of HIV/AIDS awareness growing. Many young people are already providing care to sick family members, although very few have the appropriate knowledge and skills required to deal with the complex health needs and social issues associated with HIV/AIDS, such as stigmatisation. Training young people as caregivers and as agents of stigma reduction may help communities cope better with the impact of HIV/AIDS and help motivate young people to practise protective behaviours. Towards this end, CONAJELUS closely works with the Catholic Youth Association and the Young Men Christian Association particularly in the field of HIV/AIDS and the reproductive health issues, etc.

6.2.4. Fraternité Plus

Fraternité Plus is an association of people living with HIV/AIDS who felt that they have a critical role to play in designing and implementing HIV/AIDS prevention and care programmes. People living with HIV/AIDS realised that the disease and its consequences are not just to be found outside the churches but also in the midst of churches and therefore represent the threat to the entire community members; they decided to disclosure their serostatus. *Fraternité Plus* is currently implementing innovative HIV preventive strategies related to behaviour change and help reduce fear and stigma. Since most of the *Fraternité Plus*'members are people living with HIV/AIDS, their involvement in HIV/AIDS programmes benefits PLHA by reducing their isolation and empowering them to make a difference. The group promotes a variety of prevention modalities, such as condom distribution and behaviour change campaigns. Some of its programmes are currently focused on cross-border population of KELLO province.

However, *Fraternité Plus* faces the following challenges:

1. In Chad, stigma and discrimination makes it difficult for a person to disclose his or her HIV status or become actively involved in Community HIV/AIDS activities;
2. People living with HIV/AIDS felt that many organisations in Chad are unprepared to involve PLWHA especially at the decision-making level. Instead, they felt that the National AIDS Control Programme (PNLS) is making money on behalf of PLWHA without their fully involvement in the programme.
3. People living with HIV/AIDS who wish to become fully involved in the Fraternité Plus need to develop new skills such as advocacy or counselling which are not available in the country.

Despite the above challenges, Fraternité Plus is working to create an environment in which PLWHA are comfortable coming forward as educators, community mobilisers, and active participants in community and country programmes.

6.2.5. UNAD

UNAD stands for *Union Nationale des Associations Diocésaines de Secours et de Développement*. Since 4 or 5 years ago, Catholic Bishops decided to be implicated in the fight against HIV/AIDS by initiating programmes that emphasised on care and support for people living with HIV/AIDS. In 2000, a meeting on HIV/AIDS for Christian

leaders was held in Moundou. Every bishop in Chad attended, and a consensus was reached that AIDS prevention was an important national priority. Therefore, bishops helped the dioceses establish AIDS committees and AIDS programmes in every parish. Apart from health service programme, group of community volunteers' visit and care for the sick, AIDS preventive education dramas and income generating activities are among other activities that are coordinated by UNAD. These programmes have greatly improved the quality of life for people living with HIV/AIDS; assured dying parents their children will be cared for, and brought support and comfort to families and communities afflicted by AIDS.

6.2.6. Centre Chrétien d'Education à la Vie Familiale (C.C.E.V.F)

Stigma and discrimination are major obstacles to HIV/AIDS prevention and care initiatives. Given their moral authority and their influence, Faith-based organisations are in a better position to help reduce the stigma that is often associated to HIV/AIDS. CCEVF has initiated and reinforced open and frank discussion about HIV/AIDS by the youth irrespective of their sex and church affiliation. An educational campaign helps the youth assess their risk of HIV/AIDS and other sexually transmitted infections. Peer education is a widely used approach for providing a safe and comfortable environment for adolescents to discuss sensitive sexual issues. In this regard, CCEVF is targeting both schoolchildren and youth who are outside the country formal education system. The programme also identifies and trains peer educators and develop peer education networks through music, street drama, talk shows and marches. Economic and social vulnerability to sexual abuse and exploitation also puts girls at high risk of infection. To bridge this gap, CCEVF distributes little money to young girls to help them meet their basic needs.

In Chad, HIV/AIDS is very often misunderstood as searching someone to blame. Many people have been readily identified including, tragically, people living with HIV/AIDS themselves. Many others see the cause of HIV/AIDS in the work of devil, in angry ancestors, in witchcraft, in American plot to destroy Africa. To overcome these missed opportunities, CCEVF are performing home-based care activities and home visits. They acknowledged the fact that instead of finding somebody to blame, empowerment of people to take charge of their lives is an ethical human response to combat the HIV/AIDS crisis.

6.2.7. Jeunesse de l'Assemblée Chrétienne au Tchad (J.A.C.T)

HIV is the worst pandemic mankind has ever experienced and it is still a major problem in Chad. The Assemblée Chrétienne au Tchad did much to combat the epidemic, and yet the church also avoided much when it comes to youth's involvement in the struggle against HIV/AIDS. The church found it difficult to speak openly and frankly about HIV/AIDS, sex and sexuality particularly among young people for fear that this would lead to sexual promiscuity. In the context of HIV and AIDS where the disease is leading to death 8,000 people every day, such reluctance has led to many criticisms. That is why Pastor OBED launched a national trip that allowed him chatting with youth of various backgrounds. The main outcomes were that many young people who became infected did not have adequate information about HIV/AIDS in order to protect themselves from infection. There were also a big deal of ignorance, misconception and missed opportunities both among church leaders and young people.

Currently, JACT is running an innovative youth programme (peer educators) instead of dealing with early strategies that focused on decision-making about sexuality, which attempted to get the youth to change their behaviour through messages of fear and guilt. Though problems of forced sex and incest prevailed in Chad, JACT life skills programme is underway successfully. Young people are taught skills that will help them deal with potentially harmful situations. Apart from that, young people especially young girls are given micro-credit that allows them to somehow pay their scholarship.

JACT is networking with the Ligue pour la Lecture de la Bible, Entente des Eglises et Missions Evangéliques du Chad and the Réseau National Evangélique de lutte contre le VIH/SIDA. JACT illustrates not only good practices but also the ways in which FBOs can contribute significantly to HIV prevention efforts.

CONCLUSION

In Chad, the seroprevalence of HIV/AIDS is low. This could be an indication why churches have reacted in different ways to the challenges of AIDS epidemic since the churches' response has in many cases been unsatisfactory. For instance, the first workshop for Catholic bishops was held in 2000. This helped bishops to sort out the Catholic's policy and guidelines about HIV/AIDS. By contrast, protestant church leaders met last September 2003. to develop their plan of action on HIV/AIDS issues. Before then, in many cases, given the silence of the national authorities

about the existence of the epidemic in Chad, churches have primarily communicated the message that Christian will not catch HIV. Many churches in Chad have considered HIV/AIDS as God's judgement on people who have live a sinful life. However, church leaders must understand that HIV/AIDS is not currently outside the church, amongst those who beggar on the church steps.

On the country, HIV/AIDS exists in many families, including those of pastors and church employees. What will happen when churchgoers and Christians will fall ill and die as a result of HIV/AIDS infection? Of course, these things are never taught in churches. But, poverty obviously will increase and the congregation income will dwindle since many people affected by HIV/AIDS will channel their financial resources into hospital for medicines and other health care including healthy food. It is well known that churches in Africa are willing to expand their evangelisation activities with many diaconal challenges ahead. HIV/AIDS threatens Chad and the whole society because many people diagnosed HIV+ are excluded, lose their job opportunities and social networks and are denied to live a dignified life because of stigma and discrimination.

There is no pill to cure stigmatisation and discrimination. They can partly be overcome by being opened to a frank and a constructive discussion on HIV/AIDS and sexuality. Additionally, stigmatisation must be counteracted so that people become aware that AIDS exists. This will enhance people's ability to cope themselves, both with a view to avoid HIV infection and to prolong the lives of those who are infected. Without complacency, churches must defend the rights of people affected by AIDS and advocate for treatment access to those who need them.

With regard to condom use which has wasted energy and time in many Chadian church settings and elsewhere, it is true that condoms do not guarantee absolute protection. In addition, promoting condoms as the total answer to HIV is not right. Throughout ages, Churches have nevertheless nurtured patriarchal view of society and must share its blame for the fact they have failed the more vulnerable sector of membership and the society at large by simply pronouncing moral directives without demonstrating the credibility of their positions in a society of powerful counter witness. For instance, a commercial sex worker told me in Ndjamena: "*The only way I could put bread on the table, and raise my children, is by selling my services. I had no other marketable skills."* There are many others like her crying for justice. In my opinion, education about condom is not condom promotion. My plea is about putting the condom in its rightful place as one among other measures of HIV prevention rather than drawing undue attention to its efficacy and faithfulness, or lack thereof, and its place within a hierarchy of what the Church teaches. Additionally, I know that distributing condoms is not the best way of solving the present HIV/AIDS problems. But let us not condemn the condom use until the better solution is actually in place.

Another issue that emerged during the mapping in Chad was premarital testing. Many churches have introduced a system of HIV testing for people who want to get married in church. There are several reasons that prompted churches to insist on HIV testing. For some churches, such testing would function as a preventive measure and encourage young people to refrain from premarital sex. For others, it is important for people who would like to get married to know whether they themselves or their future partner is infected with HIV. Bearing this in mind, they have to make an informed choice whether they want to enter into marriage or not. For other churches, HIV testing has a mandate to stop HIV+ persons from getting married at all, so that subsequent children do not end up as orphans.

With regard to HIV testing before marriage, churches must understand that it is a complex issue as it relates to human rights. Of course, it must be a right of individuals to decide whether or not s/he is wishes to be tested or not. Similarly people that are about to get married must know whether his or her future partner is infected. The problem that arose in Chad and elsewhere is whether the church has the right to refuse to marry a couple because of HIV infection especially when the partners themselves want to get married. Churches should understand that it is premature and unbiblical to rush into cancelling the wedding of a discordant couple. On the contrary, pastors need to gently and firmly guide them through this period characterised very often by chock, denial, and anger and on to acceptance of their condition. In short, churches must emphasise that the choice whether a discordant couple has to get married or not lies with the couple.

In Pentecostal churches, a concern on miraculous healing was raised. Pastors reported that two PLWHA were healed after a great deal of prayers and starvations. There is evidence that even in the midst of something as devastating as HIV/AIDS; Christians have a real hope in Jesus Christ. He is the prescription for hope. However, it is tempting to offer false hope to the persons who are infected with HIV, and assure them that God will heal them. God can obviously heal people with AIDS since he is a powerful God. However, healing must not be taken for granted and it does not necessarily happen when we need it. Churches should understand that God is sovereign and he does what he feels good for his children. As mentioned earlier, when the time for practical help and care of the infected person comes, the body of Christ, the church, must be willing to do what Jesus Christ would do. That is to counsel the PLWHA in a compassionate and biblical ways.

HIV/AIDS is a health, a security and a development issue. The dynamics of HIV epidemic are influenced by many different sectors of society, and vice-versa. In order to curb the spread of HIV and reduce the impact of AIDS, it is necessary for the churches to collaborate with various stakeholders in the society. In such pragmatic partnership, it is important to recall that various stakeholders will have their different strengths and different priorities and areas of focus. Therefore, the various stakeholders can compliment each other as long as the work is well coordinated. The involvement of those with HIV/AIDS is also an important contribution to the church as a whole and to the life of the parish. Together, churches can overcome the many HIV/AIDS challenges and realise tangible outcomes for God's glory.

RECOMMENDATIONS

❖ Policy

- Responsibility is the Christian and human response that churches must promote for the Chadian society with a strong thread of willingness to take their full responsibility for the tragedy unfolding before Christians and the population at large.
- Churches should make use of opportunities through available liturgy, religious and other catechistic and pastoral functions to emphasise human dignity and human rights in order to reduce the stigmatisation of people living with HIV/AIDS
- Churches should address and condemn all forms of sexual violence, exploitation and other harmful practices carried out in the homes, schools, church institutions, at work and help those who are the "victims" of such attacks;
- Churches should address and condemn policies, traditions or practices that discriminate against people living with HIV/AIDS with regard to their working lives, education or social background, cultural or religious environment;
- Church leaders should mobilise the resources at their disposal to establish effective structures which will respond to the crisis and bring hope for the people.

❖ Congregations

- Church leaders should avoid their irresponsibility that was characterised by the refusal to admit the presence of the disease in Chad and in hiding stigmatising people living with HIV/AIDS;
- Church leaders should develop and deliver information about HIV/AIDS in such a way that this information does not contribute to an increase in stigmatisation and discrimination of people affected and infected by HIV/AIDS
- Churches should cooperate with other sister churches in Chad and in the region to address the problem of how the churches teach young people on sexuality, both in Chad and elsewhere;
- Congregations should support and care for people and families who are suffering from HIV/AIDS and doing this as an integral part of the "competent AIDS church" at the congregational level;
- Church leaders should also design migrants and nomadic populations as a priority target group for HIV/AIDS interventions.

❖ Communities

- Nobody deserves to have AIDS. Church leaders must stop the culture of blame. Instead, they should have the ability to provide the people under their authority with hope and courage in the darkness related to AIDS;
- Communities need precise, up-to-date and complete factual information as part of the churches preventive work, both as regards the causes of the epidemic and its dimensions and consequences, and as regards how AIDS is linked to other issues on the church's agenda;
- The Church must accept that it has failed to educate its members on the value of sexuality and chastity. Churches in Chad must mobilise themselves to this end. But the Christian's response should be that of Jesus Christ: compassion, support and above not judging;
- The education for youth into a clear and consistent set of Christian values, which can help them survive in the era of HIV/AIDS, constitutes an essential Christian response right now.

❖ Counselling

- The church must work towards the education of conscience in the context of HIV/AIDS since many people are sometimes confused about what is the right thing to do;
- During HIV testing, when the man or woman is found to be HIV+, it is easy for the pastor to be judgemental. Pastors must understand that they are shepherds and not judges since they will keep confidentiality of issues discussed with clients;
- Several denominations in Chad have advised their pastors to require their church members to HIV testing before marrying in church. The aim of these rulings should prevent the further spread of AIDS, restore people to the path of following Christ, and care for those infected, rather than to punish the people;
- The timing of the HIV test and counselling before marriage are very important. The HIV testing needs to be done at early stage in the marriage preparations and at least six months before the marriage. This will help the pastors and the couple not to reach into cancelling the marriage when all the preparation have been already done;
- The pastor should counsel the engaged couple for HIV testing in honest way by making it clear that he desires to help them have a healthy relationship, not that he is acting as a policeman;
- AIDS is a disease and not a sin, pastors cannot stop the discordant couple from being married, but it is his own decision before God whether or not he wants to perform the wedding ceremony. The couple must make an informed decision, and the pastor must keep the information confidential, even when it is tempting to do otherwise.
- Pastors should understand that HIV/AIDS also comprises medical issues that the pastor does not feel competent to discuss with the couple, he should feel free, with the couples' permission, to refer them to a health person for further help

❖ Advocacy

- Church leaders must use national and international arenas to mainstream HIV/AIDS into church programmes and they must cooperate with sister churches be they in Chad or overseas to address the epidemic;
- Church leaders must work out strategies and lobby the appropriate national authorities so that the epidemic is given priority in Chad by the government, by churches and at international development cooperation;
- Church leaders should advocate that appropriate resources (medicines, technology) are available on a wider and fair basis with a view to help treat and support people living with HIV/AIDS, both nationally and internationally.

❖ Networking

- The *Réseau National Evangélique de lutte contre le VIH/SIDA* should be strengthened since it constitutes a reliable forum for advocacy and lobbying.

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CONGO/BRAZZAVILLE

November 2002

"Nobody deserves AIDS. Churches must envision a world where people experience and extend compassion and live together in hope as God's community with or without HIV/AIDS"

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Hendrew LUSEY GEKAWAKU
HIV/AIDS Coordinator for Central Africa

FOREWORD

In Congo, HIV/AIDS has, in a period of just two decades, reached unprecedented crisis level. It is estimated that up to two third of Congo's population aged between 15 and 24 years are HIV infected in this country. Therefore, the human toll of AIDS is a tragic reality being experienced by families, communities and the nation at large. In addition, HIV/AIDS is the greatest challenge to prospects of social and economic development and security that the Congo/Brazzaville has never encountered since HIV/AIDS is reversing the gains which have been made in social and economic development since early eighties. As an increase number of people already infected develop opportunistic infections and die, AIDS has become the major cause of illness and death among young and middle age adults, depriving household and society of potential human resources whom communities can count on.

In Congo/Brazzaville, the number of orphans as a result of HIV/AIDS related premature death of men and women is estimated to swell to more than 65,000 by the end of 1999. Due to the lack of reporting and appropriate support structures for those affected, the number is undoubtedly much higher. The numerous consequences of HIV/AIDS are putting further strain on an already overstretched social and economic structures deteriorated by civil wars.

Congo Brazzaville has several different organisations involved in HIV/AIDS activities and these include the public sector, private companies, non governmental organisations, churches and community groups participating in HIV/AIDS prevention, control, care and impact mitigation. However, during the mapping exercise, I noticed that some churches have been powerless in the face of HIV/AIDS because of the existing mountain of fear, stigma, ignorance and inaction that surround HIV/AIDS and threaten the survival and the well-being of people throughout the country.

However, the churches have a particular responsibility for overcoming this attitude by proclaiming their messages of hope, faith, perseverance and courage. Of course, HIV/AIDS is an issue of no easy solution, but the reliance of churches on the basis of Christian faith and spirituality could be the source of motivation of the churches to reach out in a meaningful way people affected and infected by HIV/AIDS.

I believe that if more people with a deep sense of calling in the churches come foreword for this ministry of HIV/AIDS, the situation can be turned around. Additionally, I am grateful for the assistance that has been received from the several organisations dealing with HIV/AIDS and the international community especially the United Nations

Inter-Agency Emergency Initiative in support of the government efforts to combat HIV/AIDS. The Director of the National AIDS programmes showed me the willingness to network with churches. The Ministry of Education is also working on integrating HIV/AIDS into the national curriculum.

The task for the Central Africa coordination office is to ensure that church leaders in Congo/Brazzaville are trained and motivated in dealing with AIDS through a participatory workshop in 2003. This will help them to emphasise the need to go beyond individual morality to address the social, economic and political issues that are directly related to HIV/AIDS. From the findings of the mapping exercise, I realised that churches have been among the first to respond to the HIV/AIDS crisis, but they can do more through a concerted and unified national church response. This is urgently needed in order to help churches bring the epidemic under effective and efficient control.

1. General and Epidemiological Data

1.1. General data on the Republic of Congo/Brazzaville

1.1.1. Republic of Congo country profile

The Republic of Congo is situated in western Central Africa astride the Equator. It is bounded to the West by Gabon, to the North by Cameroon and the Central African Republic, to the South by the Angolan exclave of Cabinda with a short stretch of coast along the South Atlantic Ocean which extends over 170 kilometres, to the East by the Democratic Republic of Congo. The Republic of Congo is divided into 11 provinces of which Brazzaville is the Capital city. Congo's 11 administrative regions are administered by a *Préfet* nominated by the government. Regions are sub-divided into districts, headed administratively by *sous-préfet*. The Republic of Congo has a total of 342,000 square kilometres.

1.1.2. Population

Many censuses which have taken place in Congo/Brazzaville showed that the population growth at a rate around 2,8% based on the 2000 census in which the total population was enumerated at around 2,864,000 inhabitants with 49% of men and 51% of women. 41% of the population lives in the rural areas whilst 59% are living in urban areas particularly in the South. The Bantu Bakongo make up nearly half the population, living primarily around Brazzaville and Pointe Noire. Pygmies live in the northern forests. There are 15 major ethnic groups in Congo. About half of the Congolese people practise traditional religions, the rest are mainly Christians, though there is a small Muslim minority.

Table 1: Demographic Indicators

Designation	*Year*	*Estimate*	*Source*
Total population (thousands)	1999	2864	UNPOP
Population aged 15-49 (thousands)	1999	1270	UNPOP
Annual population growth %	1990-1998	2.8	UNPOP
% of population urbanised	1990-1998	59	UNPOP
Average annual growth rate of urban population (%)	1990-1998	4.1	UNPOP

1.1.3. Economy

The Congo/Brazzaville's economy is predominantly based on the exploitation of its natural resources namely petroleum and woods. Congo's formal economy is based primarily on its petroleum sector, which remains by far the country's major revenue earner (65%). The Congolese oil sector is dominated by the French oil Total Fina Elf, accounting for 70% of the country's annual oil production. From a 283,000 barrels a day peak in 2000, independent

observers estimate that oil production will decline gradually over 2001-2004. If substantial discoveries are not made in the next two to three years, Congo's oil sector is forecast to enter long-term decline.

Congo Brazzaville's economy is also dominated by agriculture. Around 40% of the population earn their living from the land, mostly on smallholdings using traditional farming methods. The main food crops are plantains, cassava, sweet potatoes etc. However, reliance on this single commodity has left the economy very vulnerable.

Congo remains a highly indebted country as of 1 September 2001, Congo's external debt stood at US$:5.7 billion. In 1998, when Congo was US$:5.1 billion in debt, the government spent more than US$150 per capita on debt service repayments, as compared to approximately US$ 30 for education and US$ 10 for health (UN Plan 2002).

A number of factors which include poverty, unemployment, shortage of housing, gender inequality and some negative cultural norms and practices appear to fuel the spread of HIV.

Table 2: Economic Indicators

Designation	*Year*	*Estimate*	*Source*
GNP per capita US$	1997	670	World Bank
GNP per capita average annual growth rate	1996-1997	-2.7	World Bank
Human Development Index	2000	139	UNDP
Unemployment rate	-	-	-

1.1.4. Education

Congo has had a strong education system characterised by high participation and literate rates by Sub-Saharan Africa standards. Although, Congo identified specific targets from 1990 UN Global Conference on Education in Jomtien, by 2000-2001, virtually no progress has been identified (UN, 2000). On the contrary, enrolment levels and the quality of education have been deteriorating for over a decade.

Primary, secondary school and vocational institutes are under-resourced, of insufficient quantity and low quality particularly in rural areas. The depleted condition of state education in Congo is alarming in terms of 1,097 schools need rehabilitation. Additionally, 19% decreased in primary school participation between 1980 and 2000. An estimate of 247,500 primary school-aged children does not attend school. Chronic teacher shortages are an issue of concern particularly in rural areas where 150 schoolchildren are taught by 1 teacher. Drop-out of both rural and urban areas are due partly to a combination of parent's poverty, teacher shortage and the poor quality of education

Table 3 Education Indicators

Designation	*Year*	*Estimate*	*Source*
Total adult literacy rate	1995	75	UNESCO
Adult male literacy rate	1995	83	UNESCO
Adult female rate	1996	67	UNESCO
Male school enrolment ration	1996	60.0	UNESCO
Female school enrolment	1996	43.3	UNESCO

1.1.5. Health

In 2000, the Nation Health Policy adopted the Bamako's initiative that seeks to implement the following goals:

- Decentralisation of the health system
- Promotion of the private sector
- Access to health care for all
- Development of alternative methods for financing the health system

However, no new medical staff have been hired since 1985, no epidemiological surveillance system exists. Medical equipment and facilities have been destroyed or at best archaic and decaying and very often medicines are in short supply. Therefore, because of the many civil wars that prevailed in the country, Congo's health services are drastically deteriorated, under-resourced, understaffed and badly under-funded.

In addition, the peripheral neighbourhood of Brazzaville are characterised by the same problems as rural areas in Congo at large: access to health care is difficult, clean water supply is insufficient; basic sanitation is severely lacking (only 4% of families have access to a latrine at home) and morbidity rates are highly linked to the deterioration of the environment, notably the faecal waste. The leading causes of death among 19 to 45 year-olds in Congo are malaria, diarrhoea-related illness including cholera, measles, tuberculosis and HIV/AIDS. This fragile state of their living environment leaves the Congolese population in vicious circle of poverty and bad health.

Table 4: Health Indicators

Designation	*Year*	*Estimate*	*Source*
Crude birth rates (per thousands)	1999	43	UNPOP
Crude death rate (per thousands)	1999	16	UNPOP
Maternal mortality rates (per 100,000)	2002	810	UN PLAN
Life expectancy at birth	1998	49	WHO
Total fertility rate	1998	6.0	UNPOP
Infant mortality rate (per 1000 births)	1999	89	UNICEF
% of one- year-old children fully immunised-DPT	1995-1998	23	UNICEF

1.1.6. Poverty and vulnerability

Congo financial crisis in the mid-1980s contributed significantly towards the negative growth trend because of the government's inability to provide quality education and health services. By 1995, an estimate of 70% of the population reached an absolute state of poverty in Brazzaville. In addition, the impact of the major two civil wars (1998-1999) centred in and around Brazzaville has exacerbated an already fragile situation, wiping the development gains of earlier decades.

The two civil wars made altogether a total of 800,000 rural and urban inhabitants to flee into neighbouring forests, rural areas and the costal town of Pointe Noire. The already impoverished rural population faced the lack of income since farmers were unable to sell their products while urban consumers faced high prices.

Armed forces appear to have especially high rates of infections as do economic sectors (notably the mining, transport and constructions industries). However, during the two civil wars, estimates suggest that as many as 60,000 women were raped. 25% of these women were 12 and 15 years old. In some regions, such as Pool, rape became a systematic practice of war. In many occasions, women who could not flee were forced to become "war wives", exchanged among militaries like commodities. This is self explanatory why 55% of adults living with HIV/AIDS in 1999 were women. Hopefully, the widespread of women's rape ceased in 2000.

1.1.7. Politics

The fragile Congolese democracy faced trials in 1993 and 1994. The new elected President Lissouba dissolved the Parliament in 1992 and called for new elections in 1993. The results of those elections were contested by the major political parties. This entailed the political un-rest in the country. However, under the auspices of France, Gabon and the Organisation of African Union, the 1994 Libreville Peace Accord was agreed. Although the apparent stability was implemented, public violence started through the organisation of private militias among politicians. Presidential elections planned for 1997 did not take place, since Lissouba's, Kolela's and Sassou's militia exploded into a bloody civil war that destroyed much of Brazzaville.

1.2. Epidemiological data

1.2.1. The HIV/AIDS epidemic in Congo/Brazzaville

The first AIDS cases in Congo were diagnosed in 1993 and ever since, there has been a significant increase in the number of people living with HIV/AIDS. In 1995, it was estimated that Congo's adult AIDS infection rate was 7.8%. The National AIDS Control Programme estimated 10,223 HIV/AIDS cases reported.

Table 5: HIV/AIDS reported cases

Year	*Number*
1986	250
1987	1000
1988	330
1989	360
1990	465
1991	1077
1992	1785
1993	1126
1994	1380
1995	2450

Source: National AIDS Control Programme

Comments

The National surveillance ceased in 1996 and it only recommenced in mid-2001. Meanwhile, HIV/AIDS has been spreading at an alarming rate in Congo. As a result of the two consecutive civil wars, notification of the number of AIDS cases has not been carried out systematically for many years. In 1995, the HIV/AIDS prevalence already stood 7.8%, above the UNAIDS threshold of 4% for downward control. The years following 1995 were years of violence, including large scale of sexual violence, disruption of the health system. This suggests that the current HIV prevalence of 7.8% is much lower than the reality on the ground, as a result of some studies. An estimate of infection rate of between 10 and 12% may be true. Bearing in mind that if the HIV/AIDS is still unchecked, this epidemic will erase the benefit of peace and post-war reconstruction in Congo/Brazzaville.

1.2.2 Sentinel Surveillance

In Congo Brazzaville, the HIV/AIDS information has been available since the 1980 especially among the women attending the antenatal clinic. Brazzaville and Pointe Noire have been considered the major urban areas where many studies have been carried out at that time. The median HIV prevalence rate among the antenatal clinic attendees in these areas increased from around 5% in the late 1980s to 8% in 1994. Although the HIV prevalence in 1993 was found to be 4% among women tested outside the major urban areas, the HIV prevalence among antenatal clinic women appeared to be similar to what was seen in Brazzaville and Pointe Noire. However, nearly 50% of sex workers tested HIV positive in 1987. No further information for this group was available due to the economic turmoil and the civil wars that took place in the country. At the end of 1999, an estimated of 82,000 adults were reported to be living with HIV/AIDS of whom 45,000 were women.

During the previous 5 years, since the surveillance system did not exist, thus the accuracy of the epidemiological data is questionable. Therefore, the existing data do not reflect the reality of the pandemic on the ground taking into account the many contributing factors that are likely to spread the HIV/AIDS. However, limited information is available on HIV prevalence among the general population. A few studies carried out between 1990 and 2000 found the routes of HIV transmission below:

Table 6: Routes of transmission	
Designation	*Percentage*
Mother- to-Child transmission	03% and 15%
Blood transfusion	10% and 15%
Heterosexual among prostitutes	30% and 70%
Prevalence to those with STIs	17%
HIV prevalence	07% and 9%

Source:" Rapport National sur le Développement Humain 2002 du Congo/Brazza. Page 27

1.2.3. Contributing factors to the spread of HIV/AIDS

The are many contributing factors to the spread of HIV/AIDS. They include:

- The persistent culture of silence within the faith-based organisations
- Poverty that hinds control effort
- Wars, armed conflicts and insecurity and its consequences (rape, sexual violence..)
- Socio-cultural issues:
  - Negative cultural and perceptions issues that make women vulnerable to HIV
  - Discussion about sex and sexuality is a taboo
  - Stigma, discrimination and rejection attached to HIV/AIDS that force people who test HIV positive to remain inadvertent killers by spreading the disease
  - Gender inequity: women continue to be subject to widespread discrimination at home, in the workplace, before law, and in public institutions
- Global economic and injustice
  - Heavy external debt
  - Structural adjustment with its cut in government health and education spending
  - Inaccessibility to anti-retroviral and, to voluntary counselling and testing

1.2.4. Impact of HIV/AIDS in Congo

Despite the fact that the HIV/AIDS situation is a looming national catastrophe with an adult infection in 1995 of 8% and rising since then, no empirical data on Congo were found in the literature review.

However, like in many other sub-Saharan African countries, the impact will obviously be felt in sectors such as: agriculture, education, medical, economic etc.

In household and in the agricultural sector, illness and death due to HIV/AIDS will lead to increased expenditure, reducing saving and productivity. Despite the vast potential for agriculture, structural weaknesses, notably destroyed road infrastructure render Congo an importer of food since only 2% of arable land are currently cultivating (UN PLAN 2002).

In 2000, the education model developed by UNAIDS and UNICEF shows that, of around 450,000 primary schoolchildren, 3 900 would have lost a teacher to AIDS in 1999. This increasing mortality rates among schoolteachers leads to discontinuity in teaching with many schoolchildren that are forced to change their teachers.

In 2001, a United Nations study found that 35% of beds in urban and semi-urban hospitals were occupied by AIDS patients. Additionally, based on limited studies in the Brazzaville morgue, the proportion of adult female AIDS cases is significantly higher than the proportion of male cases, 30.2% versus 21.0%. In conclusion, further data is required for an understanding of how the pandemic is affecting the agriculture, education, health and economic sectors for the implementation of the national strategic planning which is underway.

2. NATIONAL HIV/AIDS CONTROL PROGRAMME

2.1. Background to the AIDS Control Programme

In Congo/Brazzaville, the first cases of HIV/AIDS in 1983 aroused the interest of the government which, while starting information and awareness building activities, approached the World Health Organisation for technical assistance. Under this technical assistance, it was decided that the National AIDS Control Programme (PNLS) would be established within the Ministry of Health.

2.2. The National Response of Congo

The Congolese's response in the fight against HIV/AIDS has been effective before the 1990s since Congo was a pacesetter in this specific matter within Central Africa Region. At that time, Congo mounted a strong campaign against the pandemic. However, this progress has been halted by the economic turmoil and the two civil wars. Currently, little is done to reverse the spread of HIV/AIDS. The box bellow will provide important dates and significant events.

Table 7: Dates and major events of the National Response

Dates	*Events*
1983	First AIDS cases reported
1985	Creation of Diagnostic and Prevention Unit
1987	Creation of the National Committee against HIV/AIDS
1989-1991	Elaboration of the first medium Term plan
1991-1996	No data available
1996-1998	Elaboration of the Medium Term plan
1998-2002	Plan of urgencies post civil wars

During the mapping exercise I was invited to attend a meeting aimed at elaborating the National Strategic Planning 2002-2004. The main domains of interventions in the fight of HIV/AIDS were:

- Prevention
  - Sexual transmission prevention through behaviour change and marketing of condoms
  - Blood transfusion transmission
  - Prevention of Mother-to-child Transmission
- Care
- Medical: voluntary counselling and testing, treatment of opportunistic infections and sexual transmitted infections
  - Psycho-social: counselling, social ministry and pastoral care
  - Socio-economic: care of orphans, widows etc.
  - Rights and obligations of people living with HIV/AIDS
  - Nutritional: provision of food towards the infected and affected people
- Epidemiological Surveillance
  - Capacity building of notification systems
  - Sentinel surveillance
  - Epidemiological survey and studies
- Research
  - Traditional medicine
  - Behaviour change studies
  - Socio-cultural studies
  - Operational research

- Coordination, partnership
  - Advocacy etc.

In order to contribute to halting the spread of HIV/AIDS, five main objectives were spelt out under the UN PLAN 2002 (which is working closely with the National AIDS Control Programme) namely:

- AIDS awareness and education
- Epidemiological monitoring
- Promotion of condom use and HIV testing
- Access to treatment and assistance for the affected
- National capacity and sustainable fund

Comments

It would be very crucial for the Congolese's National AIDS Control Programme to implement the required activities to achieve its objectives. However, the general public has been very critical of the government inadequate response to prioritise HIV/AIDS as a top issue and its inability to address the stigmatisation, the discrimination and the rejection attached to HIV/AIDS. However, leaders at all level not only in government but also religious and even traditional have the responsibility to create a more open society that is free from stigma, silence or denial about the epidemic.

In Congo, it took many years before the establishment of the first voluntary Counselling and Testing centre was established and the Mother-to-Child Transmission treatments are still in their infancy stages. Additionally, accessibility, availability and affordability of anti-retroviral therapy remain a major obstacle except for those with sufficient financial resources to by-pass the informal system. However, the Mother-to-Child Transmission is receiving a strong political commitment from the first Lady of the country who is partly hosting the programme in collaboration with other potential external donors.

2.3 Partnership

Although the two civil wars have destroyed much of Brazzaville including the HIV/AIDS information, several stakeholders namely local and foreign NGO, national secular and religious associations, churches, civil society, the private sector and external partners have thus associated their efforts with those already engaged by the National AIDS Control Programme to combat the HIV/AIDS.

NGO and National Associations

They are too numerous to be listed in Brazzaville. They are either secular or denominational established in the capital city and in Pointe Noire, the economic capital. Most of the associations intervene at different levels in the struggle of HIV/AIDS and are active especially in awareness raising and sometimes the care of people living with HIV/AIDS, orphans, widows, etc.

External Partners

The National AIDS Control Programme works in collaboration with the following partners such as WHO, UNAIDS, UNDP, WHO, World Bank, GTZ, French Cooperation, UNICEF, OXFAM, Red Cross, FNUAP, WFP, European Union and USAID, etc.

3. POSITION AND INVOLVEMENT OF FAITH BASED ORGANISATIONS IN ADDRESSING HIV/AIDS

3.1. The faith based organisations in Congo/Brazzaville

In regard to the mapping work of HIV/AIDS in Congo, I met either religious leaders or head of health services of the following faith-based organisations: Assembly of God, Catholic, Protestant, Kimbanguist, Orthodox, Salvation Army, Lutheran and Revival Churches.

3.2. Perceptions of HIV/AIDS by the faith-based organisations

For the time being, HIV/AIDS is not curable, but is preventive and increasingly treatable. Tragically, people continue to be put at risk of HIV infection and of an untimely death from AIDS-related illness because of the church politics and the diverse theological interpretations that hinder the right perceptions of HIV/AIDS by the many faith-based organisations. Church leaders should understand that 15 years ago, the number of reported of persons living with HIV/AIDS in Africa was only 2,324. Today an estimated of 28.1 million persons are infected in sub-Saharan Africa. Every church leader must personally break the silence about the norms and practices that fuel HIV/AIDS epidemic.

It has to be highlighted that the perceptions of the faith-based organisations vary from church to church. The following lines will deal with the perceptions of Assembly of God, Catholic, Protestant, Kimbanguist, Orthodox, Salvation Army, Lutheran and the Christian Ministry: New Life.

3.2.1. "Assemblée de Dieu de Pentecôte"

This church puts a special emphasis on faith in the miracle of curing AIDS. During the mapping exercise, I saw many people suffering from various illnesses including HIV/AIDS who have chosen the church to be both their living room and hospital.

> *"In spite of dedicated individuals of good will and pragmatic organisations dealing with the pandemic, the HIV/AIDS has become a human, social and economic disaster with many implications for individuals and communities. However, it has to be said that HIV/AIDS is a disease that could be treatable and even curable depending on God's will."*
>
> *Rev.DEMBA MBAKOU Albert, the National Church Leader of the Assembly of God.*

3.2.2. "Archidiocèse Catholique de Brazzaville"

In view of the Roman Catholic, the HIV/AIDS is a scourge which negates the efforts of the Republic of Congo in addressing the economic and political crisis into which the country has been plunged for many years.

> *"The Catholic Church in Brazzaville understood that already HIV/AIDS is the leading cause of death in Congo, and unless faith-based organisations and other stakeholders can do something to combat this deadly disease, the pandemic will continue to wipe out the earliest progress gained over the years."*
>
> *Dr MBOUSSOU*

> *"The HIV/AIDS pandemic is spreading at an alarming rate in Congo. This should help church leaders not to work in isolation even if the churches are a little bit later behind in the fight of HIV/AIDS"*
>
> *MANOU Paul Richard, General Secretary of Caritas Congo.*

3.2.3 "Eglise Evangélique du Congo"

Basically it is in the prevention that the EEC is heavily involved. Since the human kind is infected particularly due to the lack of information on the mode of HIV/AIDS transmission, discussions have been organised by the church at the parish level.

> *"As far as the EEC is concerned, after twenty years into the HIV/AIDS pandemic, nobody has taken the responsibility to reflect upon this issue. Consequently, HIV/AIDS is still a taboo probably because of the lack of knowledge"*
>
> *Mrs KODIA LEMBA, Director of Health Service.*

> *"Yet the church has not fully taken its responsibility that is why meaningful actions to slow down the pandemic is hardly visible in the society. At parish level, the issue of HIV/AIDS is talked with reluctance. This shows why stigma and discrimination of people living with HIV/AIDS characterised by silence, fear and denial fuels are increasing on the spot."*
>
> *Ms. Andréas SENGOULOU, Journalist in the Evangelical Church of Congo/Brazzaville.*

3.2.4. "Eglise Kimbangusit"

In the opinion of the Kimbanguist church, AIDS is obviously a disease caused by HIV. However, it is considered as God's punishment. This is why the Kimbanguist church cannot play a prominent role in the dissemination of preventive measures that are likely to encourage sexual promiscuity and prostitution.

"HIV/AIDS is God's punishment because people do no longer obey God's laws. One could get the HIV/AIDS infection if s/he wants it since adultery is the main entry point of HIV/AIDS. No one could suffer or die of HIV/AIDS if every body was faithful to his/her sexual partner." *Rev. BIYEKOLA Emile, the National Director of Evangelisation.*

3.2.5. "Eglise Orthodoxe"

I held a discussion with the Reverend Father Serge. In his opinion, the AIDS epidemic poses an unprecedented challenge to the entire society. However, he did not have the required knowledge tackle this issue.

> *"I do not know neither what needs to be done to fight HIV/AIDS nor what works. The challenge I am facing is to acquire the required knowledge and to turn it into action since it seems that the HIV/AIDS pandemic would be changing over the time."*
>
> *Father Serge MATULEMO SOUAGBO, Pastor of the Orthodox Church.*

3.2.6. "Lutheran Church"

Abstinence, chastity and faithfulness are the basis of the prevention measures promoted by the Lutheran Church in Congo. The use of condom is considered as one of the leading cause of spreading HIV/AIDS.

"Sins are the leading cause of death rather than HIV/AIDS. Indeed, HIV/AIDS kills the physical body while sins are soul killers. HIV/AIDS could be considered as God's punishment because the human kind has currently the tendency to by-pass God's laws since God is patient. The world is overcrowded by so many sinful actions such as sexual liberty and condoms use that God has allowed the outbreak of HIV/AIDS. Consequently, God has not yet enabled scientists to discover the effective cure of HIV/AIDS because of the overwhelming sins in the world."

"The condom use worsens the situation and sins are occurring everywhere. As long as the condom use is accepted in the community, sexual promiscuity becomes obvious. Condom is a devil's strategy that aimed at promoting sexual transmission of HIV/AIDS and sexual violence particularly against women. After misleading Eve in Eden's garden, the devil is nowadays working to cheat the human kind in the same way he tempted Eve with the so-called safe condom."

Rev.POUNGI SAMBOU, the National President of the Lutheran Church in Congo.

3.2.7. The Salvation Army

Whilst in many countries, the Salvation Army is often considered an important partner in the fight against HIV/AIDS. However, the main emphasis of the Salvation in Congo is mainly put on social issues such as: resettlement of refugees and displaced people.

"Because of the many civil wars that killed many people in Congo, the HIV/AIDS is no longer a top priority issue because the church is struggling to provide care and hope to million of civil wars displaced people and refugees."

The in Chief Secretary of the Salvation Army

3.2.8. "Ministère Chrétien:Vie nouvelle, Eglise d'Antioche"

This revival church insists on abstinence before marriage and fidelity of couples. The use of condom is merely authorised to discordant couples. During the mapping, I have been invited to speak about HIV/AIDS from the pulpit on Sunday. 107 people attended of whom 49 youth, 40 women and 18 men. Important questions have been asked, this shows the hunger of churches to receive accurate and updated information.

"HIV/AIDS is a matter of both Christians and non Christians. 3 Christians within my church have already died of HIV/AIDS. In my opinion, I feel that HIV/AIDS should be spoken from the pulpit even though there are so many warning messages on TV and radios. Fairly soon, Jesus Christ might be back. Who will see him if most of Christians die of AIDS ?"

Pastor EKOUAYA Barthélemy, Apostle of Christian New life Ministry, the Church of Antioch.

Comments on churches' perceptions

4. Despite the above miss-opportunities of HIV/AIDS, some church leaders are raising concern about the way HIV/AIDS is jeopardising human security, undermining economic development and threatening to destroy the fabric of society.
5. However, the HIV/AIDS is still perceived by other church leaders to be merely as a health issue. When I visited churches, some church leaders sent me straight to talk with health professionals rather than with the church leaders themselves. This attitude is self explanatory that churches are not fully involved in fight of HIV/AIDS.
6. Experience around the world shows that by discussing HIV/AIDS openly and sensitively and then taking action, leaders can make a difference to fight HIV/AIDS.
7. In addition, taking into account the stigma and discrimination of people living with HIV/AIDS, many churches are not seen to be places of refuge for the infected and the affected. PLWHA are automatically considered as sexually promiscuous.

8. Furthermore, because of the many misconceptions surrounding the HIV/AIDS, the voice of church advocacy has been too often silent in Congo Brazzaville.
9. According to medical sources in the country, the fear of discrimination is preventing people from seeking treatments for opportunistic infections and from acknowledging their HIV status publicly.
10. In my opinion, I do think that it is by confronting stigma and discrimination that the fight of HIV/AIDS could be won.
11. In conclusion, the churches are lacking the language to address HIV/AIDS issues.

3.3. Involvement of the Churches in HIV/AIDS Awareness for Clergy and Congregations and Laity

3.3.1. "Eglise Evangélique du Congo"

The EEC is one of the major protestant churches in Congo/Brazzaville. The church authorities allowed the health service professionals to undertake talks and negotiations with external donors in view to apply for HIV/AIDS funding.

Main activities

With regard to HIV/AIDS, "the Eglise Evangélique du Congo" focus is awareness raising and peer educator's training.

Awareness raising

According to Mrs KODIA LEMBA, the director of the Health Service, two workshops would have been organised during the last years: The first workshop was held at the attention of the youth and the second was a sort of in-service training of health professionals. However, no report was available. Contrary to the many churches which do not accept the condom, the Eglise Evangélique has allowed the use of condom for those who cannot abstain from sex or be faithful especially people living with HIV/AIDS. In those situations, the ECC believes that people living with HIV/AIDS should be allowed and challenged to use condoms for two reasons: First of all, they must prevent the transmission of HIV to others. Secondly, they should protect themselves from additional infections.

> *"If we simply proclaim a message that condoms cannot be used under any circumstances, then I believe people will find it difficult to believe that we, as a church, are committed to a compassionate and caring response to those who are suffering, often in appalling living conditions."*

Peer education training

Although 5 young people have been trained to involve the youth department in the struggle of HIV/AIDS, there is no formal peer education training programme within the church. The Eglise Evangélique is running a theological college where student's spouses are trained on HIV/AIDS as part of the reproductive health modules. With a French church partner, the Eglise Evangélique is looking forward to training 120 pastors next year. However, the AIDS module is neither available nor integrated into the theological college curriculum.

Young adults constitute the most active segment of Congolese population. They have been both the victims and actors in the repeated armed conflicts, many of them through joining militias and participating in the destruction of the socio-economic infrastructure. Rehabilitation work and education will provide them opportunity to participate in the restoration of better living conditions for affected communities. Peer education will be an opportunity to restore their sense of responsibility, work and the common good for Congo. Youth in Congo trust the church, then one could realise what an opportunity the church has to make a difference.

3.3.2. The Catholic Archdiocese of Brazzaville

As the morbidity and the mortality of HIV/AIDS rates rise through the Congolese society, most bishops are aware that HIV/AIDS is weakening the country institutions and wiping out the progress gained over the previous years. That is why a workshop for Central Africa Bishops was held in Libreville/Gabon in 2000. Each diocese has been allowed to train local people who can lead the struggle against HIV/AIDS at the grass root level (congregation).

In 2001, another Bishop's seminar was held in Malabo/ Equatorial Guinea. One of the visible outcome of this workshop was the creation of the Regional Council AIDS Control programme that aims at providing technical advice to local congregations or dioceses with regard to its felt needs. As far as the Archdiocese of Brazzaville is concerned, a part from sporadic interventions, there is no formal HIV/AIDS programme to slow down the spreading of the pandemic. According to Dr MBOUSSOU, a plan of action has been elaborated. However, the Archdiocese did not provide any funding that is likely to help the team implement the so-called programme.

Main activities

Awareness raising

- Prevention: This programme focus is life skills training, "mouvement pour la vie, foyers chrétiens", pastoral care for AIDS patients in the terminal phases.
- In October 2002, a seminar was held in collaboration with the Catholic Relief Service. There was an agreement reached on the need to train trainers namely clergy and laity in order to disseminate information, education and communication on HIV/AIDS.

3.3.3. Lutheran Church of Congo/Brazzaville

The Lutheran church seems to be active in its response to the HIV/AIDS crisis. Its approach is visionary despite "its religious extremism". What is outstanding in the Lutheran Church is the involvement of women and youth in the awareness raising. Additionally, HIV/AIDS would be preached from the pulpit.

However, the temptation to use the pharisaic approach of merely saying that: "***if you want to avoid AIDS, keep God's law***" is widespread in the Lutheran Church. In my opinion, this approach is blind because it does not take into account the realities of women who have especially been raped by soldiers during the civil wars and who are living under extreme poverty because of the death of their husbands due to the bloody wars. In my opinion, there is evidence that unless the church leaders meet people living in poverty, really listen to them and try to understand their situation, most church leaders will have a skewed theology as well as a skewed morality.

4. THE INVOLVEMENT OF THE CHURCHES IN THE STRUGGLE AGAINST POVERTY AND THE DEFENCE OF HUMAN RIGHTS

The many civil wars have impoverished communities and dislocated their social organisations in Congo/Brazzaville. In order to alleviate the apparent effects of this situation, many churches with the help of International Organisations initiated projects in Brazzaville to feed and give accommodation to displaced people. However, they should focus on capacity building of the communities to identify and execute projects themselves. In addition, church leaders were concerned with women and young girls who are increasingly vulnerable to HIV/AIDS due to extreme poverty and rape. Towards this end, they were planning to set up once again the many vocational training centres that were destroyed during the civil wars. During the mapping, I realised anyway that the major religious organisations have many good intentions but few concrete actions.

The causes of poverty are manifold. For instance, the provision of quality of health and education services in Congo is among the worst in the developing countries, particularly in rural areas. Already in 1995, before the last two civil wars, absolute poverty had reached 70% in Brazzaville, making poverty reduction a top priority. However, what is lacking in this approach is a sustained advocacy before governmental authorities for a better distribution of the national wealth with a view to reducing poverty which is the main leading cause of both the occurrence of civil wars and the spread of HIV/AIDS. Transparency in the government economic is an ongoing concern. The restoration of the rule of law should be vital, underpinning the fight against corruption, emphasising the need for transparency in public office and an end to the culture of impunity.

With regard to the defence of human rights, "the Eglise Catholique, Eglise Evangélique du Congo, Armée du Salut, Eglise Kimbanguiste and Eglise Evangélique Luthérienne" have formed the National Council of Churches that is the member churches of the World Council of Churches. They work together to promote peace, reconciliation and respect for human rights in the country through their annual ecumenical prayers. Actually, there are over 100,000 refugees that require assistance, and in some cases, repatriation, and/or resettlement. However, for the time being, churches and religious organisations are not yet aware of the link between human rights and AIDS. This may justify why there is so much stigma, and stigmatisation towards people living with HIV/AIDS.

The risk of discrimination and stigmatisation is high in respect of HIV/AIDS and is being encountered by people living with HIV/AIDS in many spheres of life. To achieve full human and constitutional rights for people living with HIV/AIDS, government corrective measures are needed to eliminate stigma against PLWHA.

5 PARTNERSHIP BETWEEN GOVERNMENT AND FAITH-BASED ORGANISED

In view of the severity of HIV/AIDS, the Congolese government has taken its responsibility to provide the leadership through the Ministry of Health to combat the pandemic. Most of the churches I visited were invited to attend at least one of the many seminars that have been organised so far by the Ministry of Health. Since 2/3 of Congo's population is aged between 15 and 24 and are the highest risk group for sexually transmitted infections and HIV/AIDS, the Ministry of Health has acknowledged the religious organisations as important partners in the fight of HIV/AIDS given their influence and their moral authority towards the youth.

Since efforts to HIV/AIDS control can be contained and eventually brought through a coherent and sustained multisectoral approach supported by political and civil leadership at all levels of society, it has to be mentioned that there is currently no fruitful partnership between the government and faith-based organisations. The lack of effective existing networks among the churches is partly the reason of this shortcoming. Consequently, churches are very often under-represented during the discussion between the government and other stakeholders in respect of HIV/AIDS. Additionally, the lack of coherent approach among and within churches is a serious impediment to reaching successful results.

> *"The government has recently launched a national campaign to slow down the epidemic. However, a catholic priest who attended a recent talk with me in the Ministry of Health made it clear that the Catholic church would no longer be involved in that campaign because the government is promoting the condom use as one of the many strategies to curb the HIV/AIDS crisis" (personal communication)*

Since the response to HIV/AIDS requires considerable political leadership and resources, in view of the magnitude of the resources needed for HIV/AIDS prevention, control, care and impact mitigation churches should commit themselves to work hand in hand with the government and other stakeholders to contribute resources to combat HIV/AIDS. Therefore they need overcome doctrinal barriers for the sake of the Congolese people.

6. ECUMENICAL ORGANISATIONS AND RESOURCE FACILITIES

6.1. Caritas Congo

In partnership with "Médecins d'Afrique", Caritas Congo has been active in prevention and awareness raising about the HIV/AIDS crisis. A reflection day has been implemented throughout Dioceses that recognised the contributory factors which lead to the spread of HIV/AIDS including poverty, denial of the illness, and the harmful effects of the media, negative beliefs and harmful cultural practises. Additionally, dioceses have found the importance of networking through the implementation of a unified plan of action. Towards this end, the local technicians are urging the 6 Bishops of Congo Brazzaville to hold a meeting where the only HIV/AIDS and its implications should be discussed. Caritas Congo is well known in Brazzaville for home care programmes and for treatment of opportunistic infections.

6.2. "Médecins d'Afrique"

"Médecins d'Afrique" is a national, non profit, non governmental organisation that seek to improve the well-being of current and future generations including the AIDS orphans and people living with HIV/AIDS around the country and to help achieve a humane, equitable and sustainable balance between people living with HIV/AIDS and the resources. The HIV/AIDS has left at 65,000 children orphaned in Congo. Due to the lack of reporting and appropriate support structures for those affected, there is no doubt that the number should definitely be higher. Médecins d'Afrique is working in close partnership with UN agencies to provide support for those children.

In addition, Médecins d'Afrique has shown a great dedication to the children who were coming back from the forests when the civil wars were over. These children were given deworming drugs. Moreover, this NGO has trained peer educators within catholic dioceses. Médecins d'Afrique conducts social science research (income generating scheme for orphans and people living with HIV/AIDS) and public health research and helps build professional capacity in Congo/Brazzaville.

6.3. Association Congolaise pour le bien-être familial

In the context of the HIV/AIDS, men and women should be informed that engaging in sex with a partner of unknown status or with different partners poses a high risk of sexual transmitted infections and HIV transmission. The "Association Congolaise pour le bien-être familial" found that prevention campaigns are reaching a lot of people, but they are also missing too many young people. That is why the youth and schoolchildren are targeted. Condoms are not being distributed whilst the incidence of new HIV infections is still on the increase. However, the Director of this association said that he is willing to collaborate with faith-based organisations wherever this is possible.

6.4. United Nations Inter-Agency Emergency Initiative

In order to contribute to halting the spread of HIV/AIDS in Congo, five UN agencies namely the World Health Organisation, UNFPA, UNICEF, WFP and UNDP have created the joint Initiative. This project is seeking to join and multiply their efforts in the fight against HIV/AIDS from November 2001 to October 2003. Activities are focused on interventions that target groups at risk such as youth, vulnerable groups (women, orphans, and victims of sexual violence). In addition, this Initiative is planning to help building capacity to produce recent and reliable data on HIV/AIDS in Congo. Since all Congolese are the expected beneficiaries of this Initiative, church leaders are expected to submit project proposals in view of obtaining funding.

7. ORGANISATION OF THE CHURCHES INTO A NETWORK

7.1. The National Council of Churches

The HIV/AIDS is a serious problem of major national significance with far reaching socio-economic impact. Therefore it necessitates a strong and unified response. However, the churches' response to HIV/AIDS has been insufficient to slow the spread of HIV and effectively and address its numerous consequences in Congo.

> *"Churches are not networking in Congo as they work in isolation. The so-called National Council of Churches is about to allow member churches just to accept each other. There is no concerted effort to fight HIV/AIDS. Perhaps, the tensions and hesitancies surrounding the issue of condom is still sap much of the collective energy that should strengthen the church's response to HIV/AIDS"*
>
> *Ms Andréas SENGOULOU*

> *"As far as the National Council of Churches is concerned, there is no ecumenical HIV/AIDS programme to tackle this issue by the member churches. We are looking forward to launching such initiative since HIV/AIDS situation is a looming national catastrophe."*
>
> *Mgr Anatole MILANDOU, Archbishop of Brazzaville.*

Indeed Christian denominations can work harmoniously within the same organisation. For instance, the Catholic church, the Evangelical church, the Salvation Army, the Kimbanguist Church and the Lutheran Church are brought together into the National Council of Churches and yet the HIV/AIDS has not been recognised as a priority by the church leaders. That is why HIV/AIDS is not integrated into their planning and programming. Church leaders should notice that:

"It is not only heads of state who have to lead in the fight against HIV/AIDS. We all have to lead, especially the million of people who are infected and affected by HIV/AIDS, and the millions more who are vulnerable to this epidemic. We are in this together. And we should lead our way out of it together."

7.2. The National Strategic planning on HIV/AIDS: 2002-2004

During the mapping exercise, the national strategic planning elaborated by the government and the national consultant of the UNAIDS and other professionals was underway. I was invited myself to attend the meeting organised by the National AIDS Control Programme in collaboration with UNAIDS to make improvements on the national strategic planning document. However, I was disappointed to see that the churches were under-represented. I personally raised concern about it, hopefully, I was assured that the churches' voice are very important and they will be integrated in the national strategic plan in due time.

CONCLUSION

In Africa in general and particularly in Congo, church based institutions are key players in the fields of health and development. The churches have large captive and loyal audience which meets at least once a week. And yet, the churches fail to use this opportunity to accurately inform and sensitise their audience about HIV/AIDS. There is no doubt that churches have done a lot to combat this epidemic. However, I think that they could do more if they could tackle both the ethic of sexuality and that of preserving and saving life of people. Of course, Jesus Christ said: "I came that you might have life and have it abundantly", but HIV/AIDS raises great challenges to that promise. What is the churches response to AIDS challenges?

My first conclusion is that many church leaders considered what is now a pandemic as judgement from God against immorality. This is why church leaders are reluctant to speak out about the HIV/AIDS and they failed to be in the forefront in breaking the silence. Therefore, instead of informing and liberating people from misconceptions, many church leaders put restrictions on sex education and place theological burdens and pitfalls that are heavy to carry.

In addition, although the civil wars should not be taken as an excuse, nevertheless, it has to be highlighted that the civil wars have destroyed much of Congo. Reliable data are inexistent, this may explain partly why churches cannot appreciate the severity of the pandemic since the HIV prevalence (7.8%) of 1995 is still considered as accurate. A part from the awareness raising, I did not come across or visit any relevant, efficient and effective HIV/AIDS programme set up by the churches. The missed opportunities, misinformation and suspicion on the part of many church leaders have slowed down meaningful behaviour change whereas the HIV/AIDS crisis continues to kill people during their productive age leaving behind older people and orphans.

Moreover, there is a widespread belief at least in Brazzaville within the Kimbanguist and the Lutheran Church that HIV/AIDS happens to "other people notably: pagan, prostitutes etc." On one hand, this attitude undermines prevention, care and support. On the other hand, it increases the impact of the epidemic on individuals, families, communities and nation. On the light of the above reasons, stigma and discrimination should be addressed. There is evidence that challenging the stigma and discrimination can lead to immediate improvement in copying capacity for people living with HIV/AIDS. Most people infected and affected by HIV/AIDS are living positively because of the social support provided by the churches, the family and people of good will etc.

Furthermore, the National Council of Churches should be the required channel and network that can bring at least the member churches of the World Council of Churches into an effective struggle against HIV/AIDS. Since most of the churches of this network are nationwide, their objective should be to harness their respective efforts for increased efficiency with regards to HIV/AIDS especially for youth, women and street children and the general population at large.

Finally, HIV/AIDS is a serious public health, social and economic and security problem affecting the whole country and requiring to be addressed as a major priority through appropriate individual and collective actions. The churches should collaborate with international agencies/organisations and the government on the HIV/AIDS policy in order to promote and guide present and future responses to AIDS in the Republic of Congo.

In the light of the above considerations, my recommendations are as follow:

Policy

- Since many church leaders still regard HIV/AIDS as a punishment for loose sexual behaviour, a fresh biblical interpretation is required through a theological reflection.
- Fear of rejection prevents many people living with HIV/AIDS from being open about their HIV/AIDS status. Church should develop policies to combat stigma and to promote the acceptance of people living with HIV/AIDS.
- Without information and education, people are still ignorant and helpless. Silence about HIV/AIDS is equivalent to death, consequently, clergy needs to be trained in theological and biblical colleges.
- A realistic compromise of condom is required since churches are slow, conservative and reluctant to move on that issue as if HIV/AIDS is equivalent to condom use.
- A situational analysis with community participation is needed to ensure that the AIDS programme will belong to the community as it is socially and culturally rooted.

Congregations

- Despite the dark moments of AIDS and civil wars, congregations should understand that they are not alone. They should minister those around them as did Jesus Christ at the Cross of Calvary since God is never, ever separated from us.
- Congregations should proclaim the message of hope, faith, perseverance and courage.
- Congregations must be equipped in pastoral care and social ministry to tackle AIDS.

Communities

- Need that the necessary accurate and updated messages on HIV/AIDS are given
- Should find out factors including beliefs, traditions and taboos that undermine churches' efforts to respond in the most effective ways.
- Should find out a safe space where sex and sexuality with relation to HIV/AIDS prevention should be discussed in a constructive and meaningful ways
- Should understand that the common enemy to be defeated is HIV/AIDS and not people living with HIV/AIDS
- Should accept people living with HIV/AIDS as resource persons and crucial allies in the struggle to overcome HIV/AIDS.

Counselling

- Churches should combat fatalism among the people by encouraging their members to know their HIV status through voluntary counselling and testing
- Because of the church's concern for people and the impact of stigma on their lives, church leaders should be encouraged to undergo HIV testing as role models
- People who provide counselling at regular or occasional basis should be provided with appropriate training on counselling and basic communication skills
- Wherever counselling takes place, whether at the home or clinic, it must be held privately and confidentiality should be given priority because of stigma
- Voluntary counselling and testing services should be accessible and affordable throughout the country
- Disclosure is a very tough process, without disclosure, prevention and care are almost impossible. Therefore, psychosocial support should be provided at clinics, families, communities and church settings.
- Pre-marital counselling and testing is required with appropriate counselling and support attitudes, environment and response for people who test HIV positive.

Advocacy

- Leaders of faith-based organisations should be effective in calling upon government's responsibility to provide generic and anti-retroviral drugs
- It is the duty of church leaders to pledge for a society that is open from stigma, silence or denial about the epidemic.
- Church leaders should play an active role in disseminating non-stigmatising and discriminative preventive messages, and in leading the fight against stigma wherever it occurs.
- The church leaders should raise awareness so that families and communities can access interventions such as prevention of mother-to-child transmission, care and support services as they become available.
- Participatory governance and accountability for resources and results are important to consider in developing new and innovative administration between churches and donors.
- Church leaders need to encourage the production, adaptation and distribution of HIV/AIDS learning and educational materials, especially in local languages.

Networking

- One particular challenge to address is the tendency of churches within and among themselves including the government to regard each other with suspicion, this often hinders opportunities for fruitful collaboration and partnership
- Alliance-building across denominational and faith organisations will be a key strategy for expanding the churches' response to the challenges of the HIV epidemic
- The National Council of Churches should integrate the fight of HIV/AIDS in its agenda and should be used as a platform for sharing best practices between member churches of WCC in terms of what works, where, when, by who and so forth
- There is a need for better quality information (accurate and timeous) for churches to collaborate with the National AIDS Control Programme and the UN agencies.
- If any significant impact is to be made in Congo against the tide of HIV/AIDS epidemic, the successful initiatives undertaken by churches and other faith-based organisations need to be expanded so they reach individuals and communities.

Social services

- Up to date, the response to orphans, widows and vulnerable children has mostly come from NGOs, still lacking, however a clear commitment on the part of many churches to address the needs of the many orphans and other vulnerable children affected by HIV/AIDS.
- Church health services should be encouraged to develop AIDS control components

World Council of Churches

- The fight against AIDS could bear fruit unless another form of cooperation is promoted. Churches have a crucial role to play in order to have access to funding, be they in the North or South.
- The World Council of Churches should urge the ecumenical organisations and member churches to brave doctrinal barriers and stand together in order to find out concerted and appropriate solutions in respect with HIV/AIDS.
- The World Council of Churches should reflect on the reservations made by certain church leaders who are not willing to collaborate with sects because of the many "harmful practices" notably faith in miracles to cure AIDS, starving of the already weakened people living with HIV/AIDS, polygamy etc.

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DEMOCRATIC REPUBLIC OF CONGO

June 2003

"The very relevance of churches will be determined by their response. The crisis also challenges the churches to re-examine the human conditions which in fact promote the pandemic and to sharpen their awareness of people's humanity to one another, of broken relationships and unjust structures, and their own complacency and complicity. HIV/AIDS is a sign of times, calling us to see and understand"

(WCC 1997:2)

INTRODUCTION

The speed and magnitude of the spread of HIV/AIDS in the world at large and particularly in Sub-Saharan Africa is alarming. Sub-Saharan Africa is home to 70% of adults and 80% of children living with HIV. In DRC, 2,000,000 people are currently HIV infected and 30% of them have already developed AIDS and related diseases.

Since in the early days this disease was first found in homosexuals whose practises are condemned by the church, many African churches consider what is now a pandemic as a judgement from God against immorality. Given the fact that talking about sex is a cultural taboo in many settings and the church fears sexuality because sex is seen as something inferior and sinful, little has been done by most of the Congolese churches to fight HIV/AIDS accordingly.

It is documented that Africans are mainly infected through unprotected heterosexual contacts, and so the stigma that was put on homosexuality has been transferred to promiscuous heterosexuality. However, HIV/AIDS is an every day reality that Christians and churches can no longer pretend to ignore. There is no excuse for churches and church related institutions to bury their heads in the sand and pretend that the HIV/AIDS problem will disappear. Churches should understand that there is steadily mounting evidence that failure to act now will mean failure to prevent a national catastrophe. An effective and heightened response by the churches to HIV will make life liveable for millions of believers and unbelievers. Of course, HIV/AIDS is an important and burning issue with no easy solution, but conscious and concerted effort can bring gradual improvement.

Towards this end, a dialogue between three groups of partners: churches, ecumenical and church related organisations in Europe and North America; and the World Council of Churches, have shared a common concern by creating a joint ECUMENICAL HIV/AIDS INITIATIVE in order to help churches build their capacities to prevent further infections, to care for and to support those already infected and affected. One of the activities under this Initiative has been the mapping of relevant activities, experiences and resources of churches and church related organisations in Sub-Saharan Africa.

This mapping exercise focuses particularly on the Democratic Republic of Congo. It has concentrated on investigating the Churches' response in the following areas:

- Information, Education and Communication on HIV/AIDS
- Awareness for clergy, congregations and Laity
- Awareness for Youth
- Gender issues
- Training by Clergy and laity in counselling infected and affected
- Care and Prevention services available:
- Voluntary Counselling and Testing
- Prevention of Mother-to-child transmission
- Hospital and Home based care
- Care of children orphaned by AIDS

1. GENERAL AND EPIDEMIOLOGICAL DATA

1.1 General data on DRC

1.1.1. DRC-Country Profile

The Democratic Republic of Congo is a country located in Central Africa, bounded to the West by Republic of Congo, Gabon, to the North by Central African Republic and Sudan, to the West by Uganda, Rwanda and Burundi, to the South by Angola, Zambia and Tanzania. DRC is divided into 11 administrative provinces. Because of the civil war prevailing in the country since 1998, almost 1/3 of the country is under rebel occupation. DRC is not only geographically vast it has a total area of 2,345,000 square kilometres but also a sparsely populated country. A major part of DRC is covered by the Congo basin, its rivers and forests.

1.1.2. People

The population of DRC is currently estimated around 60 million people with 45% of the population aged between 15-49 years old. Women represent 51% of the total population. 10 million of the population are living in Kinshasa, the Capital City while 60% in rural areas. There are 400 major tribes which occupy their own separate territory with their own traditional chiefs. Each tribe maintains communal ownership over its land. In general, Congolese tribes have a rich tradition of folklore, music and dancing and their lives are still strongly influenced by tribal institutions, norms and rules.

1.1.3. Economy

DRC is a land of great potential since the country is rich in natural resources, currently, the country produces natural gas, lead, zinc, cupper, diamond, gold and magnesium and other resources not exploited today. Additionally, DRC is predominantly an agricultural country.

However, the human development index was 0,429 (142nd out of 162 countries) in 2000. The Gross Domestic Product stood at nearly 70US$ in 2001. This makes DRC one of the twenty least developed countries in the world partially because of mismanagement of resources from governments. Indeed, the specific aspects of the economic context that impedes the development progress are:

- rising inflation and devaluation of Congolese currency
- the collapse of the industrial base with many companies having folded due to the harsh economic environment
- fiscal crisis as a result of civil wars, armed conflicts and poverty
- apparent nil investor confidence in the country
- unemployment, budget cut especially in health and education sectors
- end of structural cooperation with the Breton Wood institutions
- looting and pillage of resources in 1991 and 1993
- wide gap between rich and poor
- heavy external debt estimated at 13 billion US$
- the 1996 and 1998 wars that killed around 2,405,000 people

1.1.4. Profile of Human Development

- The literacy rate is estimated at 59% of the population. Males are more likely to stay longer in schools than females.
- Approximately 80% of the population are Christian and many of them are in contact with church structures which comprise HIV/AIDS programmes.
- Life expectancy increased in 1980s. Due to HIV/AIDS, it has dramatically dropped from 54 years to 49 years in 1998 for people living with HIV/AIDS.
- Many censuses which have taken place in DRC showed the population growth at a rate of around 3,0%. With the impact of AIDS, the population growth is expected to decline from 3,0% to 2,9% in 2010. (PNLS, 2001).

1.1.5. Health

Provision of health services is very expensive because the Government can no longer fund them. Quality of care in most of the public health sector is increasingly problematic since essential drugs are less available and drug shortages are frequent. An exodus of highly qualified and experienced health professionals also crippled the public health sector. The low morale among medical doctors and nurses has been manifested by several strikes since 1990. In addition, the low payment of health professional salaries and wages coupled with the political unrest in the country has severely weakened the public health sector. However, nearly 70% of health services are delivered by churches and church related institutions with meaningful results.

With relation to HIV/AIDS, tuberculosis and malaria are still major threats in DRC.

> *"Any effective effort to reduce the burden of disease faced by world's poorest people must concentrate on AIDS, tuberculosis and malaria. Combined these three diseases could account for 500 million or more illnesses a year and at least 6 millions deaths"*

Tuberculosis

DRC is the 11th country out 22 most infected in the world and 4th in Africa. In 2000, the total of notified case was 60,627. This represents the incidence of 116 per 100,000 habitants. The World Health Organisation (1999) stressed that the co-infection TB/HIV was about 25%. In a cohort study launched in DRC in 1999, the tuberculosis cured rate was 59,1%. Death rate was 1,875 out of 34,923 cases. It has to be mentioned that 40% of death are linked to AIDS. The working days wastage is 3 to 4 months per year because of TB infection.

Malaria

In 2000, 10million malaria cases were reported of which children represent 59 to 86%. 500,000 people have died of whom 37 to 60% were children while 5% were pregnant women. In DRC, 3 beds out of 10 are occupied by patients suffering from malaria while 85% of blood transfusions in paediatrics are caused by malaria in Kinshasa's hospitals. This represents the second route of HIV transmission. The vast majority of these infections could be prevented by reducing unnecessary transfusions by effective clinical use of blood, educating, motivating, recruiting and retaining low-risk blood donors and screening all donated blood for infections agents.

1.1.6. Poverty and Vulnerability

Poverty remains a major problem. The income gap between the richest and the poorest members of the society is widening. Unemployment and poverty due especially to looting of resources in 1991 and 1993 are found both in rural and urban areas. Rapid growth in the informal sector has been one of the main factors that explain some improvement in living standards in DRC.

Poverty influences choices people make including behaviour that increase the risk of HIV infection namely alcohol abuse, multiple sex partners and sex for money. Many young girls are forced into prostitution because of poverty. In addition to the lack of basic resources, extreme poverty dehumanises the individual to a point where self-esteem and morality become secondary. A young street girl whom I recently interviewed in Kinshasa said: *"whereas a clerk in public sector earns about US$:20 per month, I can earn that much in a single week-end".*

1.2. Epidemiological data

1.2.1. The HIV/AIDS epidemic in DRC

The first cases in DRC were reported in 1983 and ever since, there has been a significant increase in the number of people living with HIV/AIDS. The National AIDS Control Programme (2001) indicated that 2,085,764 people are infected with HIV/AIDS.

Table 1:
Number of people infected with HIV/AIDS in 2001

Designation	*Number*
Men	1,343,962

Women	671,981
Children	69,821
Total	2,085,764

Table 2:
Number of new infected cases in 2001

People	*New cases*
Men	170,748
Women	85,374
Children	38,131
Total	294,253

Table 3:
AIDS death in 2001

Designation	*AIDS death*
Men	81,663
Women	40,832
Children	31,368
Total	153,853

Source: Congolese proposal form submitted to the Global Funds 2002

Table 4:
The routes of HIV transmission in 2001 in DRC

Heterosexual	85%
Mother-to-child	06%
Injections	04%
Blood transfusions	03%
Others non specified	02%

Source: “PNLS in infection à VIH/SIDA/IST en RDC 2001”

General comment

It has to be noticed that the available data do not reflect the reality of the dysfunction of the health information system and the decrease in health services access particularly in the context of civil wars and armed conflicts particularly in the occupied territories. Recognising the limitations of available data, PNLS (Programme de lutte contre le VIH/SIDA) 2001 estimated at 5% the seroprevalence in the area under the government control against 20% in the rebel held area.

This can be due to the war context with armies from high prevalence countries such as (Zimbabwe, Uganda, Namibia, Rwanda and Angola) that are operating in DRC since 1996 up to now. It is known that in situations of conflict, the risk of sexual violence increases dramatically.

Because the hetero-sexual relationship is the main root of HIV transmission, many church leaders, Christian and people of good will fear that more open talk about sex and sex education will result in the increase of promiscuous behaviour.

1.2.2. Sentinel surveillance

In DRC, the HIV information has been available among the antenatal clinic attendees since the mid-1980s. The median HIV prevalence rate among antenatal clinic women in Kinshasa fluctuated between 3% and 7% over the 15-year period 1985 to 1999. In 1999, 4% of antenatal clinic attendees were tested HIV-positive.

It has to be mentioned that surveillance outside of Kinshasa is not frequent. A few studies only conducted in provinces namely Kananga, Kasumbalesa, Kimpese, Likasi, and Lubumbashi that showed 3-4% the prevalence rate among antenatal women tested between 1988 and 1993. Recently, Save the Children/UK has launched a study that showed more than 20% of antenatal clinic women tested positive in Kalemie, Katanga Province (Ministry of Health 2002, personal communication).

Among sex workers tested HIV-positive in Kinshasa the prevalence of HIV/AIDS is fluctuating between 27 and 38%. In spite of the limitation of HIV information outside Kinshasa, a study conducted in Orientale Province in 1991 reported that 25% of sex professionals were HIV positive. In 1997, 29 % were tested HIV-positive in Mbuji-Mayi, Kasai Province. (UNAIDS, 2000)

1.2.3. Contributing factors to the spread of HIV/AIDS

There are many contributory factors to the spread of HIV/AIDS. They include:

- Poverty that obstructs control
- Wars, armed conflicts and insecurity since the armed forced involved in the wars in DRC are well known to come from the highest HIV prevalence countries
- Socio-cultural issues:
    - Discussion of sexual issues is taboo in many cultural settings
    - Stigma, shame, rejection and blame that are associated with HIV/AIDS add an extra layer of suffering to the already difficult lives of those infected with HIV in society at large and particularly in church settings.
    - Cultural practices and perceptions which expose women in particular to the risk of HIV infection
- Global economic policies and injustices
    - Structural adjustment with its cut in government health and education spending
    - Employment practices, wars and armed conflicts that disrupt families for long periods and promote unsafe sex
    - Heavy external debt
    - Antiretroviral in the North while HIV/AIDS in the South
    - Inaccessibility of Voluntary Counselling and Testing
- Conflicting media messages and images about sex, sexuality and love

1.2.4. Impact of HIV/AIDS in DRC

Demographic impact: the demographic impact is devastating.

- In 1999, UNAIDS (2000) reported 680,000 the number of children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic.
- In 1999, UNAIDS (2000) indicated 95,000 the estimated AIDS deaths. Because of AIDS (UNAIDS,1988) showed the decline of population growth from 3,3 to 3,0%. The projection for the year 2010 will be 2,9%.
- The increased mortality rate among children under the 5 years old will go from 97/1000 per year to 116/1000 in 2010 (USAID, 1998)
- The life expectancy has decreased to 49 years old from 54 years in 1998

Economic impact

- A fairly recent study by the Harvard Institute of International Development estimated that the total cost to DRC by 1995 due to AIDS associated death was US$: 350 million, which was about 8% of Gross Domestic Product (Ojo, 1997)
- The preliminary results of a model developed in 2000 estimate the decline in GDP per capita growth as a result of AIDS by 2010 to be 0.7% (Bonnel, 2000).

- A study of a textile mill in Kinshasa found that the highest rate of HIV prevalence was discovered in the managers, followed by the foremen, with the lowest rates found in the workers. Thus the effect of HIV/AIDS will be felt most strongly in the more highly skilled workers, who are more difficult to replace. (PHNFlash issue. Feb 22.1995)

Agricultural impact

- Though no data are found for the impact of HIV/AIDS on the agricultural and business sectors, however, it is believed that the loss of members will entail the drop of their income. Thus, HIV/AIDS is reducing labour and productivity. If the productivity and the competitiveness are compromised, this will discourage new investors. (UNAIDS, 2000)
- In addition, as a result of AIDS companies should see rising sick leave rates, and higher insurance and medical care expenses, while soaring rehiring and retraining costs drive productivity down and eat into their profit margins.

Educational impact

- In public sectors, the loss of skilled labour such as school teachers is increasing. A model developed by UNAIDS and UNICEF in 2000 shows that, of around 830 000 primary school students, 7300 would have lost a teacher. This leads to discontinuity in teaching, loss of schooling and a change in teachers. Therefore, teachers cannot be trained swiftly enough to replace the predecessors who succumbed to HIV-related illnesses.
- Basic primary education should constitute a fundamental human right because to an illiterate person, immune-suppression is an incomprehensive concept.

Medical impact

- The health sector systems especially in Mama Yemo Hospital are coping with many difficulties. Because, 6,4 to 8% of employees of Mama Yemo Hospital tested HIV-positive in 1984 and 1986 respectively, reflecting a two-year incidence rate of 3.2 (Ngaly et al, 1988).
- In addition, the percentage of hospital beds occupied by HIV-positive in Mama Yemo Hospital in Kinshasa was approximately 50 percent in 1995. This implies that it is becoming more and more difficult for patients with other illnesses to receive treatment, due to possible crowding out by HIV-positive patients. (Matela et al.1993)
- The World Bank and the UNAIDS(2000) stressed that the annual cost of scaling-up HIV/AIDS programme is estimated between US$ 66 million and US$ 105 million.
- Recent data show that the cost of treating an AIDS-related condition, cryptoccocal meningitis was US$870 in DRC several times higher than the per capita income. Even though the treatment was the most expensive, advanced treatment, only 150 additional days of life were gained. Thus few families would choose to undertake the treatment, even if it were available. (Squire, 1998)

Social impact

- Social data are practically unavailable in DRC. Taking into account the burden of HIV/AIDS especially the high morbidity and mortality rates, from my own experience I see children removed from school in order to take care of the ill family members and to regain income.
- Almost everywhere and even in DRC, the extra burden of care and work are deflected onto women, especially the young and the elderly.
- Because of the war context, children who survive wars often end up as orphans with no skills to face the challenge in life. This obviously leads to a truly vicious cycle. (Givans, 2001)
- An early longitudinal study on the status of orphans due to AIDS deaths found that there was no health or socio-economic impact on their status, because the extended family was able to care for them. (Ryder et al. 1994)
- This pattern was not observed, however, in another longitudinal study that performed home visits to evaluate the welfare of AIDS orphans. This study found that, although the orphans were living with relatives, the relatives could not meet their health care and education expenditure needs. Frequently, these children were absorbed into relatives' families under a spirit of duress. The children faced a hard time, they were first to be pulled out of school, exploited as domestic and family labour, the last to be fed and they suffered from malnutrition. (Matela et al. 1993)

2. NATIONAL HIV/AIDS CONTROL PROGRAMME

2.1. Background to the AIDS Control Programme

In the Democratic Republic of the Congo, the first cases in 1983 aroused the interest of the government who, while starting information and awareness raising activities, approached the World Health Organisation for technical assistance. Under this technical assistance, it was decided that the National AIDS Control programme (PNLS) would be established.

2.2. The National Response of DRC

The Democratic Republic of Congo's response in the fight against HIV/AIDS has been quick but ineffective. In addition, political commitment and resource allocation were very slow to take off. Subsequently, its allocated budget has been largely inadequate to make any meaningful action to mitigate the impact of AIDS. (See box details for important dates and significant events)

The National Response of DRC: HIV/AIDS	
1983	First AIDS cases declared
1984	Creation of AIDS Project to collect epidemiological data in order to implement prevention and AIDS control
1987	Creation of the National AIDS Council established to develop a
1988	Creation of "Comité Mixte" for NACP's foreign resources follow-up
1991	Elaboration of revised Medium Term Plan 1991-1994Adoption of the revised MTP submitted to funding agenciesBecause of the looting of resources that took place in 1991 and 1993, The above MTP has never been implemented partially because of theEnd of structural cooperation with the Breton Wood institutionsEspecially the World Bank which was willing to fund the project at thatTime.
1994	Government announces a protocol signature between the World Health Organisation and the National AIDS Control Programme (NACP)
1995	AIDS Forum created in Kinshasa
1996	2 years emergency Short Term Plan of UNDP, WHO and UNAIDS tostrengthen the NACP
1996	Since 1991 the National AIDS Council did not hold any meetings. This undermines the NACP activities since HIV/AIDS spares no group or sector in its ravage.
1997	Meeting of the National AIDS Council to strengthen the NACP and mobilisation of all national sectors in the struggle of HIV/AIDS
1998	National Interdisciplinary Task force and National Strategic Plan adopted on HIV/AIDS
2000	National AIDS Control Programme restructured

The main domains of intervention in the fight of HIV/AIDS are:

- Communication for behaviour change
- Prevention of the transmission from mother to child
- Safe blood transfusion
- Sexually transmitted infection care (prevention and control)

- Care of People living with AIDS and HIV positives
- Epidemiological surveillance and operational research
- Management and programme coordination

Five main objectives were spelt out under the PNLS namely:

- To mobilise communities and specific groups (youth, teenagers, sex professionals, workers, refugees and displaced people etc.)
- To mobilise decision-makers, opinion leaders, managers, traditional leaders and religious leaders
- To improve access to prevention, diagnostic, support of those infected or affected by HIV/AIDS
- To reinforce the capacity building of institutions and actors involved in the fight of HIV/AIDS.
- To reinforce the national and international partnership for effective multisectoral approach to AIDS control.

It would be crucial for DRC's National AIDS Control Programme to achieve its designed objectives. However, the general public has been very critical of the Government's inadequate response, lack of prioritisation and inability to address the stigma, discrimination and rejection attached to HIV/AIDS.

In DRC, it took almost 15 years before the first Voluntary Counselling and Testing (VCT Centre) was established and the Mother-to-Child Transmission (MTCT) treatments protocols are still in their infancy. Availability of treatment of opportunistic infections is quite rare and the prospect of access to anti-viral therapy remains remote except for those with sufficient financial resources to by-pass the system.

Given the high sero-prevalence and a prevailing stigma attached to HIV/AIDS, a strong political commitment to the fight against AIDS is crucial. In fact, countries that have shown the most success, such as Uganda, Thailand and Senegal, all have strong support from the top political leaders. This support is necessary for several reasons:

> *"First of all, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that very often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organisations involved in the AIDS programmes that their efforts are appreciated and valued. Finally, it ensures that the programme will receive an appropriate share of national and international donor resources to fund important programmes."*
>
> *Ainsworth, 1998*

The Congolese Government should make AIDS a national priority, not a problem to be avoided because of the bloody war.

2.3. Partnership

In the early days, HIV the epidemic was seen as a national multi-dimensional problem requiring a multisectoral and multidisciplinary approach. Several stakeholders namely local and foreign NGO, national secular and religious associations, churches, ecumenical organisations, civil society, the private sector and external partners have thus associated their efforts with those already engaged by the PNLS (Programme de Lutte contre le VIH/SIDA).

NGO and National Associations

They are too numerous in Kinshasa to be listed. They are either secular or denominational established in the capital city and in Lubumbashi, the economic capital. Most of them intervene at different levels in the struggle against HIV/AIDS and are active especially in awareness-raising and sometimes the care of people living with HIV/AIDS, orphans, widows and widowers.

External partners

The National AIDS Control Programme works in collaboration with partners such as UNAIDS, UNDP, WHO, World Bank, GTZ, French Cooperation, UNICEF, SWAA, European Union and USAID etc.

Church and ecumenical organisations

During a Recent workshop that was organised by PNLS in collaboration with UNDP and UNAIDS, the commitment of faith-based organisations of Kinshasa in combating the HIV/AIDS was remarkable.

3. POSITION AND INVOLVEMENT OF FAITH-BASED ORGANISATIONS IN ADDRESSING HIV/AIDS

3.1. The Faith based organisations in DRC

In regard to the mapping work of HIV/AIDS in Kinshasa/DRC, I met either religious leaders or heads of Health departments of the following faith-based organisations: Catholic churches, Muslim Community, Kimbanguist church, Independent churches, Protestant Churches, Orthodox church, Revival churches, Salvation Army and Sikatenda's God church.

3.2. Perceptions of HIV/AIDS by the faith-based organisations

In general, church politics and the diverse theological interpretations, often hinder the right perceptions of HIV/AIDS by the faith-based institutions. Very often, a perceived attitude of self righteousness, judgement, condemnation and rejection has characterised many of the messages from the pulpit coupled with a high level of ignorance and misinformation from the church leaders' side.

For a long time, HIV was perceived to be merely as a health issue. In addition, cultural taboos over the issue of sex and sexuality and discussion related to sex impacted negatively on the open involvement of faith-based organisations in the early days of the epidemic and still today in many churches. In consequence, many churches have not been seen to be places of refuge for the infected and affected and the voice of advocacy has been too often silent.

However, as morbidity and mortality rates rise and the effect cascade through Congolese society, most religious leaders are aware that the HIV/AIDS epidemic is weakening the country's institutions, and reversing decades of much-needed progress in health, education, literacy, human and economic development. However, it has to be highlighted that their perceptions of HIV/AIDS vary from church to church.

Roman Catholic church

The perception and the position of the catholic Archdiocese of Kinshasa is not different from Vatican. It is summarised in 5 points.

"As far as the Archdiocese of Kinshasa is concerned HIV/AIDS infection is a human disease and is not a divine curse meant for the only the sick. The catholic church is stressing the need to avoid judgemental attitude towards people living with HIV/AIDS. On the contrary, they need a deep sense of love and compassion.

HIV/AIDS is considered as any other disease even though the catholic church realises that it poses complex problems. One can be infected with HIV either by ignorance or by neglect. That is why Catholic Church of Kinshasa encouraged scientific sound research and medical care.

People living with HIV/AIDS are not alone in their journey, God is with them.

Linking HIV/AIDS to witchcraft is false religious doctrine

Faith in the miracle of curing AIDS without a prior reliable HIV test should be condemned because of the fear of spreading HIV/AIDS and its dire consequences."

Mgr BULAMATARI, Auxiliary Bishop of Kinshasa Archdiocese

Muslim Community

Contrary to the Muslim tendency in other African countries, in DRC the Muslim Community does not consider AIDS as a punishment of God. However, because HIV is mainly transmitted through sexual relationship, HIV/AIDS is thought to be the result of disobedience to the laws of God. That is why fornication is forbidden in Muslim circle.

"Since AIDS is no longer considered as punishment of God, people living with HIV/AIDS are not abandoned for the Koran recommends that help and relief should be given to any one who is needy whatever his or her fault."

Eminence EL HADJI MUDILO, National President

Kimbanguist Church

HIV/AIDS could be interpreted as a breakdown of the relationship with God, with one's neighbour, with yourself and the with life-giving earth. HIV and its modes of transmission are well known in the Kimbanguist settings.

"The position of the Kimbanguist church in the light the above considerations is that, Christians unlike non believers should resist in order not to fall into the clutches of HIV/AIDS. Those who are already infected should not spread HIV to others. In the opinion of the Kimbanguist church leader, AIDS must not be considered as divine punishment."

Rev.Dr Bazinga, Deputy Legal Representative

This could explain why the Kimbanguist church is playing a prominent role in the dissemination of preventive information and cure of opportunistic infections.

Protestant Churches or "Eglise du Christ au Congo"

The ECC is threatened by HIV/AIDS because it is killing Christians and non Christians in their productive life leaving behind them little children and old people.

"If the faith based organisations and people of good will cannot save the country and people from AIDS, churches, mosque, synagogue, chapel and temples will be without human resources. Instead, they will be replaced by mosquitoes, spiders and flies etc. The remaining church leaders will resign because of unemployment".

Mgr Marini Bodho, National President

In DRC, the health system was already weak and under-financed before the advent of AIDS. Those structures are now buckling under the added strain of soaring needs. Rebuilding health and social service systems is a priority that requires substantial national and international resources.

"Since HIV/AIDS is an army invading DRC and the neighbouring countries, the time has come to implement the war plans that are more likely to defeat HIV/AIDS in DRC and beyond."

Mgr Marini Bodho, National President of ECC

Independent Churches

In Independent church circles, they are quite blunt on the matter that HIV/AIDS is the result of disobedience to the laws of God that provokes His wrath.

"Therefore, Independent churches are involved in the fight of HIV/AIDS in order to help people living with HIV/AIDS receive forgiveness and reconciliation from God because of their misbehaviour."

Rev. Pastor Kalonji, National President

Revival Churches

"For most of Revival churches, the real cause of the widespread of the dreadful virus is the non-respect of God's law which is expressed by fornication, infidelity, loose living and the sex trade."

Mgr Kankienza, National President.

In addition, the revival churches recognise that there are contributing factors such as: poverty which generally leads to rural exodus, migration and prostitution, to which are added ignorance, denial of the illness, the harmful effects of the media, beliefs and certain cultural practices.

Orthodox Church

The Orthodox Church recognised that HIV/AIDS epidemic is worsening since million are infected.

> *"Many others have died or have been orphaned so that HIV/AIDS threatens the social, economic, and cultural framework in DRC and beyond. In order to protect against the disease, the Orthodox church recommends to society and especially to Christians to revert to moral values and to God's laws."*
>
> *Prof Theodore Fumunzanza, Orthodox Church Secretary.*

The Orthodox Church encourages abstinence, fidelity and chastity as the most advisable means of effective prevention.

Salvation Army

The Salvation Army is aware that AIDS is a reality of its time which Christians can no longer pretend to ignore. That is the Salvation Army applies human, material and financial resources to meet the needs of intervention activities as a practical expression of love."

> *The Salvation Army uses its influence to remove stigma attached to HIV/AIDS since HIV/AIDS is like any other diseases."*
>
> *Sir Ludiazo, Colonel of the Salvation Army.*

The SIKATENDA's church of God

> *"Because many of those people who are infected and those who will be infected today and tomorrow come to church on Sunday, and to church functions at baptism, confirmation, and at funerals etc., the SIKATENDA's church of God is very concerned about the disease. The church insists on total abstinence from sex before marriage and faithfulness in marriage between two uninfected partners."*
>
> *Rev.Pastor Sikatenda, Legal Representative.*

According to Deuteronomy 28:58-62, this church believes that HIV/AIDS is God's punishment. HIV/AIDS has been perceived to be the consequences of sinful action and the responsibility lies not with the church but with the offender. However, the SIKATENDA's God church also believes in faith miracles of curing HIV/AIDS by prayers etc. According to the above Legal Representative, a few people infected with HIV would have been cured from AIDS within his church premises through prayers. This requires scientific evidence!

3.3. Involvement of the churches in HIV/AIDS awareness for clergy and Congregations and laity

3.3.1. « Eglise du Christ au Congo »

ECC has 64 churches from various backgrounds and doctrines. According the 1998 census, ECC has approximately a membership of 19 million people. Traditionally, its activities have often been community based and have targeted the grassroots including the vulnerable and the un-reached irrespective of gender.

In its health work, The Eglise du Christ au Congo (ECC), the SANRU III implementing partner in DRC unites the majority of protestant congregations. In addition, SANRU III project covers all the provinces through 75 health zones. It also works closely with other faith networks (Catholic, Kimbanguist) and secular organisations as well as government health authorities.

Main activities

With regard to HIV/AIDS, SANRU III focus are HIV testing, counselling, treatment and training.

HIV testing

Testing for blood transfusion and for people at risk (anaemia, prolonged delivery, etc.) is a key step for stopping the spread of HIV. Currently many hospitals and health centres (particularly in rural areas) do not have HIV testing equipment and capacity partially because of the high cost of HIV reagents. SANRU III looks forward to providing HIV tests and confirmation tests to all reference hospitals.

Table 5:
Number of HIV cases reported in SANRU Health zones (2001)

Provinces	*Number*	*%*
East (Occupied territories)	834	39%
Kisangani	347	17%
Kasai and Katanga	289	14%
Bas Congo	272	13%
Bandundu	194	9%

Source: SANRU Annual report 2001

Counselling and testing

Patients with sexually transmitted infections are known to be four times more likely to contract or to spread HIV infection than any one else. Counselling and treatment for STI is a key strategy to slow down the spread of HIV/AIDS. SANRU III will provide drugs and counselling materials to health zones. 7000 condoms are currently provided per Health zones per year.

Another interesting component of SANRU III is "health worker protection and post-exposure protection. Because of the lack of gloves and other barrier materials, health workers are more exposed to HIV. Health professionals are dying after years of reasonable training and experience. SANRU III will provide the drugs needed for post-exposure for post-exposure prophylaxis to reduce HIV infection after pinpricks, rape and other known exposures".

Training

Currently, SANRU III is responsible for the in-service training of 63 medical doctors and other health professionals on safe blood transfusion, Syndromic plus management and laboratory tests.

In addition, health professionals will be trained and given educational materials for educating and counselling students, military and sex workers about HIV. They will also be trained in the promotion of care and support programmes by the community for AIDS patients and AIDS orphans.

ECC HIV/AIDS Coordination office

Given its national influence, ECC is planning to undertake a national mobilisation to fight HIV/AIDS through the involvement of its church members and related institutions. In consequence, the President is willing to create an HIV/AIDS coordination office under his direct supervision. This programme would be discussed by the Executive Committee of ECC in the forthcoming days. ECC could be a key actor in HIV/AIDS related activities if a specific coordination of activities is established with clear objectives.

ECC has the moral authority and influence, particularly with regard to behaviour change communication. Therefore, it could fight stigma, denial, discrimination, and rejection attached to HIV/AIDS from grass-root level. Subsequently, through the involvement of ECC member churches, people would be stimulated to do voluntary testing and counselling and also contribute to break the silence towards HIV/AIDS.

3.3.2. Catholic Church

The Archdiocese of Kinshasa has several arms to its activities including the Medical Direction (BDOM), Youth and Women, Justice Commission etc. In addition, the Archdiocese has appointed a full-time national coordinator on HIV/AIDS who is based in Kinshasa.

During the nineties, as AIDS progressively became a leading cause of death in DRC, the Archdiocese set up a 5-year programme. This programme focused on:

Prevention: awareness raising through

- "Centre Education à la vie" which is networking within 300 schools
- Catholic School Coordination office
- "Bureau Diocésain des oeuvres médicales"
- Charismatic Renewal
- Catholic Mothers
- Mabota Commission (for family and couple)
- Radio Elykia (Radio of hope)
- Commission of CEVB
- Liturgy and Catechism
- Youth Commission

Training

- Voluntary people against the HIV/AIDS
- Counsellors for couples
- Teachers for facts of life
- Radio Journalist

Support and care

- Medical (Pre and post counselling and treatment of opportunistic infections)
- Visit and home based care
- Training of carers in family settings
- Psycho-social support
- Material support (food, shelter, funeral, medical and tuition fees)

Behaviour Communication for change

Care of orphans and Pastoral Ministry

- Through the pastoral ministry, the Catholic Church is heavily involved in the HIV/AIDS struggle. A relief programme has been implemented in mobilising community financial resources. This programme is broadcasted by the Elikia Radio through a lively emission "Solidarity Channel" in favour of the infected and the affected.
- In addition, the Archdiocese of Kinshasa through the Day Care Centre managed by the sisters of "Mère Theresa Congregation" for people who are dying, is caring for about 80 children living with HIV/AIDS.
- Out of 4000 people living with HIV/AIDS counselled by the Archdiocese, nearly 70% have been convinced to identify themselves. They have been encouraged to live positively and to die with dignity.

AIDS and the Church

In 2000, the first seminar was held under the theme "AIDS and the Church". This resulted in discussions on statements on AIDS, the acceptance of the Kinshasa statement of 1998 and the establishment of the Commission in the struggle of HIV/AIDS within the Archdiocese to organise and implement HIV/AIDS work. Furthermore, there was agreement reached on a programme to train trainers (clergy and laity), and to disseminate information, education and communication (IEC) on HIV/AIDS.

3.3.3. Salvation Army

In DRC, the Salvation Army has been extremely proactive in their response to the HIV/AIDS crisis. The approach has been visionary as well as rooted in practicability and where a need is perceived, they have not delayed in responding. To their credit, their initiatives involve the community in almost all aspects of planning, implementation, monitoring and evaluation. This involves a holistic range of support, at every level, including spiritual support. In this approach, international and regional facilitation teams work together with local stakeholders to explore key issues such as participatory caring, community as belonging, change and hope.

In the fight against HIV/AIDS, the medical service of the Salvation Army focuses its efforts on prevention, counselling and care and treatment of opportunistic infections.

Prevention

Health centres, schools, hotels, pub and military camps are locations where information, Education and communication on HIV/AIDS and Sexually Transmitted Infections are delivered. Because of sensibility that surrounds HIV/AIDS issues, this subject is dealt among other health and development problems. The target population is given the option to raise the HIV/AIDS issues and to find out the community view points. This is done mainly in Masina area as well as in Bas-Congo Province. In 2000, 55 schools, 35 churches, 66 various associations, 22 people living with HIV/AIDS have been reached.

What is outstanding in the Salvation Army HIV/AIDS approach is the involvement of the community. In the slum of Masina/Kinshasa, young people have been able to identify areas where needy people who cannot afford hotels have sex. In addition, the military have been targeted for IEC and they were able to identify dangerous sexual behaviour such as multiple and occasional sex partners that are common practices among the military especially those of who are separated from their spouses for long time because of the war.

Counselling

Voluntary counselling and testing is part of the strategy used by the Salvation Army to help reduce the domino effect. It is done in collaboration with the family of the infected and affected where this is possible.

3.3.4. Kimbanguist church

The Kimbanguist medical department of the Church of Jesus Christ on Earth in Kinshasa is eagerly involved in the struggle of HIV/AIDS especially in prevention and training, care of the infected and the affected people and safe blood transfusion.

Prevention

12 workshops have been held to sensitise the church members on the severity of HIV/AIDS and multiple consequences in 2000 alone.

Capacity building of 60 “cellules de prières” has been initiated to implement the behaviour change communication

20 focus group discussions have taken place at parishes level

Training

25 counsellors namely clergy and laity have been trained to care for people living with HIV/AIDS through information, education, spiritual and medical support.

Safe blood transfusion

A reliable and safe blood supply is still out of reach for many people particularly in rural areas. However, the Kimbanguist Hospital is one of few hospitals in Kinshasa where blood screening for transfusion is required.

Table 6:
Blood transfusion activities of the Kimbanguist Hospital

Designation	*2000*	*2001*
Donors	3125	3820
Screened blood	2915	3540
Donors tested HIV (+)	320	380

Source: Kimbanguist Medical Department 2000-2001 reports

Comments

From 2000 to 2001 almost 10% of blood donors were tested HIV positive. If they had not been diagnosed these blood donors would have become inadvertent killers since they did not know their HIV infection status. This shows the importance of a comprehensive approach that is needed in order to successfully control the HIV/AIDS infection even in church settings.

3.3.5. Partnership between Government and FBO

In DRC, a strong partnership in the promotion of preventive medicine and the provision of care exists between Government and Churches mainly through SANRU project, BDOM "Bureau Diocésain des Oeuvres Médicales", "Service Medical of Salvation Army" and Kimbanguist Medical Department.

The National AIDS Control Programme has recently organised a workshop "on the role of Faith-based Organisations in the fight against HIV/AIDS today" in collaboration with UNDP. 100 participants from Catholic, Protestant, Orthodox, Independent, Revival churches, Salvation Army and Muslim Community have attended the workshop. One of the most visible results of the workshop has been the establishment of a National Council of Interfaith-based Alliance comprising 8 religious leaders.

They have been set up to discuss HIV/AIDS issues and to lobby more resources. This has been done without segregation of any sort. In the meantime, the Director of UN system in DRC has promised to assist and collaborate with religious group to fight this pandemic. The immediate implication of the National Council Inter Faith-based Alliance is that Government cannot go alone and religious groups cannot work in isolation in the struggle of HIV/AIDS.

This shows the importance for churches to continue working closely with government structures in giving the right messages and support the communities. This concerted effort of the churches, government and other institutions is a milestone in the successes that Uganda has achieved in the fight of the epidemic. This is an outstanding example of collaboration between government and religious groups to replicate elsewhere.

4. HIV/AIDS AND YOUTH

4.1. Overview

According to UNAIDS (June 2000), about 1.7 million are infected every year in Sub-Saharan Africa. Worldwide over half of all people who become infected are under the age of 25 years. In the DRC at antenatal clinic for pregnancy attendees, aged 20-25 years, 3 to 24% have been found to be HIV positive. Since the total population under the age of 15 years represent about 45%, DRC has a serious obligation, to target this "window of hope" in order to protect them from the risk of getting the infection.

What makes young people vulnerable to HIV/AIDS?

What makes young people so especially vulnerable is that adolescence and youth are times of discovery, emerging feelings and the exploration of new behaviour and relationships. Experimentation with sexual behaviour is an important part of this and can involve risks (UNAIDS Briefing paper 1999 "Young people and HIV/AIDS").

In many church settings, prevention campaigns are reaching millions, but they are still missing too many young people. Recent surveys conducted in 17 countries show that half the adolescents questioned could not name method of protecting themselves against HIV/AIDS. (UNAIDS, 2001)

In addition, research findings indicate that people belonging to the various religious organisations are not less infected than the society at large. Therefore, one may conclude that the teachings about sexuality and moral values have not had the desired effect. This situation could be partially the result of young people who are exposed at the same time to double standards and receive mixed messages from media, advertising, culture and religious. There is no doubt that youth willingness either to participate in the control HIV/AIDS or behavioural change lies on the delivery of health education. Therefore, talking and learning about sex should be a vital part of any meaningful HIV/AIDS programme.

But in many societies including DRC, young people are failed by the lack of leadership of their elders. The ideology that HIV education lure adolescents into sexual activities has long since been disapproved and yet remains one of the many opposing factors towards finding effective solutions to the HIV/AIDS pandemic in most communities, based on the fact that these programmes violate the norms and cultural values of some.

By contrast, Denmark's peer Education for young people project is an outstanding example. Every week, trained peer educators hold meetings with other young people from sex to sexuality matters. With regard to that project reaching about 10 000 young Danes a year, there is no shortage of interest. (UNAIDS 2001, in together we can)

However, studies around the world confirm that even among well-informed young people, awareness about HIV/AIDS does not automatically translate into safe behaviour. Informing young people is not simply a logistical problem. It is process complicated by the fact that young people are not homogenous. In addition, there is lack of access to youth-friendly health services and negative attitudes from health workers are often hindering youth and other from soliciting services from clinics.

Although these studies bring out mixed findings, their results indicate that there is a need for churches and other religious institutions to revisit their messages on sexuality including the use of condoms. Similarly, there is a need to assist parents with sex education for their children. Families are very often regarded as the cornerstone of the society and the safest place on earth. At the same time, the most horrifying things are taking place within families, such as physical violence and sexual abuse against women and children, contributing factors to the spread of HIV/AIDS.

Most effective prevention campaigns should therefore tackle the underlying attitudes, values and socio-economic conditions that prevent youth from protecting themselves. This could be done until young people actively participate in designing and implementing the campaigns. Therefore, young people should not only be involved in the decision making process, but also their positive endeavours should be recognised and incorporated into HIV/AIDS programmes wherever this is possible. The time to mobilise churches to be credible, and to fulfil Jesus Christ's given mandate "let children come to me" is now.

4.2. Sex education in DRC

Every society has ways in teaching the young about sexuality, whether it is done by parents, aunts and uncles, or through sex education in schools. Traditionally, it is a taboo for biological parents to communicate any sex education to their legitimate children in DRC. In many cultures, sex education to adolescent is provided by aunts for girls and uncles for boys or any respected designated adults. However, urbanisation and changing family patterns have contributed to the demise of these traditional rules and procedures.

In consequence, young people are left in ignorance to find out about sexuality through misleading trials and sometimes fatal errors on their own, from friends, or from films, magazines, books and the consumerist messages of the advertising media. In general, sex education in school is lacking. A few schools provide a so-called sex education that consists only on basic lessons in anatomy and reproduction, and more recently, basic facts and information about HIV transmission and prevention.

Despite many good intentions to include HIV/AIDS education in the national curriculum, there is no evidence yet of its inclusion and there appears to be some resistance to its development and implementation.

It is very difficult to implement a national programme of sex education for young people when parents, religious leaders, policymakers, teachers and young people themselves have conflicting views and values regarding sexuality and therefore, about what should be taught by whom?

I asked a few questions to teachers in order to find out their opinion about the right person to teach sex education to schoolchildren. Half of them cited Health personnel because medical professional was seen to hold relevant information about the disease.

> *"The medical personnel should teach because we teachers just lecture it to pupils but the medical personnel are more knowledgeable than teachers so if they can teach that can improve health education"*
>
> *Mbakata, schoolteacher.*

¼ of them insisted that they should do it themselves because when it comes to academic staff they would do better than medical personnel. However, another ¼ of teachers reported that it would be better to do it both (medical and teachers) because of various reasons including collaboration and technical support.

> *"Both group should assist each other as it will be in a syllabus, a teacher can do it when it comes to teach in detail, I think medical personnel can do better"*
>
> *Ramazani, Schoolteacher.*

This shows how important it is to promote the multisectoral approach in the control of HIV/AIDS in order to allow community participation. If teachers knew that teaching health education to schoolchildren, who are parents of the next generation, they would be valuable contributors in the control of HIV/AIDS.

Since teenage pregnancies that could lead to the spread of HIV/AIDS both for mothers and their babies are extremely common in DRC, clergy should urgently address issues of sexuality as they pertain to youth. Churches can no longer shy away from the real issues that the HIV/AIDS epidemic presents to the world particularly in Sub-Saharan Africa. The time has come to face the problems and to deal with them within the context of fellowship. Uganda's success in bringing down high HIV prevalence taught us that fighting HIV successfully among the population at large and especially in youth is not impossible. Uganda's example must be emulated by the DRC and beyond.

4.3. Secular Response to Youth and HIV/AIDS

In DRC secular response has been and is still widespread condom promotion, which has produced angry reactions from many churches believing that this encourages promiscuity and denial of personal moral responsibility. This has led to confused messages to the general population, in particular the youth. Subsequently, the inability to move beyond the condom issue resulted in the prolonged neglect of so many issues.

The social marketing and distribution of condoms in DRC to targeted population has taken multiple approaches, such as free, targeted distribution, community based distribution programmes, dissemination via health facilities, pharmacies and stores. Unfortunately, this strategy is not coordinated among the different outlet to achieve maximum availability of condoms. In order to bridge the gap between condom supporters and opponents, Youth Programmes are now set up and managed by the young people themselves to implement a comprehensive prevention strategy.

4.4. Involvement of churches and faith-based organisations in HIV/AIDS Programmes

4.4.1. "Carrefour des Jeunes"

The Youth Programme of ECC is heavily involved in the struggle of HIV/AIDS particularly on Peer educators and Counsellors training and the syndromic management of sexual transmitted infections.

Peer educator training

In DRC, many provinces have benefited from this training. Figures written below are self explanatory.

Table 7:
Peer educators trained by "Carrefour des Jeunes" in 2001

Provinces	*Number*
Kinshasa	150
Kananga	80
Matadi	50
Mbuji-Mayi	30
Lumbubashi	30
Bandundu	30
Total	370

According to Emery Mpwate, the head of Youth Programme, despite the civil war that is prevailing in the East of DRC, resources are available to embark on the implementation of this programme in Bukavu, Goma and Kisangani.

Life-skills training

450 counsellors of whom 300 from Kinshasa and 150 from Mbuji-Mayi have been trained to acquire psycho-social skills that are likely to help them train youth and pastors.

4.4.2. EVREJ-Congo

EVREJ stands for "Education pour une Vie Responsable et le Bien-Etre des Enfants et des jeunes au Congo". EVREJ is a Christian Organisation with a vision to see young people fulfil their dreams and ambitions with respect for God and humanity. EVREJ has born from the fact that youth are fragile human beings. Without effective participation of adults especially parents, their development is quite impossible. Talking to these young people revealed that they had many goals, dreams and ambitions to achieve. Having HIV/AIDS meant to them that these aspirations would never be realised. For those other young people, living in the environment seemingly placed by HIV/AIDS, life was characterised by fear and a sense of bleak future.

In addition, young people are undergoing situation such as poverty, unemployment, poor or insufficient parenting, outmoded cultural beliefs and practices, gender bias, ignorance of life skills and Godlessness, all of which can cause increase in the spread of HIV/AIDS. They felt that some thing had to be done to restore hope where it might have been lost and to help young people develop a sense of purpose.

The objectives of EVREJ are:

- Education especially hygiene
- Biological determination of blood group, rhesus factor, G6PD, electrophoresis of haemoglobin and HIV testing
- Sexual education of children and youth in order to help them make informed decisions
- Syndromic management of Sexual transmitted infections
- Sensitisation of youth for blood donation.

Activities

Prevention activities

15 765 people of whom (3 153 parents) have been sensitised about the severity of HIV/AIDS. 3 000 young people have committed to abstain from sex. It seems that in communities where EVREJ is working, adolescent pregnancies would have decreased in 2001. However, a follow-up is needed to find out the effectiveness of the programme since it could be replicated elsewhere in DRC and beyond.

Voluntary Counselling and testing

In 2001, 1 699 young people were willing to undergo voluntary HIV test. 1 130 among them have been effectively tested and 11 have tested HIV positive. They have received pre and post-test counselling. 1 gentleman who tested HIV positive was taken fully in charge by EVREJ.

Blood donations

13 campaigns were organised. 1 699 blood units have been collected and distributed by the National AIDS Control programme.

EVREJ recognised that the above activities enable people to initiate change and sustain behaviour that promote a healthy state of mind, body, spirit and environment. EVREJ is not naïve, it recognised that behaviour change at individual and community levels in the present HIV pandemic is complex. However, an on-going process can bring the youth to the motto "today is time to act".

4.4.3. "Service Education à la Vie"

One method which "Service Education à la Vie" uses to help identify the project goals, purposes and strategies is to develop a problem tree after background information is collected. The problem definition or analysis requires an understanding of the context of HIV in the community.

Having gathered the information, the next step is to define the key problems that the community and the NGO want to address. "Education à la vie" has acknowledged that HIV prevention and care programmes are most effective if they are well planned and meet the needs of the community especially the youth. Last year, "Service Education à la

vie" reached 1,250,000 people included parents and schoolchildren. 375 schoolteachers out of 800 have been trained in life-skills in Kinshasa.

Having recognised that messages are most effective when they are directed towards a specific population group and the behavioural options advocated should reflect the "*real life*" situations of the people to whom they are directed, "Service Education à la Vie" is working hand in hand with "Carrefour des Jeunes", Muslim community, Catholic, Kimbanguist, Salvation Army and Protestant churches particularly in the areas of training of trainers and also in the implementation of HIV/AIDS youth programme.

4.4.4. Union des Jeunes Catholiques

Union des Jeunes Catholiques and Union des jeunes Protestants (Carrefour des Jeunes) used to be working together during the nineties since funding agencies, HIV/AIDS Programmes and target populations were the same. At that time, the Catholic Youth message was based on the condom use as a mean of controlling HIV/AIDS and STI as promoted by secular organisations. But the Youth Programme insisted that the condom use does not protect people from sinful action. Therefore, young people were given information and opportunity to make informed decisions. In 2000, the Archdiocese of Kinshasa decided to transfer the youth HIV/AIDS Programme under the Auxiliary Bishop of Kinshasa. From that time up to now, the Union des Jeunes Catholiques has been weakened especially because of lack of funding and lack of physical infrastructure. The condom issue could have created this barrier that needs to be removed with another revolutionary approach to be shared within the framework of the Catholic network and beyond.

5. HIV AND GENDER ISSUES

The discovery, that one is HIV positive is not only a major life crisis but also a very difficult fact to come to terms with. Many people living with HIV/AIDS especially women have indicated that it took them years to get in peace with themselves and personally accept the situation. People living with HIV/AIDS face stigma, even in countries known for their openness. In the context of HIV/AIDS, gender issues are insufficiently addressed in DRC church settings.

In DRC, it is said that traditional culture, customs and religion are two social institutions that have promoted the poor relationship between men and women. The church is said to be a male dominant institution that oppresses women. Therefore men are the main beneficiaries from that oppression. The key issue is what role the church of the 21st century can play to address these attitudes that jeopardise the status of women in the context of HIV/AIDS.

HIV/AIDS generally erupts in times of crisis. Central Africa in general and DRC in particular, like most other developing countries, are in the throes of economic and political turmoil. Per capita incomes are ranked among the world's lowest. For instance, the average is estimated at $:70 per year in DRC. Average figures mask wide disparities in wealth. Many families in Kinshasa eat only once a day and malnutrition is widespread.

Women are impoverished by the dominant social, economic and cultural orders that define their lives. Very often, women are forced into sexual relations with men in circumstances that deny them the right to protect against HIV infection. This is true both within and outside marriage. Because of wars and armed conflicts, the risk of sexual violence increases dramatically. There are large numbers of mobile, vulnerable and unaccompanied women who become easy prey for rapists especially in Eastern part of DRC (UNDP, 1999).

Even in church settings, given the low status attached to women, they are ill-equipped to negotiate safe sex and to deny sex to an unfaithful partner. Behavioural change is essential. Fidelity is not considered a virtue among men, and it is estimated that between 60% and 80% of women currently infected with HIV in sub-Saharan Africa have had only one sexual partner (UNDP,1999). It is known that churches condemned prostitution from the pulpit, but bearing in mind that it is an economic choice and the income derived feeds children, churches should use neutral and unbiased language to address sexual issues particularly for sex workers who are abandoned by the churches in order to save from getting infected.

Neutral language will help lead to more open discussion. Sex means different things to different people, and its meaning often varies by culture. In DRC, sexuality can be used to show feeling, have children, provide physical relief, gain a sense of closeness or attractiveness, or be a mean of getting money or fulfilling an obligation. With an open mind, churches can develop an understanding with each person that can likely lead to a free discussion about sex and gender issues and plan meaningful actions accordingly.

Interesting programmes that target men and women to confront their role in the marginalisation of people living with of HIV/AIDS are "Femmes PLUS and Papas PLUS"

Femmes Plus

In DRC, women living with HIV/AIDS face isolation, rejection and discrimination. They are accused of being the source of infection within households even if the opposite is very often true. The general public ignore and blame them as they are regarded as useless people with short life span.

In addition, options of health care, relationship, and career development are greatly restricted. For instance, PLWHA lack treatment and option thus even die early from a curable disease. Employment chances are few, and if chosen, fellow workmates discriminate against them and end up losing jobs through unfair dismissal. Even one's personal life in terms of relationships becomes affected, friends run away, and families give no support.

To overcome these difficulties, Femmes Plus methodology includes: Counselling, food supplement, Information, Education and communication, treatment of opportunistic infections, referral system and Training of volunteers'. 22 Women living with HIV/AIDS are encouraged to live positively within the project.

Femmes Plus is seeking additional resources to expand its programme to all provinces and is calling upon men's involvement in the fight of HIV/AIDS. What is encouraging, is that Femmes Plus is to be found in some provinces particularly in the occupied territories (rural areas) which are often neglected with regard to HIV/AIDS. Therefore, Femmes Plus is meeting a real need.

Papa Plus

Denial, blind panic and victim-blaming have been among the men's worst responses in DRC. In addition, there is a lack of relevant structures that are likely to give social support to men though DRC is a male dominant society. The objective of Papa Plus is to encourage men to reflect critically on themselves as many of the practices of men contributes to the spread of HIV/AIDS. Papa plus is distinguished by its determination to act, innovate and to lead through examples and encouragements:

- 5 antenna have been established in some clinic settings in Kinshasa.
- 15 awareness campaign of social mobilisation and testimonies of people living with HIV/AIDS have been held
- 6 social assistants have been trained in guiding reproductive health and rights, which is being handled by two sectors of life skills training and health education (counselling) for HIV positive people
- The spirit of volunteerism is compounded in the project for sound strategies of restoring lives of the people threatened with HIV/AIDS

This organisation has adopted a very practical approach to involve men to contribute to the decline in the spread of HIV/AIDS within their own forum. Monthly meetings are held where men who are HIV positive give testimonies. This is unusual in DRC. Initially, Papa Plus encountered increasing resistance from some men feeling their gender threatened. However, the growth of the organisation and the interest that has been aroused among the general public contribute to the de-stigmatisation process.

6. Involvement of Churches in Training Clergy and Laity in Counselling of HIV/AIDS Infected and Affected

HIV/AIDS continues to be a major issue and the prevalence is on the increase despite some efforts to contain it in DRC. It is clear that many challenges lie ahead in the fight against HIV/AIDS and renewed multi-sectoral efforts to include religious organisations become imperative. Religious organisations are mostly community based. No other organisations gather thousands of people at least once a week. If religious institutions are inspired to reach out their members and talk openly about HIV/AIDS, we would have an enormously powerful tool in advocating preventive measures and care.

However, clergy are ill equipped to deal adequately with HIV/AIDS in a counselling set-up. On one hand, many of them acknowledge having insufficient knowledge about the disease and its impact on affected families. On the other hand, clergy admit having ambiguous personal feelings about the dreadful virus, the disease and the sufferer. The question is how they can manage to be effective in the struggle of HIV/AIDS given their emotional feelings and their insufficient know-how.

Most of clergy who are currently in leadership position were trained before the outbreak of HIV/AIDS. Therefore, they were not given training in pastoral counselling for HIV/AIDS and care giving for the people they serve. Although, HIV/AIDS requires a pooling of energy and creativity from every society, very often clergy lack empowerment and knowledge. A large number of clergy claim never to have seen an AIDS patient even though they bury friends and relatives who died from AIDS. What is termed denial may be simply misunderstanding imposed by lack of education. That is why perhaps they partially work in isolation. Subsequently, many churches are reluctant to speak out about HIV/AIDS and they fail to be in the forefront in breaking the silence.

Doctors and nurses need help to increase their tolerance and compassion to people they are unable to heal. People living with HIV/AIDS should be treated as full human beings rather than statistics. Health professionals often hide their inadequate care towards people living with HIV/AIDS behind their so-called busy schedule. To overcome these shortcomings, "Holistic Approach to Health and Healing" is required.

This programme has been implemented in Vanga Hospital, Bandundu Province. The programme involved a considerable amount of counselling and seeks to involve both health and community workers to work hand-in-hand. It enabled counsellors to be trained in DRC and beyond. Communities involved felt empowered by the process. Unfortunately, the project ceased when donor funding ended and in addition, the American medical doctor who was the person responsible for the project went back home.

The Salvation Army operates a training camp near the International Airport of Ndjili. War displaced people namely young girls, widows and women living in difficult situations are given psycho-social support. Youths who benefited from the programmes are encouraged to become peer educators as they are more likely to sympathise with them. 200 women out of 700 have left the refugee camp since they are able to sell crops etc. because of the micro-credit that they received from the Salvation Army. This is an interesting programme worth recommending.

7. CARE AND PREVENTION SERVICES

7.1. Voluntary Counselling and Testing

Prior to 1999, no government centre offered voluntary counselling and testing services to the community outside the medical facilities. Testing was offered at the Blood Transfusions centres for donors. In many instances, private laboratory testing after referral from a private Medical Practitioner was extremely very expensive 10 US$.

In 2000 a collaborative effort between Government, PNLS and GTZ launched 4 health centres for testing. Previously testing was only performed with ELISA test. Recently the rapid test was also introduced.

In antenatal clinic, group counselling on Mother-to child transmission is given to all pregnant women in the form of health education during antennal visits. A notable example is Kingansani health centre, most of the nurses were trained by the GTZ staff during 10 days within the health centre premises (2 hours per day especially in the afternoon when they are less busy). The aims of this training were:

- to uproot the fear attached to HIV infection
- to familiarise them with various kind of problems that are found in HIV infection
- To develop empathy for people living with or affected by HIV/AIDS

The following sub-themes were developed:

- How HIV is and is not transmitted?
- HIV and safe medical practices
- Child nutrition in the context of HIV/AIDS
- Confidentiality and stigmatisation issues
- The importance of VCT

There is an apparently low uptake of counselling which is assumed to be due to the heavy workload of the nurses, lack of privacy during counselling, stigma both within and outside the clinic and a lack of access to low-cost infant formula.

During the recent workshop organised by PNLS with UNDP support, it was recommended that testing services should be introduced at all mission hospitals. This is being currently considered, as Christian medical facilities would be the right places to offer such services. Some Mission hospitals have already successfully initiated VCT.

In Binza Health Centre, the Catholic sisters who are responsible for the health centre recommended for training 2 social assistants who have already been collaborating with them as volunteers in the family planning programme. Subsequently, they received a 3 weeks training on HIV and STI counselling in specialised clinics organised by "Médecins Sans Frontrières" in Kinshasa. In addition, a gynaecologist went on the ground in order to work closely with midwives for 2 weeks in order to help them strengthen their capacities to promote safe motherhood.

VCT is increasingly integrated in routine activities of the above two health centres. Nurses are encouraging pregnant women to be tested. However, the programmes are not yet fully integrated in pre-school settings where girls of childbearing age could be targeted.

7.2. Prevention of Mother-to-child-Transmission (PMTCT)

As mentioned elsewhere, In DRC the HIV prevalence among pregnant women varies between 3-11% and the mother-to-child transmission stands at 25-30% in the context whereby breastfeeding is the cultural norms. According to the National AIDS Control Programme (PNLS 2000), the number of children suffering from AIDS has increased from 8 to 16%. Therefore, PNLS estimated at 42,000 the number of infected children per year. The routes of transmission are presented in the table below:

Table 8: Routes of Mother-to-child Transmission

Table 8: Routes of Mother-to-child Transmission	
Designation	*%*
Labour	65%
Delivery	23%
Post-partum	12%

Source: UNICEF, 1999

"The prevention of mother-to-child HIV transmission should be part of the minimum standard package care for women who are known to be HIV infected and their infants. Implementation of any of the anti-retroviral prophylaxis regimens shown to be effective in randomised clinical trial can be recommended for general implementation. There is currently no justification to restrict use of these regimens to pilot project or research settings."

WHO Technical Consultation on behalf of the Inter-Agency Team on MTCT of HIV
Geneva, (October 2000)

With GTZ support, MTCT project has started in Kinshasa with mandatory of offering PMTCT therapy. Examples are from ***Kingansani and Binza maternities***, which are densely populated slums where Catholic sisters operate.

Table 9: Management of the PMTCT programme in Kingasani and Binza		
Designation	*Kingansani*	*Binza*
Trained health workers (Counsellors)	20	0
Number of deliveries	2092	346

Number of women starting antenatal care	4427	557
Women receiving HIV Counselling	4427	557
Number of women who undergo HIV testing	2056	69
Women who returned for test results	843	1
Number of women who tested HIV positive	61	1
Number of HIV (+) women lost for follow-up	1	0
Number of mothers receiving Nevirapine	5	0
Number of babies receiving Nevirapine	9	0
Number of women who tested after one ANC	1168	-
Number of women tested after 2 or 3 ANC	1263	-
Number of HIV(+)women who delivered	10	-
Number of babies born from HIV(+)women	10	-
Number of living birth among these babies	10	-
Number of HIV(-)mothers	1995	68

Source: GTZ report from 1st December 2001 to 31 May 2002 (unpublished data)

Apart from the two Mission health centres, very few churches have been involved with the provision of MTCT. These two health centres are doing a good job since nearly 45% of all pregnant women who went for antenatal clinic accepted to be voluntary tested within a country where people are still reluctant to speak openly on HIV/AIDS.

According to Dr Richard Matendo, (GTZ, PMTCT), the dire social consequences of VCT on pregnant women are:

> *"Although many pregnant women who attend antenatal care accept to be tested, a few of them can easily tell their husbands or any other relatives that they did so unless they are told to be HIV negative afterwards. In so doing, they feel proud to know how to improve their own sexual behaviour in order to avoid HIV infection. On the contrary, (when they test HIV positive): how is my husband going to react? This is the usual question. Most of them fear divorce, stigmatisation and discrimination within the family and beyond. For instance, one of the HIV+ women followed recently by GTZ in Kinshasa has been rejected not only by her husband but also by her own family. She would be homeless and ready to commit suicide right now if a local Church had not been compassionate and given her all the social support that she needed."*

It has to be mentioned that this PMTCT programme is only based in Kinshasa. There is a great need for these services to be extended into the rural areas, where most of the population live and where the churches settings are well placed to take up this challenge. Therefore, the need for national coverage is documented and the voice of church related institutions to advocate and lobby for these services should be taken into account. Hopefully, PNLS, UNICEF, UNAIDS and SWAA are looking forward to initiating and implementing PMTCT programme in Bas Congo Province.

7.3. Christian Hospital Care

7.3.1. Kimbanguist Hospital

FRASKI (Simon Kimbangu Fraternity) and the Medical Department are caring for 30 people living with HIV/AIDS and 20 affected. Food, spiritual and psycho-social supports are provided by trained counsellors.

Table 10: Syndromic management of STI					
Designation	*1997*	*1998*	*1999*	*2000*	*2001*
Declared IST	2,228	2,431	3,463	3,950	4,981
Syndromic management of IST	749	1,446	2,728	3,040	4,056
Suspected and declared HIV/AIDS	1,437	2,144	2,349	2,847	3,247
Confirmed HIV (+)	86	156	236	320	380
Opportunistic infections treated	65	89	301	325	358
Transfusion after blood screened	182	494	767	2915	3540
Death due HIV/AIDS related disease	16	27	42	68	99

Comments

Many clients, especially women who tested HIV(+), find it difficult to discuss HIV/AIDS and STI issues with their partners because partners do not believe they have a disease particularly if they have no symptoms. In consequence, they refuse to come for treatment. The Kimbanguist Hospital has earned a good reputation for maintaining HIV confidentiality that is why many clients use its health services for testing, treatment and counselling.

7.3.2. Centre Bomoto

Reproductive tract infections and sexually transmitted diseases are an important public health concern particularly in Kinshasa. It is well known that people who have STI are at increased risk of becoming HIV or transmitting HIV to their partners. According to the Director of Centre Bomoto, many people, particularly women, who have STI do not receive proper care and treatment for the following reasons:

They may have symptoms, but they do not identify themselves as such. Many women lack information about normal vaginal discharge. Some women have had an infection for so long that they think symptoms are normal.

Centre Bomoto stressed that many clients suspect they have STI, but they do not seek care because:

- They dot not recognise the seriousness of STI
- They are too embarrassed to attend clinic
- STI carries a social stigma.
- They have not access to treatment
- They cannot afford treatment
- Most clinics are not youth-friendly

Centre Bomoto was created to gain clients' confidence particularly women and youth, for discussing problems related to sexual and reproductive health. Since most clinics where Bomoto is used for referral systems were found not youth-friendly because of health worker's judgemental attitudes towards sexually active youth that have contributed to poor uptake of reproductive health services among young people. Currently STI management including treatment is delivered in Centre Bomoto premises in order to break down barriers to youth that prevent early diagnostic and treatment. In 2001, 1,046 adolescents attended the clinic using syndromic management approach.

7.3. Care of AIDS Orphaned Children

7.4.1. AIDS ORPHANED CHILDREN IN DRC

According to the National AIDS Control Programme, the Democratic Republic of the Congo has an estimated 811,000 orphans whose one or both parents have died of AIDS. In a recent report, the programme said that the pandemic has increased the number of street children in the vast country urban centres. With the all socio-politico-economic problems that this country is facing the need for strong action is urgent and must be country-wide.

The DRC made early gains in the fight against AIDS. In the 1980s programmes were started to educate the people and promote the use of condoms. Targeted programmes were started with prostitutes and high-risk groups. As a result of these programmes, the HIV positive rate was held down in the urban areas and reduced in some high-risk group populations.

In the 1990s many of the programmes started in the 1980s closed down or greatly reduced their activity. It is not clear what is happening with HIV/AIDS at this time. With the level of poverty the highest it has ever been in DRC and the extreme decline in health services, it is assumed that HIV/AIDS is much worse than estimated. Additionally, children who survive from wars end up as orphans with no skills to face the challenge in life. Prostitution becomes the most likely way out especially for girls and the vicious circle of HIV/AIDS spread is perpetuated. This is why Bethsaida Centre and Amo-Congo are aiming to break the vicious cycle.

Bethsaida Centre

Reverend BIANSIMA LALA has set up an orphan programme in the suburb of Kinsuka.

Main activities

Advocacy:

The project is helping 100 orphaned children who are given school fees from a German Mission. Without this financial support, most of these children would be vulnerable to HIV/AIDS since they could not be able to embark on training. However, the project should foresee mechanisms of sustainability once the foreign aid is gone.

Prevention

Bethsaida Centre has trained locally 5 teams of counsellors. From January to April 2002, they sensitised 2'470 persons in many ways. They have been welcomed by most host-families since these visits were done purposefully for the follow-up of orphans in their home environment.

Care and support

Case Study

Ms "Harlette" lost her husband a couple years ago because of AIDS. Although she knew her HIV positive status, still she has turned into prostitution for survival reasons. However, Bethsaida's staff gave her spiritual and moral support that she needed. Before her death in March 2002, she repented and accepted Jesus Christ as her personnel Lord and Saviour. Therefore she died peacefully.

Health cares have been provided to orphans who are suffering from opportunistic infections.

AMO-CONGO "Avenir Meilleur pour les orphelins"

In order to mitigate the impact of AIDS on poverty and to reduce to some extent the impacts of AIDS on households, publicly funded programmes to address the most severe problems are needed. However, the political will and commitment to address this issue is lacking.

Amo-Congo (a private NGO) has included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for 5000 AIDS orphans, food programmes for children and support for educational expenses. Amo-Congo is helping families particularly widows and children survive some of the consequences of an adult AIDS death that occur when families are poor or become poor as a result of the costs of AIDS.

Recent Amo-Congo activities included the development and provision of free voluntary counselling and testing services, free treatment protocols for sexually transmitted infections, promotion of comprehensive training and income generating scheme. However, Amo-Congo should assess what it would cost for the benefits of the project to continue beyond donors' involvement. I reminded the project manager to reflect on how funding will be obtained to meet these costs if for one reason or another the project is to be handed over to local community.

It makes no sense at all to expect that pharmaceutical and diagnostic companies in developed countries should produce medical devices and drugs for free. The fight against HIV/AIDS must be a sustainable business for every one involved in terms of economically viable arrangement which is long lasting and self sustaining.

Street Children

DRC has been the hardest hit country due to lack of adequate HIV/AIDS control measures, buttressed by war and poverty. This has lead to increasing street children who are well known in DRC. In vernacular language, Street children are called "chegge", "phaseurs" and "Londonienne."

The first category of street children are those who decided to make streets their living rooms for several reasons including financial hardship, poverty, family breakdown etc.

The second group is those who drift to the street during working hours. The money earned helps them partially assist their families with whom they remain in touch somehow. Sometimes, phaseurs come from extended families where life conditions become so unbearable that the hardships and potential dangers of the street are the only option to be chosen.

The third group consists of vulnerable young girls and women who have to sell themselves and their sexual favours as a coping strategy. However, I should say that the above categorisation of street children is complex. By experience, I saw some children running away from fairly respected and middle class families in order to join street children probably because of peer pressure. This warrants further exploratory studies.

The needs of street children are vast and growing. The experience of malnutrition, lack of education, marginalisation, inadequate supervision, and increased poverty and reduced opportunities will have decades-long impacts on street children in the societies in which they live in. To overcome these difficulties, some street children programmes provide basic services.

On one hand, Catholic Relief Services make sure that basic needs are met for them e.g. schooling, medical care, immunisations, love, warmth, etc. On the other hand, most NGOs working under UNICEF's funding are offering services that aim at facilitating reunification and reintegration of street children from the street into the communities from where the children have come from.

It is grounded and driven by the conviction that children and adolescents living in AIDS-affected communities have the right to protection, and appropriate care and support. In DRC, the responses to date have been fragmented, uncoordinated, and small scale. There is an increasing need for a sound principle guide for an effective action at local, district, provincial and national level in the development and implementation of expanded and comprehensive initiatives that meet the needs of vulnerable children and adolescents.

8. OTHER

AJIC," Association des Jeunes vivant avec le VIH/SIDA au Congo"

The youth represents an increasing percentage of HIV infections globally. The impact on young people is proving far worse than anticipated. In 2000 alone, some 53,000 children under 15 were infected with HIV in DRC (UNAIDS, 2000). But young people are also among those who act first and most decisively. Among 220 tested HIV positive in a local hospital after VCT, 32 youths trained to date are living positively under AJIC. 5 of them would have killed themselves after HIV testing. They have been hopefully saved by their colleagues. They are committed to support the design and conduct behaviour change activities targeting them. In addition, they are sharing experiences, concerns, curiosities and solutions for reducing their own sexual behaviour risks. Meaningful involvement of youths in peer counselling is critical in creating an enabling environment for traumatised youths. It also provides a supportive environment for sharing and learning.

ALPI+ "Association pour la Libération des Personnes Infectées"

ALPI's concern is to provide replies to exclusion, solitude, and despair and restore the social link of patients. Meetings are organised between people living with HIV/ANDS so that they get to know each other, break out isolation and share their experiences. The objectives of ALPI+ have several components as follows:

- Promoting the dignity and self sufficiently of people infected by HIV
- Promoting early screening for HIV/AIDS
- Educating women and young in the prevention of HIV/AIDS

- Promoting income-generating activities to improve economic access to health care
- Promoting psychosocial and medical care of people living with HIV/AIDS
- Distributing food and clothes to people in great need

RCP+ "Réseau Congolais des personnes vivant avec le VIH/SIDA"

In many communities, people still blame circumstances or others for being the cause of their suffering. Such statements like "it's the government", "it's my wife or my husband", "it's peer pressure", "I was bewitched" are common. People are still pointing fingers. In its efforts to prevent further infections, RCP has set up the space for people living with HIV/AIDS to receive medical attention, counselling and support, pastoral care and possibly financial assistance to be able to cope with the situation.

CONCLUSIONS

My first conclusion is that the involvement of churches and church related institutions in the struggle of HIV/AIDS is a brave effort to raise clergy and laity awareness in order to help them contribute in the control of HIV/AIDS. However, the clergy is currently ill-equipped for an effective HIV/AIDS control. Clergy end up with inaccurate data and only half of the message partially because of the reluctance to break the silence on sex and sexuality issues.

Since HIV/AIDS is a development issue that has damaged economic and social aspects in DRC, it is helpful that the necessary messages are accurately given. Clergy should play a crucial role in the control of HIV/AIDS if in service-training about the disease is provided and if they fully understand that teaching HIV/AIDS is a key part of clergy's duties in this HIV era. It is imperative that the church employs a holistic approach to address the problem.

In addition, currently individual churches are trying to implement HIV/AIDS activities. The major focus has been awareness raising through public campaigns. Much can be gained through the commitment of churches to expand, integrate and intensify response of all churches and church-related institutions to take actions, increase resources and build up their capacity to sustain their efforts to slow down further spread of the epidemic.

Next, church leaders can play a very vital and prominent role in influencing attitudes and behaviour of the general public in order to reduce the stigma, the shame, the rejection and blame that are attached with HIV/AIDS and that add extra layer of sufferings to the already infected and affected by HIV/AIDS.

Moreover, HIV infection in many church settings has not been taken seriously for a long time, so I find it most salutary that some churches are now determined not to repeat the mistakes of others especially the current situation in which many people have no knowledge of their HIV infection status. This means that many millions are falling prey to the virus every day. Indeed, churches can assure that the knowledge of the individual HIV status is provided to every citizen on a voluntary basis, but in a completely confidential context that eliminates any chance of stigmatisation.

Furthermore, as is evident from the statistics provided elsewhere, the HIV/AIDS epidemic now kills many family breadwinners, undermines business, creates orphans and decimates the workforce. It is an illusion to assume that wars and natural disasters will vanish from the earth. Therefore, the new streams of AIDS related refugees and orphans must be added to those already existing.

Finally, during the mapping exercise I found that most of churches policy-making organs are clergy dominated with minimal involvement by professionals even from their own congregations. However, AIDS is a technical issue calling for a professional approach. Therefore, the church should look beyond its traditional structures and approaches in order to become an effective player to combat the disease. Subsequently, a decisive response will not only call for theological input, but for social and medical skills in a vigorous and holistic manner through positive and effective prevention and curative measures.

Even though most churches have reacted against the condom, it has to be mentioned that they failed to vigorously teach and promote abstinence holistically. The churches have been silent when it comes to talking about human sexuality with or without AIDS. To repeat simply the commandment "thou shalt not commit adultery" is not enough without theological rationale of human dignity and sexuality as purposeful gift of God. Therefore, theological and ethical thinking is needed for church leaders and their congregations to speak honestly about HIV and AIDS and to act practically in response to it.

In the light of the findings, the following issues need to be made to improve the church based HIV/AIDS control:-

Clergy/Church leaders or church policy makers

Policy

- Prior to embark on any HIV/AIDS project, a situational analysis with community participation is required to make sure that the project will belong to the community since it is socially and culturally accepted
- HIV/AIDS related stigma continues to inform perceptions and shape the behaviour of people living with HIV/AIDS. Churches should develop policies to combat discrimination and rejection
- Each congregation should develop its own policy in the light of its beliefs within the context of Christian fellowship
- Too much time has been wasted in discussing condom issues and too many lives have been lost. A realistic compromise of the condom issue should be adopted
- Every church leader must personally break the silence about the norms and practices that fuel HIV/AIDS epidemic. A church leader seminar is needed!
- Clergy are ill prepared to deal with HIV/AIDS in a counselling set-up. Training in HIV/AIDS needs to be incorporated in theological and biblical colleges.

Congregations

- Clergy need to teach on the biblical verses that encourage and support people infected or affected by HIV/AIDS rather than criticise and condemn
- Congregations should look at the social, cultural, traditional and theological understanding of HIV/AIDS issue in the light of God's grace
- Congregations need to be equipped in pastoral care and social ministry

Communities

- Need that the necessary messages on AIDS are accurate and updated
- Should be involved in a common struggle to overcome HIV/AIDS, with actions and strategies that combine all members and component parts of the community resulting in a true partnership
- Emphasise men's responsibilities towards women and girl children
- Should find out a safe space where sex and sexuality with relation to AIDS prevention should be discussed in a constructive way
- Need to be trained in counselling and home based care approach
- Need to understand that the struggle against HIV/AIDS will be won by communities; in every family, village, township and settlement across DRC partially if volunteers and caregivers are given community support
- Should understand that people living with HIV/AIDS are human beings in full possession of their human rights. Therefore, they must be valued as a resource and as crucial allies in the struggle to overcome HIV/AIDS.

Counselling

- In many church settings, there are no counsellors *per se*, but several different staff members such as clergy, laity, health professionals etc. share in the counselling process. Therefore, all staff members and community workers who provide counselling on a regular or occasional basis should be provided with appropriate training on counselling and basic communication skills.
- There will be an increased need for counsellors, especially if anti-retroviral drugs become available for those testing positive
- Wherever counselling takes place, whether at the home or in the clinic, it must be held privately and confidentiality should be given priority since the major barrier of VCT is stigma.
- Counselling is part of the education process: VCT should be encouraged at every opportunity
- Promoting VCT for behavioural change as a prevention strategy alone will have limited impact without quality and/or referrals for those who test HIV positive
- Pre-marital counselling and testing is highly desirable with appropriate counselling

- For discordant couples, there is no place for divorce except in case of infidelity. Enrichment courses for couples to maintain marriage are needed
- Pre-counselling, on-going and post-test counselling are essential
- Ongoing counselling is known to help individuals to accept their HIV status and develop positive attitude. Disclosure, however, is still a very difficult process. Therefore, psychosocial support should be provided at clinics, schools, and communities and in church settings.

Advocacy

- Peace is an essential pre-requisite for effective programmes against HIV/AIDS. The extent of ongoing war in DRC seriously undermines any realistic programmes to combat HIV/AIDS especially in the occupied territories. It is imperative that church leaders in collaboration with Government take decisive steps to create and maintain peace and security in DRC and the Great Lakes Region
- Leaders of faith-based institutions should be effective in calling upon government for openness and political commitment to the promotion of preventive measures and the provision of care.
- It is the duty of religious institutions to inspire and mobilise other institutions such as local, foreign funding agencies and religious institutions in the North to assist and support their brothers and sisters in the South. Therefore, the church should have a united voice to lobby for more resources.
- The church should lobby for the promotion of national conscience to reduce stigma hence helping people to take Voluntary Testing and Counselling
- Participatory governance and accountability for resources and results are important to consider in developing new and innovative administrative between churches, government and donors.

Networking

- The National Inter-faith Council Alliance that has been recently created should be strengthened with the right leadership and the required resources in order to make the fight of HIV/AIDS by FBO their top agenda
- There is a need for better quality information (accurate and timeous) for churches to collaborate with the Government and UN agencies
- Best practice (on what works, how, why and so forth) should be shared among churches and church related institutions etc.
- One particular challenge to address is the tendency of governments and churches to regard each other with suspicion, which often hinders opportunities for collaboration.

Social services

- To date, the response to Orphans and vulnerable children has mostly come from women and NGO who respond by visiting orphan household, establishing income-generating projects and sending children back to school. Adapting and replicating many of these initiatives in church settings can help protect and support greater number of vulnerable children.
- Orphan care should be in response to community action undertaken with local resources. This type of targeted assistance goes hand-in-hand with community capacity building.
- The target population should include child-headed households, widows, grandparents, orphans and youths. The goal is to develop the capacity to be self-supporting
- Church and church related institutions should reach HIV positive children with adequate medical attention to alleviate their suffering and reach adolescent with information about infection prevention and actions they take to manage their HIV infection.

Donor community

> *An NGO can achieve wider impacts in many ways including expanding its operations; introducing or developing technologies which spread, developing and using approaches which are then adopted by other NGOs and/or by government, influencing changes in government and donor policies and actions; and gaining and disseminating understanding about development.*
>
> *Robert Chambers*

- Although churches are truly constituency-based organisations which are committed to working with their communities, churches will find it difficult to meets the needs of infected, affected by HIV/AIDS and uninfected within their own congregations. Church should act as conduits, monitors and evaluators in HIV era. However, the challenge that most funding agencies are facing is finding out a reliable and accountable conduit!
- The traditional partnership between churches and ecumenical organisations of the North and the South does not seem to take into account the new dimensions of HIV/AIDS control measures. A variety of country or regional HIV funding programmes exist locally. However, many churches have the tendency to turn to their traditional donors with their church alone. To successfully resolve a problem of high HIV/AIDS prevalence, churches need to open new avenues for additional potential donors and resources.
- The customary attitude of international organisations and donor countries that still requires that all developing countries should follow the donor's prescribed guidelines without taking into account the local HIV/AIDS context should be replaced by an open and fruitful dialogue between the North and the South in mutual respect and consideration.
- Research should be encouraged and sustained in order to get a better picture of people's knowledge, attitudes and practices about the HIV/AIDS realities in DRC and beyond in order to plan and implement strategic interventions.

ABBREVIATIONS

AIDS	: Acquired Immune Deficiency Syndrome
ANC	: Antenatal care
AJIC	: Association des Jeunes vivant avec le SIDA au Congo
ALPI	: Association de Libération des personnes infectées par le VIH
BDOM	: Bureau des oeuvres médicales
DRC	: Democratic Republic of Congo
ECC	: Eglise du Christ au Congo
EVREJ	: Education pour une vie responsible et le Bien-Etre des enfants et des Congolais
FBO	: Faith-Based organisation
GDP	: Gross Domestic Product
GTZ	: German Technical Cooperation
HIV	: Human Immune Virus
IEC	: Information Education and Communication
IST	: Infection Sexuellement Transmissible
MTCT	: Mother-to-child transmission
NACP	: National AIDS Control Programme
NGO	: Non Governmental Organisation
PMTCT	: Prevention of Mother-to-Child Transmission
PNLS	: Programme National de Lutte contre le SIDA
RCP	: Réseau Congolais des Personnes vivant avec le VIH
SANRU	: Santé en milieu rural
SWAA	: Southern Women African Association
TB	: Tuberculosis
UN	: United Nations
UNAIDS	: United Nations Acquired Immune Deficiency Syndrom
UNDP	: United Nations for Development Programme
USAID	: United States Aid International Development
VCT	: Voluntary Counselling and Testing
WCC	: World Council of Churches
WHO	: World Health Organisation

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GABON

February 2004

*"Responding to AIDS with blame, or abuse towards people living with AIDS, simply forces the epidemic underground, creating the ideal conditions for HIV to spread. The only way of making progress against the epidemic is to replace **shame** with solidarity, and **fear** with hope"*

Peter Piot, UNAIDS

FOREWORD

HIV/AIDS is the most far-reaching and damaging epidemic the world has ever seen. Within a single generation, it has grown into an individual and social tragedy with huge implications for human security, for social and political stability and for economic development and spiritual challenge that sub-Saharan Africa region including Gabon is now facing. Taking into account the many people in their prime ages especially women that have succumbed to HIV/AIDS and leaving behind them generation of orphans that should be cared for by grannies, HIV/AIDS is worsening than any other attack that has ever befallen on mankind since the slave trade and the continent conflicts combined altogether. Therefore, HIV/AIDS should be a priority in Gabon since it is the greatest challenge facing the development community today as devastates entire communities and roll back decades of development progress gained in Gabon and elsewhere.

As mentioned earlier, the number of people that are dying because of the dreadful virus is not just statistics but they are people namely our parents, children, brothers, sisters, cousins, nephews etc. Additionally, they are neighbours, workmates, church members and church goers and above all members of the body of Jesus Christ.

The unfortunate reality of HIV/AIDS in Gabon is that it carries out stigma, denial and discrimination rarely associated with diseases in modern times we are living in. Those people infected and affected by HIV/AIDS can be fired from their respective jobs, their properties, denied insurance, medical and spiritual care and they are even ostracised just because of their illness. In my opinion, the issue of stigma really call all of us to deeper level of prayer and concrete actions and deeds to turn hearts from fear to love.

In Africa, many meetings have been held over the HIV/AIDS issues. However, I am afraid to mention that sometimes little information gets down to the grass root levels where they are badly needed. That is why I call on the churches and church related organisations that are very close to those affected and infected in Gabon to help end all forms of discrimination and stigmatisation against HIV/AIDS. On the contrary, the church must remain the bastion of love, compassion, tolerance and forgiveness that are part of the Christian's heritage and background. This will be feasible with concerted effort of people of good will to build the capacity of Gabonese churches in developing sustainable, effective, comprehensive approaches to stop the spread of HIV, and provide services to their communities.

In Gabon, HIV/AIDS was originally viewed as just another disease although it has long since moved beyond the boundaries of the health system. It is now generally acknowledged that addressing the pandemic requires concerted efforts across all sectors involving a wide array of actors. Therefore, churches should know that they are the primary partner of the government and other people of good will to combat HIV/AIDS. They need to be equipped, empower and engage themselves to expand and sustain their responses to HIV/AIDS. Hence, HIV/AIDS must be both passion and priority for the churches to reduce its impact through partnering with government, key agencies, organisations, faith and the local communities for increased HIV prevention, AIDS care and advocacy. In addition, as Christian organisations, they have a unique opportunity to share God's hope with those suffering and in pain in this particular context of HIV/AIDS in Africa.

1. GENERAL AND HIV/AIDS EPIDEMIOLOGICAL DATA IN THE REPUBLIC OF GABON

1.1. General data

1.1.1. Country profile

Located in Central Africa region, Gabon has 267, 000 square kilometres. Gabon is bounded to the East by Congo/Brazzaville, to the South by Atlantic Ocean, to the North by Cameroon and Equatorial Guinea. The Republic of Gabon is divided into 9 provinces of which Libreville is the Capital City. Gabon is ranking among the intermediate income countries and benefits from political stability and social cohesion. It is rich in natural resources such as oil, uranium, manganese and forestry. Mineral resources attract many internal and external migrants and sex workers to mine fields. Gabon acquired her independence in 1960 from the French. After the independence, the government began to set up post-colonial structures to comply with the state of independence and to adjust to the socio-cultural realities of the nation in many sectors. This led to progressive reforms in most sectors which was the public service. In the early 1980s, public service reforms in turn produced impact on sectors such as health, education, social affairs and public work.

1.1.2. Population

According to the census carried out in 2003, the Gabonese population is estimated at 1,321,560 of whom 42.3% would be less than 15 years old, 53.5% would be 15-64 years and 4.2% 65 years and over. It is estimated that 73% of Gabonese live in urban cities. The population growth is estimated at 2.54%. Although life expectancy at birth is 55 years for male while 58 years for female, estimates for this country explicitly take into account the effects of excess mortality due to AIDS. Consequently, this can result in low life expectancy, higher infant mortality and death rates, lower population and growth rate, and changes in the distribution of population by age and sex than would otherwise be expected.

In Gabon, Bantu tribes comprise four tribal groupings such as Fang, Bapounou, Nzebi and Obamba. Other Africans and Europeans count for 154,000 inhabitants including 10,700 French and 11,000 persons of dual nationalities. In Gabon, Christianity and Animist respectively 55% and 75% are the main religions whereas Muslim is less than 1%. French is the official language whereas Fang, Myene, Nzebi, Bapounou and Bandjabi are the vernacular languages. The table below shows basic demographic indicators

Table 1: Demographic Indicators

Designation	*Year*	*Estimate*	*Source*
Total population (thousands)	2003	1321	National census
Population aged (0-14) %	2003	42.3	“
Population aged (15-64) (%)	2003	53.5	“
Population aged > 64 and over (%)	2003	4.2	“
Annual population growth (%)	2003	2.54	“
Birth rate	2003	36/1000	“
Death rate	2003	11/1000	“

1.1.3. Economy

When it comes to comparing the Gabonese economy, it has to be mentioned that Gabon enjoys a per capita income four times higher than that of most sub-Sahara nations. Gabon mainly depended on timber and manganese until early 1970s when oil was discovered offshore. The oil sector currently accounts for 50% of GDP. Due economic international rules, principles and constraints Gabon is facing fluctuating prices for its oil, timber and manganese exports. In addition, devaluation of its Francophone currency by 50% in 1994 sparked a one inflationary surge, to 35%; the rate hopefully dropped to 6% in 1996. These shortcomings coupled with poor fiscal management are weakening the economy.

In 1994-1995, the IMF provided a one-year standby arrangement at near commercial rates followed by another standby credit worth of USD 119 million in 2000. Those agreements made some progress in privatisation and fiscal discipline. France provided additional support in 1997 after Gabon had met IMF targets for mid-1996. In 1997, an IMF mission to Gabon criticised the government for overspending on off-budget items, over borrowing from the Central Bank, and slipping on its schedule for privatisation and administrative reform.

Short-term progresses are nevertheless depending on an upbeat world economy and other fiscal and adjustments in line with IMF policies. Although Gabon has recently established a fund to fight HIV/AIDS, criticisms fault President El Hadj Omar Bongo for failing to respond quickly to rising prevalent rates.

Table 2 shows updated and relevant economic indicators in Gabon

Table 2: Economic Indicators			
Designation	*Year*	*Estimate*	*Source*
GNP per Capita USD	1997	4120	World Bank
Human Development Index rank	2000	123	UNDP
External Debt (billion)	2002	3.8	UNDP

1.1.4. Education

At the 1999 Biennale Meeting in Johannesburg, South Africa, President MBEKI made a strong plea for the Development of education in Africa (ADEA) to tackle the educational and social challenges presented by HIV/AIDS epidemic in Africa. In response to this call, ADEA launched an initiative called “Identifying Effective response to HIV/AIDS” whereby ministries of education and training institutions in sub-Saharan Africa were invited to take the stock and analyse effective preventive practices and policies in the education sector in the fight against HIV/AIDS.

In response to these requests for a sub-regional meeting on HIV/AIDS and education in Central Africa region, ADEA and the Inter-Agency Task Team are working with the affected countries to combine a technical seminar and ministerial meeting in Libreville, Gabon, May 24th to 29th 2000.

In Gabon, some schools have an HIV/AIDS programme in place. It focuses on using appropriate protocols to limit the risk of infection as well as education about HIV/AIDS, but only some staff has participated in the programme. However, child counselling has not been firmly integrated into the academic mainstream in primary teachers’ colleges. Consequently, children (such as orphans) frequently faced with psychosocial problems are in dire need of counselling services.

Table 3 illustrates the education indicators in Gabon

Table 3: Education Indicators			
Designation	*Year*	*Estimate*	*Source*
Total adult literacy	1995	63	UNESCO
Adult male literacy	1995	74	UNESCO
Adult female literacy	1995	53	UNESCO

1.1.5. Health

Like other developing countries, Gabon is facing major health problems that include diseases of poverty such as tuberculosis, malaria, poliomyelitis etc. According to health experts, the outbreak of infectious diseases in Gabon is due to unequal medical care and poor public health services. The high cost of medical care and increasing poverty, mostly among the country most disadvantages people have given way to an outbreak of the mentioned diseases successfully controlled in other Central Africa countries.

According to Mr Benoit Makana, head of epidemiological services at the health ministry, the effectiveness of the health service is mainly the result of political choices and strategies. He went on saying that sometimes in one area there will be two programmes for the same issue, while in other region certain issues will be unaddressed.

This was recently seen when the national UNDP representative handed over XAF: 642,000,000 the Ministry of poverty in order to help combat both poverty and HIV/AIDS. This money was given to the so-called civil society perhaps including faith-based organisations. However, nothing or little was written on how faith-based organisations could access those resources. Additionally, the follow-up mechanism that was described to manage these resources was similar to those in place in the Ministry of Health. This could lead to duplication of efforts and time consuming.

According to Minister of Health, the fight against malaria, which remains Africa's most deadly disease, is a priority. He stressed that the roll back of malaria goal in Gabon is to halve malaria-related deaths by the year 2010 and to roll the toll by another 30% by 2015 and 20% by 2020. Of course, worldwide malaria kills between two or three million people every year. "Of 487,688 people examined in 2000, 79,401 (16.28%) had malaria. This is an indication showing that an infection rate such as this with Gabon's most deadly disease among all other groups remained an issue of great concern.

It is well known that AIDS is ravaging several African countries, and Gabon is no exception. The most recent estimates are that 9 % of the sexual active population is HIV+, a jump from 1.6% in 1986. According to government, in Libreville alone, the numbers are 7.8%. Although, the government has recently established a fund to fight HIV/AIDS, privately national officials and donors complain that not all allocated money to control public health conditions is used as intended since waste and corruption remain serious problems in the government sphere.

Table 4: Health Indicators

Designation	*Year*	*Estimate*	*Source*
Health indicators	Year	Estimates	Source
Crude birth rate (birth per 1000 pop)	1999	37	UNPOP
Crude death (death per 1000 pop)	1999	16	UNPOP
Maternal mortality rate/100 000 live birth	1990	500	WHO
Life expectancy at birth	1998	52	UNPOP
Infant mortality rate (per 1000 live births)	1999	56	UNICEF
% birth attended by trained health personnel	1999	80	UNICEF
% of one year old children fully immunised	1998	54	UNICEF
Total fertility rate	1999	5.4	UNPOP

1.1.6. Poverty and Vulnerability

According to the Red French Cross, the HIV prevalence rate increased from 2.2% in 1989 when oil production and the government revenues were still rising comfortably, to 9% in 2003 when oil production was in free-fall as offshore reserved dried out and government spending has been cut accordingly. Consequently, road infrastructures have been deteriorated and spending on health and education sectors have fallen.

A recent survey of 15 to 26 year-old carried out for the UNICEF showed that unemployment was the main concern in life, with catching HIV in second place and final poverty. In Gabon, where government spending is falling and unemployment growing as the oil starts to run out, young people are more worried getting jobs than catching HIV/AIDS.

In response to help slow down the spread of HIV/AIDS, the government set up USD: 20 million last year. This money was also expected to help people living with HIV/AIDS to meet their needs. But both the PNLS and the Solidarity Fund failed to effectively use the money at their disposal.

Mrs Edith Bongo, First Lady of Gabon to the participants in one workshop that she organised in interior of Gabon that despite progress in mobilising many sectors of society against HIV/AIDS, there still a lot to do. She went on

stressing that ignorance is one of the worst enemies, and knowledge is the ultimate tool in tackling the epidemic effectively.

Additionally, she urged the youth not to become discouraged by the enormous challenges, pointing to progress on the national and international levels in providing access among the youth, linking efforts to overcome poverty and HIV/AIDS and providing care and support for mothers infected with the virus.

In fact, the reality is that most Gabonese teenagers have their sexual encounter between the ages of 12 and 14 and teenage pregnancies are common. This could be increased by the current unemployment rate of 21% (estimates of 1997) of the population that lives under the poverty line. Meanwhile the state is faced with the challenge of looking after estimated 9, 000 orphans of people who have died from AIDS. The projection is that the number of AIDS orphans in Gabon would increase to 14,000 by 2010 unless people changed their behaviour. The government policy is to encourage extended families to take these children under their wing.

It is well known that poverty goes hand in hand with HIV and AIDS. This also concerns Gabon which the already fragile economy should be further weakened with much of the trained labour force lost to HIV/AIDS. Poverty facilitates the transmission of HIV, makes adequate treatment unaffordable, accelerates death from HIV-related illness and multiplies the social impact of the epidemic.

1.1.7 Politics

Gabon is a republic. Its head of State is an elected president. The president nominates a Prime-Minister. Ministers are appointed by the prime-minister in consultation with the president. Also elected in general elections, the legislative branch consists of lower (Parliament or National Assembly) and upper (Senates) chambers. It is responsible for creating and controlling laws. The opposition parties were legalised in 1990s. The constitution was adopted in 1991 and the legal system is based on French civil law system and customary law.

President Omar Bongo, Africa's longest serving head of state has declared the fight against HIV/AIDS to be a "national priority". However, though it should be encouraged, the government programme to combat AIDS has been marred in recent years by the corruption of certain administrators who have used funds for their own need sand this is well known, said Hubert G., a leading member and AIDS activist Group Solidarity for Young Christians.

However, the first outpatient treatment centre for people living with HIV/AIDS was only established in Libreville in 2001. Antiretroviral are difficult to obtain despite the willingness to deliver them free of charge to those (poor people) that need them most. When talking to the general population, there is a widespread belief that government efforts to combat the pandemic are hampered by rampant corruption.

Despite the political will to make antiretroviral free of charge for ingenious people, another problem is that many people living with HIV/AIDS cannot afford treatment at local hospitals; some of them were complaining that AIDS patients were not even welcome by health professionals.

2. HIV/AIDS EPIDEMIOLOGICAL DATA IN GABON

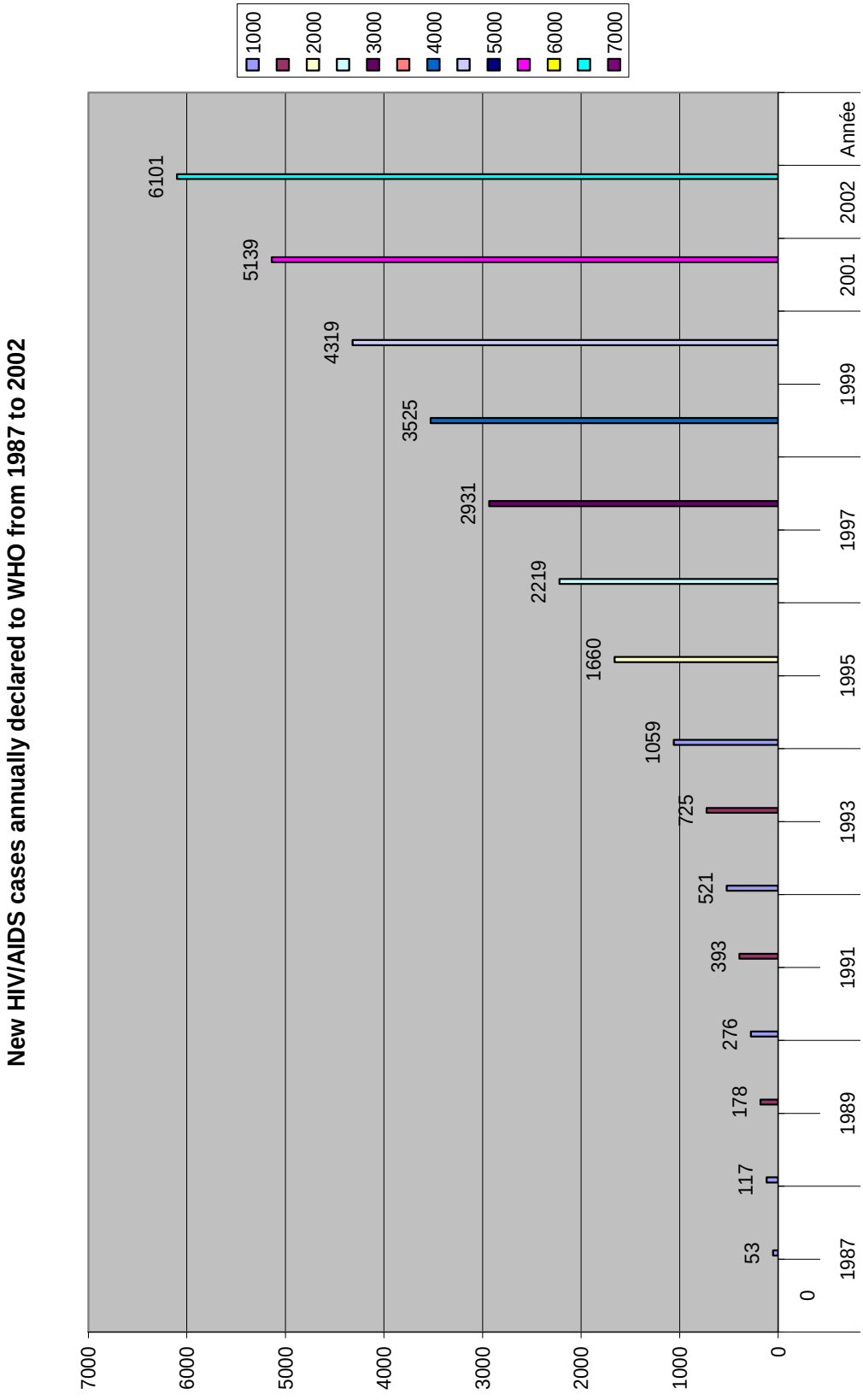
2.1. HIV/AIDS epidemic in Gabon

The first cases of HIV/AIDS were diagnosed in 1986. The fight against HIV/AIDS started in 1987 through the establishment of the National Committee to fight HIV/AIDS and other Sexually Transmitted Infections. Shortly afterwards, it was decided the National AIDS Control Programme would be the executive body. With regard to the national data on HIV/AIDS, no data were found. However, a study was jointly carried out by *Institut de Recherche et de Développement* and the University of Montpellier 1 in order to find out the seroprevalence in urban areas. This study showed that the seroprevalence in Libreville7.7%. The HIV/AIDS epidemic increased from 1.8% in the late 1986 to 7.7% in 2000.

According to the National AIDS Control Programme, nearly 60% of people living with HIV/AIDS are diagnosed at the stage of full blown AIDS. In 1991, 2.3% of hospitalised patients at the *Centre Hospitalier de Libreville* people were living with AIDS compared to 23% in 1999. This means that the disease was 10 times higher than initially. At *Jeanne Ebori Fondation,* 3 patients out of 10 admitted to the *service de réanimation* would have developed full blown at an advanced stage. According to the *Rapport sur l'épidémie mondiale de VIH/SIDA* published in 2000, AIDS claimed the death of 2000 people aged between 15-49 against 400 deaths from the youth people.

STI are an important public health concern although existing data in Gabon are not reliable since they come from a few health service reports. The consequences of untreated STIs can be devastating to health of men, women and their children. These conditions are responsible of infertility, chronic ill health, and sexual dysfunction and disseminated disease in Gabon. According to National AIDS Control Programme, STIs are leading to chronic pelvic pain and pregnancy complications such as ectopic pregnancy.

Fig 1: shows the new cases of HIV annually declared at WHO from 1987 to 2002



Comments

Although these figures are alarming, the Ministry of Health's surveillance system is weak and provides unreliable data due partly to underreporting. However, it should be noted that some movement took place following the UN General Assembly on HIV/AIDS in June 2001, when the Ministry of Health adopted official guidelines for HIV/AIDS work and declared the epidemic a priority.

In Gabon, many people, particularly women, who have HIV or other Sexually Transmitted Infections, do not receive proper care and treatment for the following reasons:

- Stigma, denial and discrimination against people living with HIV/AIDS is rampant in the communities;
- Individuals may have symptoms of STIs, but they do not identify them as infection;
- Since sexual education is no longer given in families and in the communities, many young girls lack information about normal vaginal discharge;
- Some women have had an infection for so long that they may think the symptoms are normal;
- Many people suspect they have HIV and STIs, but they do not seek care because:
  - They are too embarrassed to attend a clinic;
  - HIV/AIDA and STIs carry social stigma;
  - They do not recognise the seriousness of HIV/AIDS and STIs;
  - They have no access to treatment;
  - They cannot afford treatment.

2.2. Sentinel surveillance

HIV/AIDS prevalence information among antenatal clinic attendees has been available since the mid-1980s. In Libreville, the Capital city, HIV prevalence among antenatal women tested increased from 1% in 1988 to 4% in 1995. Outside, Libreville, HIV prevalence information is available from Franceville in 1996, 1987, and 1989-90; from South-Eastern Gabon in 1987-88 and from Estuaire in 199. There is no information available on HIV prevalence among sex workers. In the late 1980s, 2%-4% of STI clinic patients tested in Libreville were positive. In 1996-1997, 17% of STI patients in Libreville, Franceville, Moanda and Port-Gentil tested HIV-postive. In 1997, 6% of military personnel in Port-Gentil tested HIV-positive. The following figure and table illustrate the HIV prevalence in Gabon.

Table 5: HIV prevalence in main towns

Towns	*Period*	*Percentage*
Libreville	December 2000	7,7%
Port-Gentil	January 2001	9,1%
Franceville	October 2001	3,8%
Lambaréné	October 2001	3,8%
Makokou	October 2002	5,7%

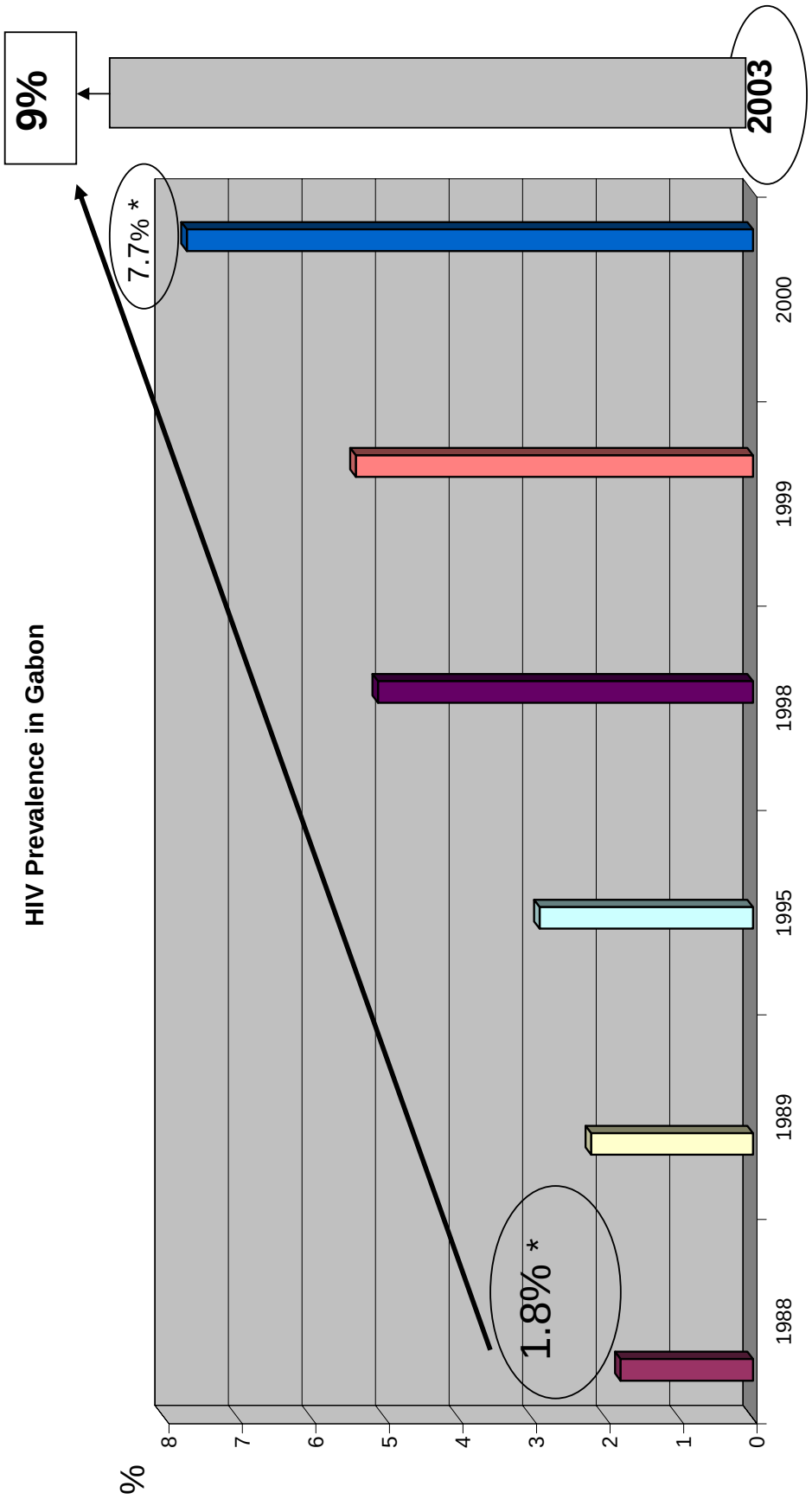
Source: Epidémiologie du VIH/SIDA au Gabon, December 2002

Comments

This table provides hints and insights that HIV/AIDS is obvious in main towns since the epidemic has increased. Churches can play a unique role in delivering prevention and care interventions and can use its structures as entry points for reaching out to people in need.

Figure 2: shows the distribution of HIV prevalence from 1986 to 2003

Source: Epidémilogie du VIH/SIDA au Gabon



Comments

The figure indicates that since the outbreak of HIV/AIDS, the disease is still on the increase. This requires a community response that put in place effective leadership and committed participation from involved stakeholders including churches.

The church in Gabon has an opportunity and responsibility to lead a rights-based approach to orphan and child care, to continue to advocate for policies and public programmes that address the underlying causes of HIV/AIDS crisis, to coordinate community level efforts in partnership with the National AIDS Control Programme, etc.

In order to achieve these goals, national churches in Gabon must build their capacity to play an effective and leading role in order to help curb the epidemic.

2.3. Contributing factors

- Lack of political will: it took longer than expected to develop a proactive leadership to combat HIV/AIDS. One of a high-ranking leader said on the national television "*Gabonese are immunised against HIV/AIDS. Therefore, they cannot get HIV*" (personal communication)
- Potential barriers which include: ignorance, interpersonal and system-wide
    1. Knowledge barriers are indicated since many people have only rudimentary knowledge of HIV/STI transmission and symptoms; Example of the knowledge barriers mentioned above are evident in these statements gleaned from verbal data: "*I cannot get STIs from clean girls*", and "*condom do not work*". In addition, misinformation on AIDS is widespread. Many people are still arguing whether mosquito bites can transmit HIV.
    2. Other barriers related to knowledge include a disbelief that HIV exists in Gabon, a disbelief in the ineffectiveness of condoms, and misinformation related to HIV and STI transmission and symptoms; interpersonal barriers reflected in statements such as "*I do not like condoms. Sex feels best "carne a carne"; and, " drinking gives me courage to meet girls and have sex*"
    3. The systematic barriers included a lack of available condoms when troops deployed on missions, non-disclosure policy when a patient tested positive for HIV and limited access to voluntary testing and counselling. System-wide barriers appeared in: "I cannot find condoms when I am in mission, but I can find girls", "*I do not know where to get tested for HIV"; and "Even if you do have HIV, the medical doctors will not tell you*".
- Poverty: Gabon has the highest GNP per capita (4,120 USD) in Central Africa region. Yet, poverty is crucial since a huge proportion of the Gabonese wealth is benefiting by only a few proportion of the population. Additionally, unemployment is very high.
- Heavy external debt: According to the estimates made in 2002, Gabon is heavily indebted with USD: 3.8 billion. This could partially explain why unemployment is still an issue of concern particularly for the youth.
- Sexual behaviour and sex education: the reality is that most Gabonese teenagers have their sexual debut and encounter between the ages of 12 and 14 and teenage pregnancies are common. I met one university student who said that her parents are reluctant to discuss sexual issues with her and other children. She said:" *It is difficult to talk about sex education at home. It is a taboo subject. I am 25 years old; my sexual education has been carried out in streets, at school and in the homes of other friends and families*".
- Resource misallocation: Both the National AIDS Control Programme and the Solidarity Fund have been widely criticised for falling to use effectively the money at their disposal.
- Broadly speaking we know that poverty; income inequality, labour migration, gender inequality, low education status, and a range of context-specific socio-cultural variables and poor health facilitate the spread of HIV/AIDS and are associated with higher prevalence rates.

2.4. Impact of HIV/AIDS in Gabon

Virtually there is no study carried out in Gabon in order to measure the impact of AIDS on individuals, families, communities and the country as such. This section discusses the impact of AIDS from data gathered through limited surveys that took place on the ground during the AIDS situational analysis in Gabon

2.4.1. Impact on individuals

HIV/AIDS affects the physical, mental and social well-being of people living with HIV/AIDS particularly when it comes to the development of opportunist infections. In 1998, the Foundation Jeanne Ebori Internal Medicine department in Libreville diagnosed the following opportunistic infections.

Table 6: opportunist infections diagnosed at Jeanne Ebori Foundation

Opportunistic infections	*Percentage*
Candidose	37%
Zona	18%
Salmonella	18%
Tuberculosis	14%
Kaposi Sarcoma	06%
Toxoplasmosis	02%
Cryptococcus meningitis	2%

Source: République du Gabon, Plan Stratégique de lutte contre le VIH/SIDA 01-05

Additionally many people affected and infected by HIV/AIDS are not treated with respect, love and dignity. Instead, they are ostracised, rejected, stigmatised and discriminated. Another problem is that many people with HIV/AIDS cannot afford treatment at local hospital, some of which complain that they are not welcome.

2.4.2. Impact on the community

HIV/AIDS has impact on the communities since they lose the most economically active-groups who are breadwinners. The death of a parent can have disruptive impact on orphans. The impact of the disease on individual children depends on a variety of factors such as their age, the socio-economic status of the families, the number and age of their siblings. Very often, the care of these children falls on extended families over stretched because of their limited and declining resources. In Gabon, there is an estimated of 8,600 orphans due to HIV/AIDS. Many children are more likely to be out-of-school, malnourished, less likely to receive assistance and are extremely poor. Many end up on streets where they may be abused, exploited, vulnerable to contracting HIV/AIDS.

2.4.3. Impact on different development sectors

Impact on health

In Gabon, health care system-one the front-line with the AIDS crisis-are overburdened and the services that health professionals can provide are woefully inadequate. In addition, not only are beds filling up with AIDS patients but also health professionals themselves are vulnerable to HIV/AIDS. A study carried out by the National AIDS Control Programme between 1996 and 1999 showed that out of 482 health personals whom undergone HIV testing, 33 tested HIV positive. This lead to personal shortage since their skills will be difficult to replace.

Impact on other developmental sectors

According to the National AIDS Control Programme, HIV/AIDS severely affects other societal sectors such as mining, oil, agriculture and housing, etc. In the public sector, the HIV prevalence would be 10% between 1996 and 1999. Similarly, the education sector is devastated since 439 personals tested, 65 tested HIV+ in 1999. Because of early sexual debut and sexual promiscuity, students and schoolchildren are vulnerable. This is equally true for lorry drivers and militaries.

3. THE NATIONAL HIV/AIDS CONTROL PROGRAMME

3.1. Background of the National AIDS Control Programme

In order to contribute to halting the spread of HIV/AIDS in Gabon, an inter-ministry commission convened by the Prime Minister in collaboration with 11 ministries was set up in 2000. This was an indication that HIV/AIDS deserved attention from the highest level of the government. The role of the inter-ministry commission is:

- To propose a multi-sectoral approach to fight against HIV/AIDS;
- To coordinate the fight inter-sectoral against HIV/AIDS;
- To help implement the national plan adopted in respective ministry;
- To analyse progress reports of those institutions that are fighting HIV/AIDS on the ground;
- To define modalities of actions taking into account the context and constraints of HIV/AIDS in Gabon.

The *Comité National contre le VIH/SIDA et les Infections Sexuellement Transmissibles* which is responsible for defining the HIV policy and guidelines was established in 1993. The Ministry of Health is the head of the so-called committee. The National Committee comprises an ethical and a follow-up committee, the National AIDS Control Programme, the Coordination Office, nine provincial committee and departmental committees.

The National AIDS Control Programme is the executive body of the National Committee to combat HIV/AIDS. The main roles of the NACD are as follow:

- To improve the knowledge related to HIV/AIDS and reinforce the epidemic surveillance;
- To prevent HIV transmission through sexual encounter and through blood transfusion;
- To improve an enabling environment in health institutions and to help administrate adequate care to PLWHA;
- To set up management boards in health institutions which are fighting against HIV/AIDS.

Comment

The National AIDS Control Programme is acting as an executive body rather than a coordination mechanism. Therefore, the NACD finds it difficult to play its role of infusion and facilitation. The many sub-committees put in place are ineffective. For instance, the ethical committee is paralysed since there is no legal protection draft towards the rights and obligations of people living with HIV/AIDS. There is little implication from ministries other than Health to fight against HIV/AIDS accordingly. The multisectoral approach to combat HIV/AIDS did not take off because of the inexistence of the National Committee. There are quite no networks between associations and Non Governmental Organisations dealing with HIV/AIDS issues. Provincial and departmental committees hardly work since they exist on papers and there were no mechanisms for follow-up. Moreover, financial and material resources are limited for decentralised structures. Training of health personnel, epidemiological, social and clinical research planned within the second medium-term did not take place. The above comment is self-explanatory about the poor quality of the national response.

3.2. The Gabonese National Response

Since the first HIV/AIDS case was reported in 1986, the disease spread rapidly in the country. Thus, a National HIV/AIDS and Sexually Transmitted Infections Control Programme was established in 1987 in order to coordinate with the Ministry of Health, a sound control of the epidemic as well as a monitoring of the programme. However, the second medium-term did not take place because of the change in the leadership. The new team that took over carried out Information, Education and Communication as well as epidemiological surveillance. The table no 6 provides important dates and significant events.

Table no 6 indicates Dates and main events of the national response

Table 7: Dates and main events of the national response

Dates	*Events*
1986	First cases reported
1987	Creation of the National AIDS Control Programme

1987-1988	Short term Plan
1989-1993	First Medium-term plan
1993	Creation of the National Committee to fight AIDS
1996	Common Programme for the UN against HIV/AIDS
1997-1999	Second Medium-term Plan
2000	Strategic Planning and *"atelier de mise à niveau"*
2000	Creation of the *Comité Consultatif SIDA*
2001	National Strategic Plan 2001-2005

The National Strategic Plan 2001-2005 was mooted, reviewed and amended during a national workshop which brought altogether 4 provincial representatives of whom the governor, representatives from ministries, representatives from the Prime Minister Office, delegates from the national presidency, delegates from the National Assembly, delegates from faith-based organisations, People living with HIV/AIDS and delegates from private sector.

The general objectives of the National Strategic Plan for 2001-2005 are as follow:

- To reduce the HIV/AIDS prevalence within the general population by implementing preventive strategies;
- To guarantee the well-being of people living with HIV/AIDS through psychological and medical accompaniment, social, legal and economic measures;
- To mitigate, evaluate HIV/AIDS impact in the country.

3.3. Donors and Partners in the fight against HIV/AIDS

Although it took sometimes for people to realise that HIV/AIDS is not merely a medical problem, and the fight against HIV/AIDS does not involve the only National AIDS and STI Control programme. Several other partners, donors and partners are involved in this fight; they can be grouped into several categories such as:

Donors

- The bilateral and multilateral partners are many and provide a technical and financial support. They include Coopération Francaise, Fonds monétaire International, Banque du Développement des Etats de l'Afrique Centrale, CEEAC, CEMAC, etc.
- The United Nations agencies such as UNESCO, WHO, UNAIDS, UNICEF, FNUAP, PNUD, World Bank, etc are providing financial support.

Partners

- The Non-Governmental Organisations which are numerous and mainly intervene trough awareness-raising, information-education-communication activities;
- Association of people living with HIV/AIDS;
- Some churches are involved through awareness-raising, education for the moral and spiritual integrity of citizens.

4. PARTNERSHIP BETWEEN GOVERNMENT AND RELIGIOUS COMMUNITIES TO FIGHT AIDS

The early Gabonese national response did not include religious communities to fight HIV/AIDS since religious communities were not considered as key players in the fight against HIV/AIDS. This could be probably because the early church response was indifference, silence, condemnation, and inadequacy for faith leaders to speak or to act as disciples of to Jesus, the compassionate. Additionally, the National AIDS Control Programme staff felt at that time, churches leaders would oppose the condom use since many of them used to associate the epidemic with God's punishment of immorality.

The Ecumenical HIV/AIDS Initiative in Africa has been recognised by many church leaders to be the first organisation that helped churches in Gabon to work hand in hand to fight against HIV/AIDS. In fact, many Gabonese delegates attended the theological reflection held in Yaoundé in 2002 and the theology of compassion in 2003. These regional workshops gave opportunities to network between workshop participants themselves with the spirit of ecumenism when they went back home. Since then, many things have changed in a positive way. For instance, the National AIDS Control Programme is working closely with two religious communities namely the Catholic and the Revival churches. In addition, a revival pastor is working as full time staff in the National AIDS Control Programme. He is also member of the Country Coordination Mechanism for the Global Funds.

During the mapping study, the NACP asked the Catholic Priest and the Revival Church Pastor to submit a paper related to the spiritual accompaniment of PLWHA. I attended the meeting where this paper was discussed. Once this paper is amended by other pastors involved in the fight against HIV/AIDS from the rest of the religious communities, the spiritual accompaniment paper will be adopted as national strategy to help churches address the spiritual needs for those who are affected. This good practice is relevant and can be replicated elsewhere since they show how the government and the churches could make plans to defeat the common enemy, which is HIV/AIDS.

5. FAITH-BASED ORGANISATIONS RESPONSE AND INVOLVEMENT IN ADDRESSING HIV/AIDS

5.1. Faith-based organisations in Gabon

With regard to the mapping study, I met religious and other interested people of the following religious communities: *Eglise Evangélique du Gabon, Eglise Catholique, Centre d'Evangélisation de Béthanie, Eglise Protestante Réformée and Eglise Alliance Chrétienne et Missionnaire du Gabon*.

5.2. Perceptions of HIV/AIDS

5.2.1. Eglise Evangélique du Gabon

Religious leaders are well aware of AIDS although the disease still affects people before preventive measures are launched. This could be the results from confusion about which values serve people best. The culture of silence related to most aspects of sexual behaviour may have served the people in the past, but this is no longer applicable in the context of HIV/AIDS, which affects many people in Gabon. Finally, internal problems related to the leadership did not help the Eglise Evangélique du Gabon to get involved in the fight against HIV/AIDS since the onset of HIV/AIDS.

> *"HIV/AIDS is every body's concern. However, because of the many internal leadership conflicts that the church faced, the Eglise Evangélique du Gabon did not have the opportunity to put in place appropriate mechanism to fight against AIDS".*

5.2.2. Eglise Catholique

In spite of the debate over condom promotion, there is a responsibility within the Catholic Church to the community to do what can be done within theological boundaries to both prevent HIV/AIDS and support the individuals who have the disease and their families. Other comparative advantages within the Archdiocese of Libreville include a long historical commitment to address the issue of HIV/AIDS and its openness at "individual" instead of "institutional" level to collaborate with other churches in order to put HIV/AIDS in Gabon under control.

> *"Recognising that HIV/AIDS affects and is affected by all aspects of life, the Episcopal Conference response entails a broad of strategies aimed at creating a supportive environment in which individuals can make informed choices, free of stigma and prejudice, in a context where basic rights as citizens and humans are recognised and upheld".*
>
> *Father Jean Kazadi, ACERAC, Coordinator.*

5.2.3. Eglise Evangélique Réformée du Gabon

The Eglise Evangélique Réformée du Gabon recognises that sexual promiscuity, poverty, gender inequality and rapid urbanisation foster the spread of HIV/AIDS that would be a scourge because of God's punishment for immorality.

> *"There is nowadays such a huge sexual promiscuity in Gabon that it goes down to incest. HIV/AIDS could be a sign of divine malediction from God according to Deuteronomy 28:58-61. That is why I should preach the word of God without compromising the truth that is revealed in it".*

5.2.4. Eglise Alliance Chrétienne et Missionnaire du Gabon

For the past years, Eglise Alliance Chrétienne et Missionnaire du Gabon has been very concerned with the increase of HIV infection within the Gabonese population. Eglise Alliance Chrétienne et Missionnaire du Gabon had participated in a number of workshops in order to identify the role and the place of the church in the fight against HIV/AIDS.

> *"The stigma of AIDS is still so high in Gabon that people have a high threshold to cross in order to speak with someone about the illness and their fears about it. Additionally, counselling is a new concept in this culture, so it is not easy for someone to understand how sitting down and speaking with a stranger may help him or her. This is at the core of what makes HIV/AIDS so deadly in this society: the nature of transmission of the virus, coupled with a reluctance to talk about it openly works together to greatly exacerbate the problem."*

5.2.5. Centre d'Evangélisation de Béthanie

As part of its mandate, Centre d'Evangelisation de Bethanie has, for over a decade, supported the efforts of people in poor, marginalised communities including church members to understand the roots of the problem, to find ways of preventing the virus from spreading further and mitigating its impact. Centre d'Evangélisation de Bethanie recognises that it has much to learn from the men, women and children who live the day-to-day reality of HIV/AIDS and seeks to contribute to the global response to the HIV crisis by ensuring that their voices are heard by decisions making at all levels.

> *"In churches, HIV/AIDS issues are still confined with the fact that many people would like to know whether HIV/AIDS is a natural disease, or a curse or a judgement from God. I think that HIV/AIDS is not a curse is because HIV/AIDS does not discriminate as it embraces every body. HIV/AIDS is a preventable disease whilst a curse is imposed. In my opinion, HIV/AIDS is a disease like cancer, diabetes and Hypertension, etc. The God of my understanding is love and merciful and he cannot punish his children through a dreadful virus like HIV."*
>
> *Pastor Gaspard Obiang, Centre d'Evangélisation de Béthanie.*

Comments on HIV/AIDS perceptions by churches in Gabon

Although church leaders' perceptions brought out mixed findings, their statements give some indications on the limited their knowledge to fight against HIV/AIDS accordingly. Of course, some churches are doing their best to respond to the HIV/AIDS crisis but there is still a lot to do.

There are many barriers to an effective response within church settings in Gabon. These include:

- The attitude of churches towards the HIV/AIDS epidemic, including fear, ignorance and denial are real barriers towards mobilising them to work in HIV/AIDS.
- Some churches are afraid that if they start providing HIV/AIDS interventions, they will harm their institutional image and they will thus lose the people they now serve.
- In many churches, people living with HIV/AIDS are unwilling to disclosure their status because of the associated stigma and discrimination. Consequently, PLWHAs have difficulties organising themselves into organisations led by churches.
- Many churches believe that HIV/AIDS is not a problem for the church members and churchgoers they work with and that there is no need to get involved.

- Others believe that those people who are infected by HIV are responsible for their infection, so they are only concerned with prevention.
- Additionally, there is a misleading tendency in some churches to believe that only sex workers and their clients are at high risk of contracting HIV.
- A few churches believe that investing in care and support for PLWHAs is a waste, because they will die anyway.

In my opinion, these barriers have to be addressed if churches are to engage communities to respond to the epidemic in a positive and caring ways.

5.3. nvolvement of FBOs in addressing HIV/AIDS

The responses of churches confronted with the HIV/AIDS issues in Gabon are simply limited to simple prevention messages particularly on World AIDS Day. Therefore, I did not come across a single church that is providing holistic comprehensive care apart from public hospital. The involvement of Faith-Based Organisations is outlined as follow:

5.3.1. Eglise Catholique

ACERAC stands for (*Association des Conférences Episcopales de la région d'Afrique Centrale*) is the catholic structure in the fight against HIV/AIDS in the Archdiocese of Libreville/Gabon. It is affiliated with many other groups and movements such as CARITAS, GSM, *Foyers chrétiens, Equipe notre dame, Légion de Marie, Renouveau Charismatique, Chevaliers de l'immaculée, SOJECS, MES, Disciples d'Emmaus, JEC, JOC, Chorale, Serviteurs du Christ, les amis de Jésus crucifié, Visitation, Triomphe de Marie, Toutes les chorales, les Commissions liturgiques Catholiques, et toutes les communautés ecclésiales de base.*

Objectives

The ACERAC's objectives from 2002 to 2003 were:

- To reinforce sensitisation in school, in parishes, in organised groups and universities using medias (TV, printed leaflets and banners, newspaper publication)
- To broadcast advertisements or spots on Television channels about voluntary counselling and testing before marriage;
- To actively involve clergy, pastoral agents and catholic school headmasters in the sensitisation in the fight against HIV/AIDS
- To disseminate accurate information about sensitive issues related to HIV/AIDS
- To reinforce the partnership with business world (public and private enterprises, trader unions) in Libreville and elsewhere.

Main Activities

- Day care prevention activities run at Sainte Marie, Saint Michel de Nkembo, Saint André and Rois Mages d'AKEBE
- Skills training for schoolchildren and students (College de Quaben, Immaculée Conception, College Bessieux, CEMEF, CEFOR, ESAM, ALFRED SAKER)
- Community talks with parents and their children during Christmas at Saint Jean Seminary in 2002
- Television spots and sensitisation
- Participation during the World AIDS Day
- Organisation of a regional consultation with Bishops and partners in the field of HIV/AIDS in order to assess best practises and to help churches address reasons for failure.

Results

- 4/6 Dioceses are fully engaged in the fight against HIV/AIDS
- A core group of trained Christians meet once a week in order to acquire the capacity to reflect on their concerns about HIV/AIDS, make decisions and changes in the area of prevention, name indicators of these changes, document their response, and transfer experience and skills to others.
- In collaboration with *Centre d'Evangélisation de Béthanie*: Elaboration of "ten commandments" against HIV/AIDS in Gabon

- *Cloche d'Or:* an HIV/AIDS newsletter used to be a resource learning material
- Twelve Bishops from Gabon, Congo/Brazzaville, DRC, Chad, Cameroon, and Central Africa Republic committed themselves to mainstream the issues of HIV/AIDS in their respective Dioceses.

5.3.2. Centre d'Evangélisation de Béthanie

The Centre d'Evangélisation de Béthanie received the complete endorsement and support of its partnership (Fédération des Eglises de Réveil du Gabon). There is one activist pastor who responded by working to build the capacity of partner churches. At the time the partnership was established there was limited HIV/AIDS programming due to lack of resources, education, material and services.

In conjunction with the National AIDS Control Programme, the Centre d'Evangélisation is also working to build capacity of churches from different denominations, enterprises and lastly the members of Parliament. The aim is to provide a comprehensive HIV/AIDS programme to equip church leaders, senior staff of enterprises and Member of Parliament in addressing the challenges of the HIV/AIDS pandemic within congregations and communities.

During the official launch of "ten commandments to fight AIDS in Gabon", the Archbishop of Libreville thanked the Centre d'Evangélisation de Béthanie for its commitment to working with faith communities in Gabon. The process of writing the Ten Commandments to fight against HIV/AIDS in Gabon has forged new linkages between the Catholic Church and the Centre d'Evangélisation de Béthanie. They have not only joint meetings but also they have developed a joint HIV/AIDS Spiritual Accompaniment requested by the National AIDS Control Programme.

The Pastor of Centre d'Evangélisation de Béthanie is finally seen as a vehicle with the National AIDS Control Programme using a common voice on policy issues. The weaknesses of Centre d'Evangélisation de Béthanie is that when its pastor is invited to carry out a workshop at any denominational church, the local pastors are not encouraged to take the lead to fight against HIV/AIDS within their congregations. Consequently, the activist pastor of the Centre d'Evangélisation de Béthanie felt overloaded and overworked with many responsibilities. Additionally, the relationship between the Catholic Church is more interpersonal rather than interfaith one.

6. YOUTH, SEX EDUCATION, HIV/AIDS AND MIGRANTS

6.1. The youth people

Rates of HIV/AIDS and other Sexually Transmitted Infections are increasing in sub-Saharan Africa including Gabon where AIDS is the leading cause of death. The interaction between HIV/AIDS and STIs are well known since STIs are very often precursors to HIV/AIDS. Whilst STIs can be treated successfully with antibiotics, no cure is not yet available for HIV/AIDS. This leaves prevention as the primary method for controlling the epidemic. In Gabon, youth are particularly vulnerable to STIs and HIV infection due to their high level of sexual activity, temporary sexual relationships, and insufficient of condom use, "sugar daddy phenomenon" and poverty.

"To overcome this situation, the ACERAC's Coordinator organised a 4 day-workshop in Libreville in order to discuss preventive measures and what could be done to curb the AIDS epidemic among the youth. The Coordinator invited a well-known Tanzanian priest as the main resource facilitator for the seminar. In the end of the workshop, the priest requested youth people who would like to remain abstinent to sign a written commitment. Most participants who were girls refused to sign it because sugar daddy provided them with financial and material support."

Comments

This statement is in contrast with the influential Roman Catholic Church, while active in the fight against AIDS, and steadfastly preaches abstinence before marriage. "*The Church favours dialogue above all else*", said Father José Maria who works with street children. "*We tell young people about the dangers they face if they have sex in an uncontrolled manner"*, he added.

AIDS is ravaging several countries African countries, and Gabon is no exception. The most recent estimates, issued in 2003, are that 6% of the sexually active population is HIV positive, a jump from 2.2 in 1989. In Libreville alone, the numbers are even higher: 7.8 % according to the government.

Although many youth realise that STIs and HIV constitute a threat for young people in their communities, some of them find it difficult to personalise risks and make required decisions to reduce the risk. Studies indicate that youth often use partner attributes such as appearance or reputation to determine whether they are safe (Hillier et al, 1998). Likewise, many youth presume that trusted partnership contain high level of emotional commitment, intimacy, and fidelity.

There are some opportunities in terms of youth networks such as *Union des jeunes Chrétiens Catholiques, Union des jeunes Chrétiens Protestants, and Union des jeunes Musulmans.* However, these networks are not fighting HIV/AIDS. In my opinion, there is a significant contrast in terms of AIDS prevention that is recognised as national priority in Gabon and in some churches since officials said that they have implemented intensive AIDS prevention programme and the unwillingness for the youth to undertake appropriate measures to address the HIV/AIDS crisis. This could be a matter of priorities setting. For instance a recent survey of 15-26 years-old carried out by UNICEF in Gabon, showed that unemployment was the main concern in life, with catching HIV in second place and poverty in third.

6.2. Sex education in Gabon

Mobilising churches to tackle sex education is not easy since sexuality is a taboo subject in Gabon particularly when HIV/AIDS is perceived as a theoretical threat. The traditional source of sex education in sub-Saharan Africa is the paternal or maternal uncle/aunt. In general, sex matters are not discussed at interpersonal level. This cultural tradition is no longer a viable strategy because of the increasing rural-to-urban rapid urban migration in Gabon and the subsequent social change.

Following this line of thinking, sex education is not considered necessary and is even unwanted, because "theory may lead to practice". Many church leaders have negative attitudes towards sexual education as they feel that sexual education is conducive to sexual promiscuity.

A priest from the Solidarity of Young Christians put it even more strongly when he says: "*In my view, contraceptives should not be distributed because they just encourage young people who have not yet had a sexual experience to try it. In addition, most of available contraceptives are often of poor quality in Gabon".*

Despite the many efforts, that churches and other interested organisations in the field of HIV/AIDS are deploying, in my opinion, HIV/AIDS is still perceived as a medical issue and church leaders are ill equipped to deal with. However, Catholics are to the fore of all the religious communities since during the mapping study, I attended a one day-workshop organised and facilitated by ACERAC in collaboration Mrs Lucette LALABACHE, Professor of Psychology at Sorbonne University. The workshop theme was "Understanding Human Sexuality: a challenge for a truly behaviour change in the context of HIV/AIDS in Africa".

This was the first time that such a sensitive topic was discussed in a participatory manner in the Catholic setting especially within a nun's convent. 50 participants of whom 30 were young people attended this workshop. This shows the hunger of accurate information on sexuality that the youth needs more.

Another issue that emerged during the mapping is the unwillingness and the reluctance that many parents are expressing to discuss sexual issues and HIV/AIDS with their children. The perception is similar to that of church leaders stressing that sex education will violate religious teachings as well as cultural norms and principles. Instead, abstinence must remain the name of the game. This constitutes an enabling environment for the youth to be exposed to double standard messages coming from various sources namely: the media, advertisements, culture and religion.

Peer support organisations face even greater challenges. The lack of role models and the fear of negative consequences for themselves or their family, have contributed to the fact that very few people living with HIV/AIDS are willing to identify themselves in any forum, let alone in public. SIDA-ZERO/GROUPE DES PAROLES, the national peer support network for people infected with, or affected by AIDS, is in contact with only about 100 PLWHAs nation-wide. Those who meet share their experiences about HIV although they come from different social, education and professional backgrounds.

Ms Emilie (PLWHA) said: "*In my family, nobody knows my new serological status. Very often, my parents kept saying that I should pay attention to HIV/AIDS whilst I am already living with the virus. I am very pleased to be part of SIDA ZERO/GROUPE DES PAROLES. In the end of its meetings, I feel relaxed and edified as I share my concerns with people who are HIV+ as I am."*

Many others like her are crying for open discussions with parents on sex issues including HIV/AIDS. Thus, a culture of silence, denial, stigma and discrimination is no longer the answer. People have a right to know their HIV status, and testing and counselling should be widely accessible through innovative, ethical and practical models of delivery even in the home environment. Whatever the route of HIV transmission could be HIV, testing and counselling are entry points to HIV-related care and prevention services.

6.3. HIV/AIDS and migrants

Gabon is one of the few stable countries in Central region. Therefore, it attracts many people who request asylum as refugees. There are now 20,000 refugees in Gabon. Most of them live in provinces such as Ogooué Ivindo, le Haut Ogooué, la Nyanga and la Ngounié. Refugees are very often moving to major urban areas by creating "spaces for urban poverty" where fornication, sex for many, homosexuality and paedophilia, and behaviour risks related to HIV and other STIs take place. Of course HIV/AIDS is a serious problem for refugees especially women and young girls who are vulnerable to HIV because of family breakdown, poverty, powerlessness, social instability, exploitation and sexual abuse. "*HIV/AIDS is a disease related to foreigners particularly refugees that come to Gabon to seek asylum*", a Gabonese woman said.

Not only local people, but also politicians, media people, people working at immigration services hold such resentments. This could one reason among other explaining immigration is so complicated to enter Gabon. In a world of increasing hostility towards asylum seekers, there are too many misperceptions about refugees and HIV/AIDS. Studies across the world documented that HIV/AIDS rates are lower in refugee camps than in surrounding populations. In addition, a new study found that the perception related to spread of HIV by refugees into the country of asylum following the transmission of HIV to host population false and discriminatory (RUUD, 2003).

What is outstanding in the Gabonese Strategy Plan 2001-2005 is that the National HIV/AIDS strategies to combat HIV/AIDS among the refugees are included. Therefore, refugees should neither be blamed nor they should be ignored. Instead, they must be actors rather than spectators in the fight against HIV/AIDS if sustainable response to HIV/AIDS is to be reached in Central Africa region, which is beset with armed conflicts and civil wars.

The international community has the responsibility of adopting innovative and creative approaches to fighting HIV/AIDS epidemic across national and international boundaries. Recent armed conflicts and civil wars in Rwanda, Burundi, DR Congo, Congo/Brazzaville, Chad and Central Africa Republic are self-explanatory about refugees moving across borders in Central Africa region.

7. GENDER ISSUES AND HIV/AIDS

In the context of HIV/AIDS, many factors count for why vulnerability and risk differ for men and for women, and for men and women at different ages. There are three critical factors-all interconnected-that place gender issues at the core of HIV/AIDS in Gabon. Some are physiological, where women's risk of infection is higher than in men. Others

are socio-cultural, reflecting different roles, norms, and expectations and duties. Finally, economic reasons that influenced over assets such as productive resources, employment and education entailed different in power relationship. The power relationship between men and women grounded in economic inequality and vulnerability are the major factors contributing to the spread of HIV/AIDS. The July 2000 Durban conference on AIDS identified power relations between men and women as fundamental to both sexuality and gender.

> The unequal power balance in gender relation that favours men, translates into an unequal power balance in heterosexual interactions, in which…men have greater control than women over when, where, and how sex takes place. An understanding of individual sexual behaviour, male and female, thus necessitates an understanding of gender and sexuality as constructed by a complex interplay of social, cultural and economic forces that determined the distribution of power. Source: Geeta Rao Gupta

A major problem is the lack of information and insufficient analysis of the responses that failed to address social, economic, and power relations between women and men. In fact, strategies to prevent the spread of HIV have focused on the promotion of condom use, reduction of sexual partners, and treatment of STIs. Additionally, most HIV surveillance studies have been done among pregnant women and female sex workers, leading to a tendency to "feminise" the epidemic on women, although it could be that the epidemic is concentrated among men. The dynamics of HIV transmission in the context of men's vulnerability have received little attention. Consequently, prevention strategies have concentrated on women and school children, while prevention efforts among particularly vulnerable groups have not been taken to scale.

Unfortunately, I did not come across many women's organisations dealing gender issues and HIV/AIDS. *Pont de la Vie*, a new Non Governmental Organisation is addressing discrimination, inequalities, low education status, economic dependence on men in a timid way. In churches themselves, women are very often excluded from decision-making process. Since the Gabonese society is a male dominating society condoning the subordination of women, one could understand why desperate measures such as "prestigious prostitution", sexual promiscuity and begging are still the strategies implemented particularly by women and young girls who have kids to feed.

Another issue that is worth to be mentioning here is the wide misconception that sex with virgin (girl child) will cleanse an infected man of HIV/AIDS. Some traditional healers and witchcrafts promote this strategy whose recommendations clash with those of scientific medicine. This misconception has to be addressed in a meaningful way since this could lead to increased incidence of rape among young girls. As far as HIV/AIDS is concerned in Gabon, one of the lessons to learn is the need to address openly the underlying cultural and behaviour factors that contribute to the spread of HIV particularly among women.

8. POVERTY, HIV/AIDS AND HUMAN RIGHTS

In Gabon, 75% of the general population live in urban areas where financial hardship, sexual promiscuity and poverty are conducive to the spread of HIV. As mentioned earlier, Gabon still relies on wood and oil, which lost its values because of international market uncertainty. The subsistence agriculture sector is underdeveloped and Gabon is provided with food by neighbouring countries namely Cameroon, etc. According to a recent study carried out by the World Bank, 20% of Gabonese living in Libreville and Port-Gentil are falling below the line of poverty. Rural exodus increased since most of unproductive people reach main urban areas where unemployment is high.

Gabon is ranking among the intermediate income countries although it is heavily indebted. Due to its so-called "high income", Gabon cannot benefit from assistance provided to other African poor countries. In response to this, the Gabonese government reacted to the spread of HIV/AIDS by setting up a billion XAF (USD 20 million) solidarity fund to help people living with HIV/AIDS and prevent the disease from spreading. However, this study did not look at the efficiency of this huge amount of money.

Another problem that I came across is that many people living with HIV/AIDS cannot afford treatment at local hospitals, some of which quite plain that AIDS patients are not welcome because of stigma and discrimination attached to HIV/AIDS.

"Dr Chantal Zamba is well known in this country as the medical doctor that deals with HIV/AIDS epidemic. Last week, she sent me to the laboratory for ordinary medical check up. The lab technician was not pleased to take my blood for examination because of Dr Chantal's signature. I wasted 3 hours without being tested since the lab technician knew that I was HIV positive", a PLWHA said.

By contrast, the medical signature might have a positive effect in certain settings. Another PLWHA commented:

"I went to my insurance company with a letter written by Dr Chantal Zamba in which she asked my insurance company to provide me with financial resources for medical reasons. Since the cashier knew Dr Chantal's good job in the field of HIV/AIDS, he gave me the money without delay".

Despite the existence of mixing results, time is come to mention that stigma and discrimination are still rampant from the political level down to the community in Gabon. Few people know their serostatus and the motivation is constrained both by the lack of subsequent availability of treatment and denial. In addition, the widespread ignorance of HIV status is the result of poor access to HIV testing, or serious problems with its delivery and uptake.

In Gabon, the lost of opportunities for providing care and for strengthening prevention efforts are enormous because of legal aspects of HIV/AIDS that are not respected once somebody is found to be HIV+. The table below illustrates the motive of doing HIV testing.

Table 8: Motives of testing

Motive	*Number of testing*	*% of tests*
Not known motives	297	3.29
Administrative reasons	225	2.49
STIs related motives	480	5.32
Antenatal clinic	2156	24.00
Blood donation	2708	30.00
Spontaneous reasons	1165	13.00
Clinical suspicious	1989	22.00
Total	9020	100.00

Comments

12. Unless stigma and discrimination are progressively replaced by acceptance, care and support for people affected and infected by HIV/AIDS, the changing face of the HIV/AIDS epidemic that has resulted in many opportunities, as well as imperatives might not increase access to HIV testing and counselling and to knowledge of HIV status.
13. Time has now come to implement HIV testing and counselling more widely using existing health-care settings, moving beyond the model of provision that relies entirely upon concerned individuals seeking out help for them to permit broader access for all in respect to human rights.
14. Increased access to care and treatment, and decreased stigma and discrimination in Gabon present new opportunities associated with taking an HIV test.
15. The right one has to know his/her own serostatus helps communities reduce the denial, stigma and discrimination surrounding HIV/AIDS as well as mobilise support for appropriate responses.
16. The information presented here relies on service statistics and on expert assessment and is therefore much less precise than estimated based on population-based surveys.
17. These results should be interpreted with caution but they are useful indicating the starting point in effort to achieve future goals.

9. RESOURCE FACILITIES

9.1. Réseau National Pour la Santé de la Réproduction des Adolescents et des Jeunes (RENAPS A.J.)

is an institution dedicated to strengthening the capacities of organisations and youth working in the field of reproductive health, population and development in order to contribute to improving the quality of life of families in Gabon. To achieve its mission RENAPS A.J conducts workshops, seminars and refreshing courses for youth in order to help them acquire life skills because of the widespread of early sexual debut and subsequent sexual promiscuity. Highly qualified professionals, who form a multidisciplinary team within the fields of reproductive health and population and development, provide its service in three provinces in Gabon. RENAPS A.J is looking forward to scaling-up its programme to the remaining six provinces since RENAPS is opened to working with youth from different religious backgrounds.

9.2. SIDA ZERO/GROUPE DES PAROLES

is forum where HIV infected and affected Gabonese and their care givers meet together to share experiences, ideas and updates on the responses to the HIV/AIDS epidemic. During the mapping study, I noticed how quickly trust levels developed in the group when a PLWHA who submitted to be member of the group came to justify why she could not attend the meetings so far. She said that she lacked money for transport in order to be part of the group every day. Additionally, she went on saying that she was worried because of her son who is HIV+ did not get medicine for opportunistic infections. The group care for the women by identifying somebody else who was living with her in the same area to look after her when this is needed. A quick fund raising between the members gathered some money that was given to her for satisfying her needs. Furthermore, the members raised concern about income generating activities. They bought a ground where crops and vegetables could be sown. While some members participated with financial contributions, others promised to offer the work force in terms of weeding the field.

9.3. REGOSIDA

Following the theological reflection on HIV/AIDS and the theology of compassion and healing that were organised by the Ecumenical HIV/AIDS in Africa respectively in Yaoundé and Brazzaville. Upon their return at home, the workshop participants established the platform whose mission is to work ecumenically through church structures at grass root level by training pastors and volunteers to not only raise HIV/AIDS awareness, but also to provide care, training, and support, and follow-up.

9.4. RESEAU GABONAIS DES PERSONNES VIVANT AVEC LE VIH/SIDA (REGAP).

Began in 2003, REGAP is meant to be the response to the widespread misperception that AIDS is contracted because of sin that has caused intense stigma and discrimination towards people living with HIV/AIDS and their families. REGAP has a large network of volunteers and peer educators who work in communities, clinics, youth centres, office and projects. REGAP is committed to the fact that it is only by confronting stigma and discrimination that the war against HIV/AIDS will be won. "*Responding to AIDS with blame, or abuse towards people living with AIDS, simply forces the epidemic underground, creating the ideal conditions for HIV to spread. The only way of making progress against the epidemic is to replace shame with solidarity, and fear with hope*…" Peter Piot.

9.5. Centre de Traitement Ambulatoire (C.T.A)

CTA is among the few organisations that provide access to voluntary counselling and testing in Gabon by offering free confidential testing services through local health facilities. Additionally, CTA is providing treatment for opportunistic infections, including tuberculosis, antiretroviral therapy and palliative care and psychosocial support. The professional counselling offered at CTA so far helps one make informed choice on whether or not to take an HIV test. CTA helps and encourages one to know his/her HIV status and live positively with whatever the result.

Care and understand by ensuring proper and prompt medical attention in sickness proved to be of great value. I met a PLWHA in C.T.A who told me that if she had a job she would not care about the HIV/AIDS infection. What is harmful for her is unemployment and not the HIV/AIDS since her child who is also HIV+ is not provided with proper medical care.

CONCLUSION

My first conclusion is that churches like society as whole are being devastated by HIV/AIDS and the church responses is a brave effort to raise the congregation awareness in order to involve them in the control of HIV/AIDS. However, in Gabon, the Christian response is currently inadequately arranged for effective church responses towards HIV/AIDS since most of them are weak and scattered. Christians end up with inaccurate data and only half of the message because of misconceptions and theological barriers that need to be overcome by Christians in the struggle against HIV/AIDS. Since HIV/AIDS is a major problem not only for churches but also has damaged economic aspects for Gabon, it is important that the necessary, updated and accurate information is given.

Next, apart from the Catholic and the Revival Churches, silence is the motto in many Gabonese church settings. Many church leaders remain detached, silent and inactive not only to combat HIV/AIDS but also in advocacy and policy development. In my opinion, I think that church leaders should play a crucial role in the HIV/AIDS control if in-service training programme about the disease is provided and if they fully understand that addressing the HIV/AIDS issues is a key part of their Pastoral ministry.

Moreover, some churches have the willingness to fight against HIV/AIDS accordingly, but they have limited resources. Since Gabon is ranking among the intermediate income countries, major donors have not found ways of reaching small, community level groups with funding to scale up the church efforts to combat HIV/AIDS. Consequently, most funds are driven to the government's institutions with no or little implication of church structures. There is no doubt that churches are well positioned to mobilise people and implement programmes, especially at the local level. Therefore, coverage for services related to prevention, care, treatment and support would need to increase significantly through churches in the next few years if the goals of the Declaration of Commitment on HIV/AIDS and the millennium development goals are to be met.

The data available from this mapping clearly indicate that, although progress has been made in some areas, such as blood screening, much work remains to bring essential services to a significant portion of the population in need. The perception that AIDS is contracted because of sin has caused intense stigma and discrimination towards people living with HIV/AIDS and their families. Stigma and discrimination has enabled HIV to spread unchecked over the last twenty years in Gabon. Time is come to stress the theology of compassion in church settings because stigma and discrimination associated to HIV/AIDS is one of the greatest barriers to preventing further infections and to accessing the care, support and treatment that allow people living with HIV/AIDS to lead productive lives. Christians are called by God to show compassion, love, and mercy and to serve others without judgement. Therefore, there is an unprecedented urgency for compassionate care of those infected and affected by HIV/AIDS including any other dangerous infectious disease.

In Gabon, talking about sexuality is a taboo. Since HIV/AIDS is inextricably intertwined with human sexuality, the church is often reluctant to talk forthrightly about sexual behaviour activities that encourage alternative prevention measures such as abstinence and fidelity, which have received scant attention in most HIV/AIDS strategies. The church should be the forum where every one enjoys sexual and reproductive health rights and access to services in a society free of sexual violence and HIV/AIDS. During the mapping, REGOSIDA organised a workshop entitled: "understanding the human sexuality". This workshop proved to be of great value taking into account the lively and constructive discussion that followed. This is an indication to me that sexuality could be discussed in church settings and the church could provide a welcoming community to those who are willing to break the silence surrounding sexual issues. Churches must become involved in affective and sexual education for life in order to help young people and couples discover the wonder of their sexuality and their reproductive capacities. Out of such wonder and respect flow a responsible sexuality and method of managing fertility in mutual respect between men and women.

The result of this mapping study suggests that most people in Gabon do not have access to several key prevention and care services. In addition, access is very low for voluntary counselling and testing, the prevention of mother-to-child, antiretroviral therapy and prophylaxis for opportunistic infections. The services are available are usually located in capital cities and other urban areas and not in rural areas. Churches that I met in Gabon had national coverage since they reached from the educated elite to the urban slums to the village. It is well known that Churches

often provide high quality services than government or secular institutions, with political constraints and more highly motivated personnel. This set of compared advantages of churches necessitates churches to play a crucial role in combating HIV/AIDS if the results have to be sustainable in Gabon and elsewhere.

Successful HIV/AIDS programmes in sub-Saharan Africa have involved local communities in the design, preparation and implementation of activities. However, most communities particularly churches lack the resources to mount programme of adequate scope and the Central Government in Gabon lacks the means to deliver resources quickly and sustainably to the community. Towards this end, African leaders and the International Community at large have recognised the need for quick, forceful and sustain action against the epidemic. Guided by these principles, Global Funds and the Multi-Country HIV/AIDS Programme (MAP) are established to channel funds directly to the communities. The Revival Church Pastor who is the vice-president of Global Fund could be influential to help churches benefit from those funds.

Finally, one has to realise that poverty goes hand in hand with HIV and AIDS since the fragile economies should be further weakened with much of the trained labour force lost to HIV/AIDS. Poverty facilitates the transmission of HIV/AIDS, makes adequate treatment unaffordable, accelerates death from HIV-related illness and multiplies the social impact of the epidemic. In the light of these issues, Christians are called to "let all the parts of the one body feel the same concern for one another". The battle against AIDS ought to be everyone's battle. Therefore, I urgently ask church leaders and other interested people of good will in the field of HIV/AIDS moved by love and respect due to every human being, to make use of every means and opportunities at their disposal in order to bring gradual improvement by slowing down the epidemic for God's glory. "Never give in then, brothers and sisters, never admit defeat, keep on working at the Lord's work always, knowing that, in the Lord, you cannot be labouring in vain" (1 Corinthians 15: 58)

RECOMMENDATIONS

Based on the findings the following issues have implications in the design of appropriate church response on HIV/AIDS:-

Policy

- The HIV/AIDS issues must be raised as a high priority on the church agenda, ensuring that it is streamlined, coordinated and included in all church endeavours;
- Churches should focus on breaking barriers to effective HIV/AIDS prevention, care and support. It is only by confronting stigma and discrimination that the war against HIV/AIDS will be won;
- Churches have to rise above theological differences to collaborate in addressing the suffering caused by HIV/AIDS;
- Churches should make use of being represented at the Country Coordination Mechanism to advocate boldly in national settings for policies favouring the poor and marginalised and for increased resources for the struggle against AIDS;
- Churches should pay for God's blessing on those infected and affected by HIV/AIDS and show compassion, love, and mercy to serve others without judgement.

Congregations

- Church leaders should help their congregations break the silence and eliminate the stigma and discrimination surrounding HIV/AIDS and provide a welcoming community to those infected and affected;
- Church leaders could undertake special programmes that can mitigate the impact of HIV/AIDS by addressing some of the most severe problems such as reduced school fees can help children from poor families and AIDS orphans to stay longer at school;
- Church leaders should empower men, women and youth to rise above the predominant, often destructive, sexual practices including female genital mutilation;
- Congregations should support and care for people and families who are living with HIV/AIDS and doing this as an integral part of "the competent AIDS church" at the congregational level
- Church leaders should also help design refugees and migrant populations as a target group for HIV/AIDS interventions

Communities

- Communities are well positioned to mobilise people and implement HIV/AIDS programme, especially at the grass root level with an unprecedented urgency for compassionate care of those infected and affected by HIV/AIDS;
- Church leaders must teach communities to consider women and youth, two vulnerable groups, that are often not accepted as equal members of the faith community to play a leading in the fight against HIV/AIDS;
- Communities need precise information, up-to-date and complete factual information as part of the church preventive work, both as regards the causes of the epidemic and its dimensions and consequences, and as regard on how HIV/AIDS is linked to other issues;
- Church leaders should teach communities on unpleasant and unfounded beliefs and myths such as some men believe sex with a virgin and young girls can cleanse them of HIV/AIDS;

Counselling

- AIDS is not a sin; pastors cannot stop discordant couples from being married. Instead, church leaders should establish voluntary counselling and testing facilities where couple should make informed decision on their marriage;
- Church leaders should encourage members of their congregations and communities, especially those intending to marry, to get to know their HIV status through voluntary counselling and testing and develop positive attitude;
- Church leaders should ensure that all church members involved in the HIV/AIDS work observe both in public and private life the following values: confidentiality, respect, integrity, stewardship, faithfulness and diligence, etc.;
- Churches should promote primary and secondary sexual, abstinence, and faithfulness in marriage and avoid condemning the use of condoms;

Advocacy

- Church leaders should advocate for open, constructive and frank discussion on sexuality and HIV/AIDS;
- Church leaders advocate for gender considerations regarding access to resources, education, health care, other essential services, decision-making in communities and sexual practices;
- Church leaders should advocate for accessible and affordable antiretroviral and opportunistic infection drugs;
- Church leaders should advocate for the support of marginalised and disadvantaged people such as orphan and vulnerable children, etc.
- Church leaders should advocate for dignity and human rights for people living with HIV/AIDS and their families;

Networking

- Churches should collaborate with National AIDS Council, National AIDS Control Programme, other government departments, parastatals, other churches, NGOs, Community Based Organisations, AIDS service organisations, religious institutions and groups, national and international partners.
- REGOSIDA should be revitalised since it constitutes an appropriate channel and forum for advocacy and lobby.
- Church leaders could reduce to some extent the impact of AIDS on household level by submitting to the government project proposals that could address the most severe problems. Such programmes could include home-based care for people with HIV/AIDS, support for the basic needs of households copying with AIDS, foster care for orphans, food programmes for children and support for educational expenses etc.